Final report

"Rapid qualitative assessment of the impact of Pantawid Pamilyang Pilipino Program (4Ps) on nutrition outcomes in beneficiary households in selected municipalities"

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unicef

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Abbreviations and acronyms

4Ps	Pantawid Pamilyang Pilipino Program
ADB	Asian Development Bank
CCT	Conditional Cash Transfer
CVS	Compliance Verification System
DepEd	Department of Education
DOH	Department of Health
DSWD	Department of Social Welfare and Development
EPRI	Economic Policy Research Institute
FDS	Family Development Sessions
FGD	Focus Group Discussion
FNRI	Food and Nutrition Research Institute
KII	Key Informant Interview
MIS	Management Information System
NHTS-PR	National Household Targeting System for Poverty Reduction
NNC	National Nutrition Council
NNS	National Nutrition Survey
OTP	Operation Timbang Plus
PIDS	Philippine Institute of Development Studies
PHP	Philippine peso
PMT	Proxy means test
PPAN	Philippine Plan of Action for Nutrition 2017–2022
RHU	Rural Health Unit
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene

Executive summary

Background

Since 2008, the Philippine Government implements the flagship social protection programme *Pantawid Pamilyang Pilipino Programme* (4Ps) – a conditional cash transfer targeted at poor households with children below the age of 18 years and/or pregnant women. While the programme has……. on education- and health-related conditions, questions around its impacts on beneficiary children's nutrition status have risen to prominence, especially in light of the prevalence of high stunting and wasting in the country. However, so far, different impact evaluations of the 4Ps have revealed mixed results on the programme's impact on nutrition indicators.

Assessment purpose and scope

The **purpose** of this assessment is to bridge the evidence gap between past impact evaluations and to understand reasons for the mixed impact on nutrition outcomes of the 4Ps programme. The findings provide additional background information for the evolving policy discussions on nutrition-sensitive social protection in the Philippines, and more specifically on the role of the 4Ps in achieving nutritional outcomes. The **scope** of the study entailed a rapid, largely qualitative assessment of the 4Ps' impacts on nutritional outcomes in six selected municipalities in the provinces of Bulacan, Catanduanes, Lanao del Sur, Negros Occidental, Samar and Zamboanga del Norte. These municipalities were selected based on criteria such as the prevalence of stunting and wasting, the number of 4Ps beneficiaries and the share of indigenous people living in the area.

Methodology and limitations

The assessment was guided by UNICEF's conceptual framework for malnutrition, which is also employed in the Philippine Plan for Action on Nutrition (PPAN), which focuses on the first 1,000-days between conception and a child's second birthday as window of opportunity to impact children's nutritional status. The framework identifies several factors influencing malnutrition and distinguishes between basic, underlying and immediate causes of malnutrition. The **basic causes** are rooted in the wider socio-economic context of the community and national level, while u**nderlying causes** relate to factors at the household level, namely ***food*** insecurity, inadequate ***care*** practices, and ***health*** services. All these factors are linked to each other and mutually reinforcing. In combination, they form the basis of the **immediate causes** of malnutrition, which are insufficient dietary intake and disease, because they determine children's nutritional intake and health status at the individual level.

To carry out the assessment, a range of methods, including a structured literature review and participatory research to collect and analyse primary, qualitative data through key informant interviews, focus group discussions and in-depth interviews, was employed. In addition, a short quantitative household survey was administered to selected households to gather some key characteristics of the sample. Prior to interviews and discussions, informed consent of all

participants and interviewees was gathered, and the purpose of the assessment, their role within the assessment, and what kind of information will be asked from them was explained.

The representativeness of the findings of this assessment are limited by the geographic scope of the assessment as the six municipalities were purposively chosen to participate in the assessment. Additionally, the quantitative household survey merely serves to support and triangulate qualitative findings and to outline key characteristics of the households included in the sample. The findings presented in this report on household's and children's food security, as well as health and child nutrition status are based on caregiver's self-assessment and therefore may suffer from perception bias.

Findings

The assessment explored to what extent the 4Ps has impacted the food security, health care and care practices in 4Ps beneficiary households and to what extent these were translated to outcomes at the child-level. The assessment also investigated the circumstances under which the programme has achieved impacts and what main barriers to achieving impacts currently exist.

4Ps design and implementation

In terms of reaching vulnerable households, across all six locations there are vulnerable households with children that are currently not included in the 4Ps, as targeting is carried out using *Listahanan* 2009/10 data. In addition to not reaching all poor and vulnerable households, the 4Ps programme currently also does not formally capture any children born since then. Most beneficiaries agreed that compliance with the health conditions is not stressful and that they would go to the health facility even after the transfer had ended. This can partially be ascribed to the 4Ps condition to attend Family Development Sessions, as beneficiaries confirm that they do apply the information on care practices and health seeking behaviour. Beneficiaries report to enjoy the sessions and observe improvements in their overall mental attitude.

Most beneficiaries reported that they primarily spend the cash benefit on expenses related to schooling of children, transportation to health facilities and food items such as rice, fruits and fish, among other things. While this shows that households do consider child-needs and care practices when prioritising expenditure items, most beneficiaries agreed that the cash benefit is too low to adequately augment their household income. They mentioned rising costs of living as a major reason for the corroding value of the cash transfer. Especially bigger households consider the value of the cash grant as too low because it is ultimately shared between all household members. The assessment found that in some locations, payments are on time while in others, where the same payment modality is used, delays increased recently. Less frequent pay-outs and delayed pay-out make it more difficult for beneficiaries to plan their purchases and expenditures. Without knowing when the next cash transfer will be paid out, beneficiary households often resort to borrowing money from lenders, in order to smooth/maintain their consumption until the next payment.

Underlying causes of malnutrition and 4Ps impacts

Most beneficiaries across locations said that the cash transfer had positively impacted their food security (access to food), their food consumption (quantity of food) and food diversity (quality of food). Beneficiaries reported that overall, the quantity and quality of food they consumed had improved because of the 4Ps. Beneficiaries also mentioned the FDS as a reason for the improved variety in their meals, as they learned different, more nutritious recipes there. Bigger households, with a higher dependency ratio, tended to be more food insecure.

The assessment further looked at the use of health care services and their quality, with most beneficiaries mentioning vaccinations, growth monitoring, and getting vitamins and supplementation for children as the most commonly used for children. Beneficiaries also visit the health facility to check on the availability of free medicines which is frequently disappointing, leading beneficiaries to buy medicines for instance at hospitals. These out of pocket expenses, as well as transportation cost were mentioned as the most frequent obstacles to using health services. The 4Ps cash transfer, however, supported households in covering these health-related costs.

Further, to assess the role of care for nutritional outcomes, caregivers were asked to rate their own health, with two thirds of beneficiaries rating their own health as 4 or 5 out of 5. Some caregivers mentioned serious physical illnesses affecting them while others emphasized the stress and physical burden of being a parent and symptoms of other forms of stress. Parents identified their financial situation as biggest source of stress and the worry to not being able to afford enough food for the household and the transportation fare for school children also severely stresses them. Many beneficiaries mention the FDS as a source for care practices they apply, yet most caregivers use traditional knowledge and family members to learn about care. Although only one mother made explicit mention of complementary feeding practices, most mothers cite correct feeding practices for infants. The assessment found that nearly all primary caretakers are women and that a third of all female caregivers have no help with childcare and household.

Immediate causes of malnutrition

The dietary intake of most 4Ps beneficiaries has changed with the availability of more cash in the household, as the quantity and quality of foods consumed increased. This applies for all children living in the household, irrespective of whether the individual child is enrolled in the 4Ps programme him or herself. A substantial share of all focus group discussants stated that they like to take their children to a fast food restaurant on payday, as a special treat and a way of family bonding. Similarly, most caregivers assessed their children as healthy and caregivers seemed to be aware about the effects that their own health has on their children's health. The assessment found that the cash transfer does strengthen household food security and that the FDS empower caregivers to fulfil parental roles more adequately. The 4Ps functions as a platform to connect beneficiaries with other existing, complementary initiatives.

Factors promoting impacts

Overall, the 4Ps **cash transfer has strengthened the food security** of beneficiary households. The transfer constitutes a (more or less) regular form of household income, which allows households to plan their food expenditure accordingly. As a result, for most households the 4Ps cash grant positively impacts the quantity of foods that they buy, as well as the diversity of foods. The specific ways in which the cash transfer impacts the households, are largely defined by the household's economic situation and the income generating activities of adults living in the household. In households where no adult earns a regular income, or income is only seasonally earned, the cash transfer plays a bigger role in impacting the availability and quantity of food.

The **family development sessions seem to have played a major role in empowering caregivers**. By providing caregivers with knowledge on a range of topics they felt empowered and better equipped to handle their children in different situations and overall learned to be more confident in their interactions with children and other household and community members. In bringing together caregivers from different households to learn and discuss together, the FDS have also played a vital role in creating a feeling of community among caregivers. By addressing caregiver stress, empowering them and overall enhancing their well-being, the FDS thus, at least partially, addressed underlying cases of malnutrition resulting from inadequate care practices.

Through its **linkages to other initiatives**, 4Ps has shown to be able to promote impacts on household's food security and also sanitary environment, which will ultimately impact the health of children and other household members. By providing FDS participants with seedlings or linking beneficiaries to free toilet bowl initiatives, for example, the programme contributed to promoting nutrition impacts by addressing underlying drivers of malnutrition at household level.

Factors hampering impacts

The 4Ps cash **benefit level** has not been adjusted to inflation since programme roll out, resulting in a substantial decrease of the real value of the transfer. With increasing prices of foods, beneficiary households cannot purchase the same amount of foods as they used to. Likewise, the limitation of the education grant to three beneficiary children per household has limited the cash transfer's potential to enhance household's food security. As the cash grant is shared among all children, or even household members, the grant value per capita is relatively low, particularly for bigger households, in turn reducing the cash transfers' ability to achieve meaningful impacts.

Furthermore, the **irregularity and infrequency of payments** in some locations, usually linked to a change in the payment modality, constitutes a barrier for the cash transfer to achieve more profound impacts. Not knowing when the next payment comes, reduces beneficiaries' ability to plan their food purchases and expenditure. In locations with less frequent pay-outs, beneficiaries frequently borrow money and/or food to bridge the gap between payments and once the 4Ps cash transfer is paid out, the money is used to pay back the borrowed money plus interest.

Moreover, reliance on the 2009 wave of the Listahanan for targeting of the cash transfer means that all newly poor families and families that did not have children in 2009 yet, are **excluded from the 4Ps programme**. In addition to not reaching all poor and vulnerable households, the 4Ps programme currently also does not cover the youngest children living in 4Ps beneficiary households. While the cash transfer is typically shared among all children living in the household or even all household members, the lack of enrolment of younger children in the household, means that the education and health conditions are not monitored for these children. With the first 1,000 days constituting the primary window to achieve nutritional outcomes for children, the 4Ps thus misses a major opportunity to positively impact the nutrition outcomes of beneficiaries.

Whereas the FDS are a popular activity among beneficiaries, the **transmission of knowledge and information to beneficiaries to induce behavioural change seems to be falling short**. A major challenge to more effectively transfer knowledge and induce permanent change seems to be the format that the FDS are currently conducted in. The spaces are often too crowded and loud, and presenters do not make use of microphones and visual aids to better engage the beneficiaries. Moreover, the modules on health and nutrition are rather brief and do not provide detailed enough information.

Likewise, there is **limited monitoring** as to whether beneficiaries apply knowledge acquired during the FDS. For most sessions, no monitoring activities are carried out, as also indicated by some beneficiaries not being able to recall topics covered during the last FDS. Together with the non-conducive learning environment that FDS are conducted in, the lack of monitoring likely also contributed to limited behavioural change at household level.

Basic factors hampering nutrition impacts

Basic factors, such as access to and quality of services and the broader socio-cultural, economic and political environment can influence the nutrition status of children. And while the 4Ps programme does not aspire to directly impact these basic factors, the latter still play a significant role in determining the 4Ps success in positively impacting the nutrition status of its beneficiaries, as these factors shape the environment within which the programme operates. Lack of **economic opportunities** for beneficiary households in the assessed municipalities, shortage of medical supplies and free medicines in **nearest health facilities** and limited **availability of resources** for the wider nutrition response, all seem to play a role in hampering the 4Ps ability to more positively influence children's nutritional status.

Conclusions

The assessment further found that more positive outcomes were observed when the payment cycle was **frequent, timely and reliable**. Many households largely depend on the cash grant under the 4Ps because they do not have a regular income. The **size of the household** plays a role for improved outcomes and key informants report that they observe a link between caretaker well-being, including mental and physical appearance, and programme outcomes. Likewise, **financial**

constraints hamper beneficiaries from experiencing stronger positive outcomes. It was further found that beneficiaries felt that food security improved, that beneficiaries use health care regularly and that caregiver health plays a decisive role for child health. Likewise, through the FDS, the 4Ps influences knowledge and attitudes of beneficiary households to some extent, however permanent behavioural changes in the areas of nutrition remain to be achieved. Finally, positive nutrition outcomes were observed more often, when households benefitted from mutually reinforcing interventions, for instance in sanitation and nutrition programmes.

Recommendations

To strengthen the observed, positive outcomes on beneficiary children's nutrition status, a range of recommendations are proposed:

Periodically retarget the 4Ps programme to ensure that vulnerable children and households are covered. Crucial in this is the updating of the *Listahanan*. If updated regularly and adequately, this step can safeguard the inclusion of pregnant women and children below the age of five years, a prime target group, if nutritional impacts are to be achieved.

Revise the benefit structure and regularly adjust the benefit level to inflation to ensure that benefits reach households and beneficiaries as designed and counters dilution of the benefit level. To achieve that 4P beneficiary households and children do receive the benefit amounts as intended by design, it should be assessed whether the limit of three children per households can be lifted and/or whether the health grant could be provided on an individual per child level, instead of per household basis.

Strengthen the quality of the family development sessions by improving the infrastructure of locations, as well as the relevance of modules. Relatively straightforward steps, such as providing microphones and visual aids to the speakers during FDS, could go a long way in establishing a more conducive environment to provide participants with relevant information and also engage them better in an interactive discussion, as opposed to a one-way lecture that FDS currently resemble.

Integrate nutrition indicators within the 4Ps management information system (MIS). Currently, the anthropometric measurements for 4Ps children are captured during visits to health facilities but not integrated into the programme MIS, neither recorded in the compliance verification forms nor used for compliance tracking. By integrating these indicators into in the programme MIS, implementing staff would be enabled to continuously track the status of beneficiary children at any given point in time and monitor progress (or lack thereof) more effectively.

Linking the 4Ps more explicitly to nutrition-specific activities and nutrition-related outcomes, for example by tagging 4Ps children in the OTP and feeding programme for malnourished children. This could help to create more evidence on the nutrition status of 4Ps children, enable monitoring of their status, and create more awareness among 4Ps caregivers, that the nutrition status is relevant and being monitored.

Further formalise and structure linkages of 4Ps to other initiatives and programmes, especially in the realm of livelihoods development and income generating opportunities. As a cash transfer programme, the 4Ps can provide income support to households, however, cannot replace income generating and livelihood opportunities for households. Hence, there is a need to better link and formalise linkages from 4Ps to livelihood programmes and employment opportunities.

Link the 4Ps programme to a more elaborate case management mechanism to facilitate integration and coordination and effectively support and monitor outcomes at household- and child-level. Nutrition outcomes are complex to achieve and depend on a myriad of factors at household- and child-level, and hence, households might require support tailored to their specific needs. Case management can support this approach by assessing the individual household's situation and linking the household to relevant services.

1. Background and context

1.1. Achieving nutritional outcomes through social protection

Adequate, nutrition-sensitive interventions and programmes targeted at the 1,000-day window offer a chance to positively impact nutritional indicators of children. As malnutrition is the result of multiple causes, achieving nutritional outcomes and impacts is complex and requires a multidimensional effort. As a result, the design and effective implementation of a well-rounded, effective and sustainable intervention is highly complex. There is no one single cause for malnutrition, but instead, malnutrition is the result of a variety of interconnected economic and social risks and vulnerabilities. Furthermore, the causes of malnutrition vary in space, time and according to households' livelihoods and social, economic and cultural characteristics.

Fighting malnutrition comprehensively through means related to social protection and addressing the different types of causes requires a combination of short- and long-term actions, as well as curative and preventative aspects of interventions, which can be achieved through increasingly fostering linkages between different social protection interventions. Well-designed social protection interventions can be instrumental in addressing the different causes of malnutrition. At the individual and household level, social protection programmes, in particular cash transfers, can directly help to (i) increase overall food consumption (quantity of intake); (ii) improve dietary diversity (quality of intake); and (iii) increase utilisation of health services, by providing households with the necessary financial means. Social protection programmes can also influence other determinants of nutrition, such as practices related to child care and feeding, and sanitation.[1]

The existing UNICEF conceptual framework for malnutrition picks up the various determinants and defines basic, underlying and immediate causes of malnutrition (see ***Figure 1***). Wherein the basic causes are related to the wider socio-economic context at community- and nation-level, the underlying causes relate to the household level. Within the household, three categories of underlying causes of malnutrition can be defined – ***food*** insecurity, inadequate ***care*** practices, and unhealthy household environment, including poor access and availability of ***health*** services. Food insecurity comprises the challenges household's face in the availability, access, utilization and stability of safe and nutritious food supply; whereas inadequate care practices can entail poor breastfeeding, inadequate complementary feeding practices, poor personal hygiene and child care, among others. Unhealthy household environment and poor access to, and availability of health services also includes a lack of clean and safe water, as well as sanitation. All of these underlying factors are intertwined and contingent on each other, eventually determining children's nutritional intake and health status, which are the immediate causes of malnutrition at

[1] (UNICEF, n.d.)

the individual level. Both immediate causes are interlinked and directly define children's nutrition outcomes.

Consequently, when assessing the nutritional status of children, all underlying and immediate causes, as well as basic causes, such as the broader socio-cultural, economic and political context, within which households and children exist, must be explored. Neither of the single cases can provide a full explanation for nutritional outcomes, when assessed in isolation.[2]

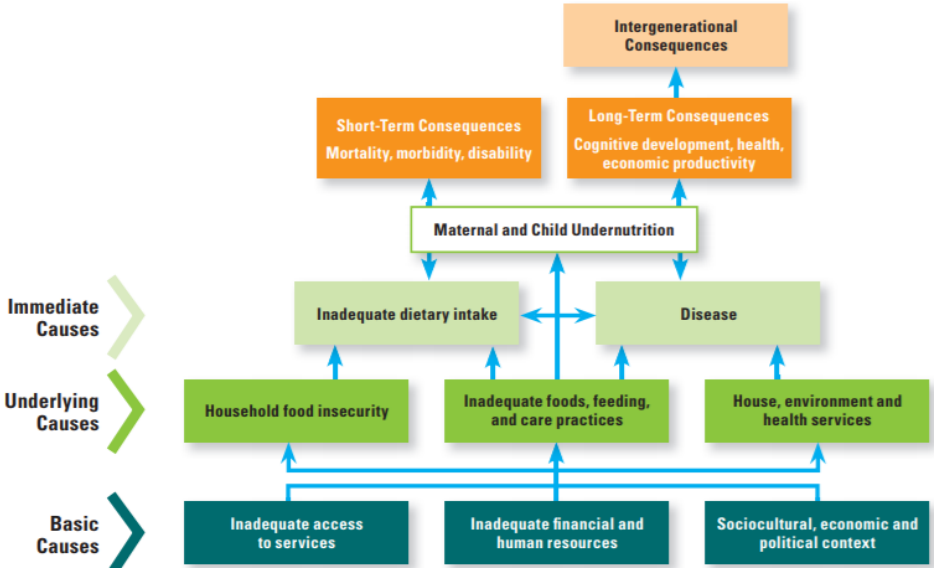

Figure 1. UNICEF conceptual framework for malnutrition[3]

For governments, international organizations, and donor agencies to design and implement social protection interventions to achieve strong impact on nutrition indicators, it is vital to understand these pathways and inter-mediate determinants through which they do so, and under which conditions. While evidence suggests that cash transfers can be instrumental in providing households with resources to raise overall food consumption, these transfers are not necessarily effective in stimulating the behavioural change at individual- and household level that is essential to enhance dietary quality, care practices, health seeking behaviour and sanitary habits. Therefore, conditions are often added to cash transfer programmes to incentivise behavioural change with regards to maternal and child nutrition. As a consequence, a direct cash transfer to the recipient household is often combined with factors which influence three core determinants of child nutrition namely 1) food security, 2) health, and 3) care.[4]

[2] (de Groot, R., Palermo, T., Handa, S., Ragno, L.P. and Peterman, A., 2015)
[3] As also used in the Philippine Plan of Action on Nutrition. (de Groot, R., Palermo, T., Handa, S., Ragno, L.P. and Peterman, A., 2015)
[4] (Ibid.)

***Box 1.** Nutrition-sensitive cash transfers*

Evidence shows that although impacts of nutrition-focused social protection programmes are heterogeneous, five programme design parameters may strengthen the likelihood of positive impacts more than others. The first aspect discussed in this context is **transfer size**. Programmes which provide between 15 and 25 per cent of household baseline expenditure usually seem to have an improved likelihood of achieving impact on relevant outcomes. In Mexico, it was observed that conditional programmes with a larger transfer strengthened compliance rates and had a positive impact on anthropometric measures, child height specifically. A larger effect on child nutritional outcomes was also observed in a comparative study of five cash transfer programmes in Latin America. The second aspect seems to be the **age of children**, with programmes for younger children usually attaining larger effects. This is in line with the policy debate and focus of interventions on the first 1,000 days of life. The third aspect is the **targeting** of transfers to poor and populations at risk because it provides them directly with the relevant inputs to provide more nutritious foods to children, which they may otherwise not be able to afford. The fourth aspect refers to the **supply side factors**, namely access to services and their adequacy because demand-side factors, such as lack of financial resources, are usually not the only reason for poor usage of services. If programmes are not designed to resolve the underlying obstacles to using services, meaningful impact is unlikely. The last aspect worth pointing out is the **length of participation** in a programme, intuitively it appears that children's nutritional outcomes improved with longer programme participation.

Source: (de Groot, R., Palermo, T., Handa, S., Ragno, L.P. and Peterman, A., 2015)

1.2. Context in the Philippines

Poverty rates improved and economic growth was stable in the Philippines over the past decade,[5] but around 22 million Filipinos still lived below the national poverty line and a further 8.2 million below the national food poverty line in 2015. Often, access to education and health services seems to be a matter of income; roughly 20 per cent of school-aged children in the lowest income quintile are not enrolled in school, compared to only two per cent of the highest income quintile. Similarly, in health, only 25 per cent of births are attended by a skilled nurse in the lowest income quintile and as little as 13 per cent of births take place in a health facility (highest quintile 94 per cent and 84 per cent respectively). Infant mortality and under-5 child mortality rates remain high, particularly for the poorer segment of the population.

Likewise, malnutrition, as measured by stunting and wasting, of children remains a major public health problem faced by the Philippines. Results from the National Nutrition Survey (NNS) indicate that from 2013 to 2015, the national rate of stunting in the Philippines significantly increased from 30.3 per cent to 33.4 per cent and wasting significantly increased from 20 per cent to 21.5 per cent. UNICEF quantifies that currently 3.6 million Filipino children under the age of five years are underweight and 4 million are stunted.[6] It is estimated that 700,000 children under the age of five years – or seven per cent of the age group – are wasted in the Philippines.

[5] Between 2006 and 2015, poverty decreased from 26.6 to 21.6 per cent and economic growth was about 5.4 per cent.

[6] (National Economic and Development Authority (NEDA) & UNICEF Philippines , 2018)

These high prevalence rates of stunting and wasting and even increases over the past years are alarming, because the foundations for healthy development and growth are laid in the early stages of life. Particularly the first 1,000 days in a child's life – starting from conception to the child's second birthday – present a crucial window of opportunity to ensure prosperous growth and development throughout the lifetime. Chronic malnutrition stunts children's physical growth and their brain development and damage incurred at both physical and cognitive level in the first two years can leave a child impaired for life. Balanced nutrition in this period is decisive to avoid stunting, micronutrient deficiencies, as well as wasting, which have lifelong effects such as impaired cognitive development, reduced school achievement, lower economic productivity in adulthood and poorer maternal reproductive outcomes.[7]

1.3. 4Ps in the Philippines

In 2008, the Government of the Philippines introduced the *Pantawid Pamilyang Pilipino Programme*. Today, the conditional cash transfer programme covers about 4.4 million households[8] and accounts for almost 20 per cent of social protection spending in 2017.[9] The cash transfer is implemented by the Department of Social Welfare and Development (DSWD), together with the Department of Education (DepEd) and the Department of Health (DOH). It is targeted at poor households with children below the age of 18 years and/or pregnant women. The households are identified through the National Household Targeting System for Poverty Reduction (NHTS-PR), also known as *Listahanan*,[10] which is based on a proxy means test (PMT). The 4Ps pursues the two-fold objective of (i) alleviating poverty by supplementing the income of poor households to address their immediate consumption needs, while (ii) improving human capital by keeping children in school and healthy, enabling them to break the intergenerational cycle of poverty.[11]

The 4P requires families to fulfil a set of conditions in health and education. The health conditions aim to promote healthy practices, improve the nutritional status of young children, and increase the use of health services. The education grant aims to improve school attendance of children 6-14 years old (school-age) living in poor households. For the health grant (PHP 500 (USD 9.50) 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 the Department of Health's de-worming protocol at schools. For the education grant

[7] (World Bank, 2018)
[8] (World Bank, 2017)
[9] (Department of Budget and Management, Republic of the Philippines, 2017)
[10] The *Listahanan* or the National Household Targeting System for Poverty Reduction (NHTS-PR) is an information management system that identifies who and where the poor live in the country. The system holds a database of poor families, which is used as a basis to identify potential beneficiaries of social protection programmes. The first round was carried out in 2009. (Department of Social Welfare, n.d.)
[11] (Fernandez & Olfindo, 2011)

(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. At programme inception in 2008, the maximum monthly transfer amount for a fully compliant household made up about 23 per cent of household income;[12] however, as the benefit levels were not adjusted for inflation over the years, the value of the transfer as share of household income today must be substantially lower. In 2017, a rice subsidy of PHP 600 monthly per household was added to the benefits.

In addition to the conditions in health and education, the household grantee and/or spouse are required to attend Family Development Sessions (FDS). The FDS is a parent group activity that encourages beneficiaries to become more active citizens in society. It aims to enhance beneficiaries' knowledge and skills in various topics, including parenting, health, women's empowerment and financial literacy. The FDS are based on a structured manual which provides lessons on these and other topics.[13] In order to improve recipient households' understanding of balanced nutrition and food security, the FDS curriculum includes 14 sessions on nutrition and related government services. The household grantee and/or spouse is required to attend these FDS at least once a month.[14]

Recipient compliance with the programme's conditions is verified through the Compliance Verification System (CVS). Compliance is registered manually in forms which are distributed to schools and health facilities where the beneficiary household members are enrolled and registered. Health and education facilities staff identify those failing to comply with the programme conditions for the reporting period. To process pay-out, the completed forms are collected, passed on for data entry at the regional level and submitted to the national office to initiate payment.[15]

1.4. Nutritional impacts of 4Ps programme

So far, different impact evaluations of the 4Ps have revealed mixed results on the programme's impact on improving nutrition indicators. The first comprehensive impact evaluation of the 4Ps, carried out in 2012, found a 10 per cent reduction of severe stunting among children between 6 and 36 months but no improvements for other anthropometric indicators, or other maternal and child health outcomes. It did find a significant increase in mothers seeking antenatal care, higher rates of infants' and young children's supplementation with Vitamin A and iron, and higher use of weighing and deworming services. However, no significant increase in the skilled delivery, facility-

[12] (Chaudhury, Friedman, & Onishi, 2013)
[13] (Center for Economic Policy Research, 2017)
[14] (Department of Social Welfare and Development, 2015)
[15] (Department of Social Welfare and Development, World Bank, Australian Aid and Asian Development Bank , 2014)

based delivery, postnatal care in the health facility, and improved full immunization rates was found.[16]

In 2014, the second comprehensive impact evaluation of the 4Ps was carried out. It found no significant difference in the nutrition outcomes for beneficiary and non-beneficiary children. Only a few statistically significant differences for beneficiary and non-beneficiary families were found across all nutrition indicators; and the existing differences were small. However, access and use of maternal and child health services did improve.[17]

Contrary to the second 4Ps impact evaluation, a small study of the nutritional status of children and maternal knowledge, attitudes, and practices of 4Ps beneficiaries and non-beneficiaries in Lucena City, a first class and highly urbanized city in Quezon, revealed better nutritional status of beneficiary children compared to non-beneficiary children in the sample, as measured in the prevalence of underweight (2.2 per cent difference), stunting (5.5 per cent difference), and wasting (8.8 per cent difference). The study also concluded that the 4P successfully contributes to more investment in human capital through good health but acknowledged that malnutrition prevalence remained high among 4Ps beneficiaries and non-beneficiaries alike. According to the same study, beneficiary mothers had lower levels of chronic energy deficiency, obesity and overweight, and also performed better on practices on maternal and child care. While this could suggest that the FDS have a positive impact on households' knowledge of a balanced diet and overall nutrition information, the study also reveals that the mothers' main source of information were health centre lectures and not the FDS.[18]

Going beyond the effects of 4Ps on the nutritional status of beneficiary children, a recent study explores the local spill over effects of the 4Ps, shedding light on the effects of the cash transfer on non-beneficiary children. Relying on the data from the first wave impact evaluation, the study suggests that the 4Ps has negative effects on food prices and the nutritional status of non-beneficiary children. It points towards an increase of prices of perishable protein rich foods after programme introduction, especially in areas with high programme coverage. As a result, the findings suggest, stunting rates and other anthropometric measures of child health worsen among non-beneficiary children.[19]

1.5. Identified challenges

Additional insights from stakeholder discussions during the inception mission suggest that socio-cultural factors might also be at play in explaining the weak outcomes for nutritional indicators for 4Ps beneficiary and non-beneficiary children alike. During the inception mission stakeholders

[16] (Chaudhury, Friedman, & Onishi, 2013)
[17] (Orbeta, et al., 2014)
[18] (Zarsuelo, Hurtada, Suva, & Juanico, 2015)
[19] (Filmer, Friedman, Kandpal, & Onishi, 2016)

reported that a general perception that Filipino children 'are small' might be prevailing among the population and even health workers in the communities; creating a sense of normality around stunting and diminishing the need to address the problem.

Likewise, stakeholders revealed that the design of the 4Ps and the implementation of some key components, most prominently the FDS, might not be conducive to achieving positive nutritional outcomes. For example, the 4Ps uses data from the first round of *Listahanan* in 2009 for targeting. Newly poor households or children born in households that were not included in the *Listahanan* then, are excluded from the programme. Furthermore, the benefit value has not been indexed in line with inflation since programme inception, thus decreasing the real value of the transfer for the household and the amount of food that could be purchased with it.

Stakeholders also pointed to an ineffective implementation of FDS. Designed to educate parents and caregivers and induce behaviour change at household level, these sessions have become a platform for all types of communication towards beneficiaries. As a result, the FDS might be lacking depth and profoundness to induce longer-term behaviour change at household level. Moreover, the sessions are said to resemble a one-way lecture with little interaction between the speaker and the beneficiaries.

Consequently, the stark differences in the results of the different evaluations – which might partially be explained by different quantitative methods employed – and additional qualitative insights highlighting socio-cultural factors and programme features obstructing positive impacts on nutrition indicators, point towards a need to further explore drivers of and barriers to nutritional impacts, especially at the household level. This rapid assessment aims to build on existing work, and complement it, by shedding light on the factors that drive nutrition impacts and obstruct impacts within 4Ps beneficiary households under which circumstances.

2. Evaluation purpose, objectives and scope

Taking into consideration the findings and recommendations of the two existing impact evaluations of the 4Ps and recognising the need for further research into the effects of the programme on nutritional outcomes, this assessment addresses the following.

2.1. Purpose

The purpose of this assessment is to help bridge the evidence gap between the different impact evaluations conducted so far and help explain the programme's mixed impact on nutrition outcomes. Based on the National Nutrition Survey, which revealed that the highest prevalence of stunting occurs in the poorest households and in light of the 4Ps nature as a poverty targeted programme, the assessment will yield decisive information for improving the programme's coverage among children and households who are most vulnerable to and at risk of malnutrition. In doing so, the assessment will contribute to the evolving policy discussions on nutrition-sensitive

social protection in the Philippines, and more specifically the role of the 4Ps in achieving nutritional outcomes. In providing such insights and contributing to current discussions, the results of this assessment will further support the development of a strategy accompanying the recently passed *First 1,000 Days Bill* (Senate Bill No. 1537 or "The Healthy Nanay and Bulilit Act") to address challenges faced by infants, young children, and pregnant and lactating women in the areas of in health and nutrition, among others.[20] The assessment's recommendations for programme and implementation levels present options to resolve barriers at those stages and suggests specific measures to create a more conducive environment to achieving desired outcomes.

2.2. Objectives

The objective of the assignment is:

1. To generate an **understanding of the factors** that drive nutrition outcomes among 4Ps beneficiaries.
2. To understand under **which circumstances positive** effects have been achieved.

To this end, the assessment:

- documents specific **circumstances and conditions** in which the programme has achieved such effects;
- documents where **family's behaviour, knowledge and practices** with regards to infant and young child feeding, health seeking behaviours and nutrition awareness **changed**; and
- assesses which **role the programme design and implementation** played in achieving these outcomes.

2.3. Scope

The scope of the study includes a qualitative assessment of the impacts on nutritional outcomes, achieved by the 4Ps as implemented in the Philippines today, including the different programme components of the cash benefit and the FDS. While the programme is implemented nation-wide, the geographic scope of this study is limited to six municipalities, across six provinces. Primary data collection activities were carried out in the provinces of Bulacan, Catanduanes, Lanao del Sur, Negros Occidental, Samar and Zamboanga del Norte. In the following, ***sub-section 3.4.*** *Sampling for data collection* elaborates further on the selection of provinces and municipalities, along with the sampling of participants for primary data collection activities.

[20] (Senate of the Philippines, 2018)

3. Methodology

The study used a combination of different research methods to arrive at the aforementioned objectives and answer the research questions. In addition to a review and analysis of secondary sources and information, the evaluation relies on participatory research to collect and analyse primary, qualitative data. To capture multiple dimensions of potential nutritional impacts of 4Ps on beneficiary children, and to safeguard the robustness of findings, collected data was triangulated using the following methods: a desk review of pertinent documents, an analysis of secondary data, interviews with key informants at national and sub-national levels, focus group discussions (FGDs) with 4Ps beneficiaries, in-depth follow-up interviews with selected beneficiaries and a short household questionnaire. The following sub-sections further elaborate upon the single methods, and subsequently, sampling, methodological limitations and ethical considerations for the assessment are expounded upon.

3.1. Assessment framework for nutrition impacts of the 4Ps

Following the findings from the desk review and discussions with DSWD, UNICEF and other partners during the inception mission, the framework and research questions to guide this assessment were finalised. This research, just like the Philippine Plan for Action on Nutrition (PPAN), uses UNICEF's conceptual framework on malnutrition, as displayed above. In ***Figure 2*** below, the assessment framework links the different programme parameters of the 4Ps relevant to this assessment (green boxes) to UNICEF's conceptual framework. It identifies how the 4Ps could achieve outcomes at household level (blue boxes), which are in line with the underlying causes of malnutrition, and outcomes at the individual level, i.e. the beneficiary children (orange boxes), aligned with the immediate causes of malnutrition. Moreover, the basic causes of malnutrition (yellow box), including inadequate access to services for beneficiaries, inadequate financial and human resources dedicated to services, and more broadly socio-cultural and economic factors, are reflected in the assessment framework. Further below, ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.

- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3.

As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

Additionally, respondents were asked to assess the **weight** of their children. Since no anthropometric measures were taken as part of this rapid assessment, caregivers were asked to classify their child(ren) into 'normal', 'overweight' or 'underweight', based on the information they might have received during growth monitoring at the health centre, for example. Based on their caregivers' assessment, 70 per cent of children are considered of normal weight, 6 per cent overweight, and 24 per cent underweight. In Hinigaran (29 per cent), Caramoran (33 per cent) and San Jorge (46 per cent) more children are assessed as underweight, compared to the other municipalities. The least number of underweight children was reported for Dipolog with 8 per cent.

Furthermore, caregivers were asked to assess their children's **height** and categorise it into 'normal', 'short', or 'tall'. Based on the caretakers' self-assessment, 72 per cent of children are of normal height, while 15 per cent and 13 per cent, respectively, were reported as shorter or taller compared to other children of the same age. The highest shares of short children were reported in Caramoran (33 per cent) and Hinigaran (21 per cent).

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Risks:

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- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

Box 3.

As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

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Furthermore, caregivers were asked to assess their children's **height** and categorise it into 'normal', 'short', or 'tall'. Based on the caretakers' self-assessment, 72 per cent of children are of normal height, while 15 per cent and 13 per cent, respectively, were reported as shorter or taller compared to other children of the same age. The highest shares of short children were reported in Caramoran (33 per cent) and Hinigaran (21 per cent).

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Furthermore, caregivers were asked to assess their children's height and categorise it into 'normal', 'short', or 'tall'. Based on the caretakers' self-assessment, 72 per cent of children are of normal height, while 15 per cent and 13 per cent, respectively, were reported as shorter or taller compared to other children of the same age. The highest shares of short children were reported in Caramoran (33 per cent) and Hinigaran (21 per cent).

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Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
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- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
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- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs., with the minimum and maximum weight being 1.6 lbs. and 11.2 lbs., respectively.

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3.

As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

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Furthermore, caregivers were asked to assess their children's **height** and categorise it into 'normal', 'short', or 'tall'. Based on the caretakers' self-assessment, 72 per cent of children are of normal height, while 15 per cent and 13 per cent, respectively, were reported as shorter or taller compared to other children of the same age. The highest shares of short children were reported in Caramoran (33 per cent) and Hinigaran (21 per cent).

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
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  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

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- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

Box 3.

As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

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Furthermore, caregivers were asked to assess their children's **height** and categorise it into 'normal', 'short', or 'tall'. Based on the caretakers' self-assessment, 72 per cent of children are of normal height, while 15 per cent and 13 per cent, respectively, were reported as shorter or taller compared to other children of the same age. The highest shares of short children were reported in Caramoran (33 per cent) and Hinigaran (21 per cent).

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.

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As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.

- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.

- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

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- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
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  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

Box 3. ***Box 2.***

Assumptions:

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
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  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
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- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

Box 3.

As part of the in-depth interview respondents were asked to recall the birthweight of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

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- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Box 3.

As part of the in-depth interview respondents were asked to recall the birthweight of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Furthermore, caregivers were asked to assess their children's height and categorise it into 'normal', 'short', or 'tall'. Based on the caretakers' self-assessment, 72 per cent of children are of normal height, while 15 per cent and 13 per cent, respectively, were reported as shorter or taller compared to other children of the same age. The highest shares of short children were reported in Caramoran (33 per cent) and Hinigaran (21 per cent).

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Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
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  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
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  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
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- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
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Box 3. *Box 2.*

Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
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- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

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- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
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Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
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Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
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- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

Box 3.

As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs, with the minimum and maximum weight being 1.6 lbs and 11.2 lbs, respectively.

Additionally, respondents were asked to assess the **weight** of their children. Since no anthropometric measures were taken as part of this rapid assessment, caregivers were asked to classify their child(ren) into 'normal', 'overweight' or 'underweight', based on the information they might have received during growth monitoring at the health centre, for example. Based on their caregivers' assessment, 70 per cent of children are considered of normal weight, 6 per cent overweight, and 24 per cent underweight. In Hinigaran (29 per cent), Caramoran (33 per cent) and San Jorge (46 per cent) more children are assessed as underweight, compared to the other municipalities. The least number of underweight children was reported for Dipolog with 8 per cent.

Furthermore, caregivers were asked to assess their children's **height** and categorise it into 'normal', 'short', or 'tall'. Based on the caretakers' self-assessment, 72 per cent of children are of normal height, while 15 per cent and 13 per cent, respectively, were reported as shorter or taller compared to other children of the same age. The highest shares of short children were reported in Caramoran (33 per cent) and Hinigaran (21 per cent).

Box 3. ***Box 2.***

Assumptions:

- 4Ps' programme design adequately addresses the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

Box 3. ***Box 2*** summarises the assumptions on which the assessment framework is based and implicit risks, which may prevent the attainment of outcomes.

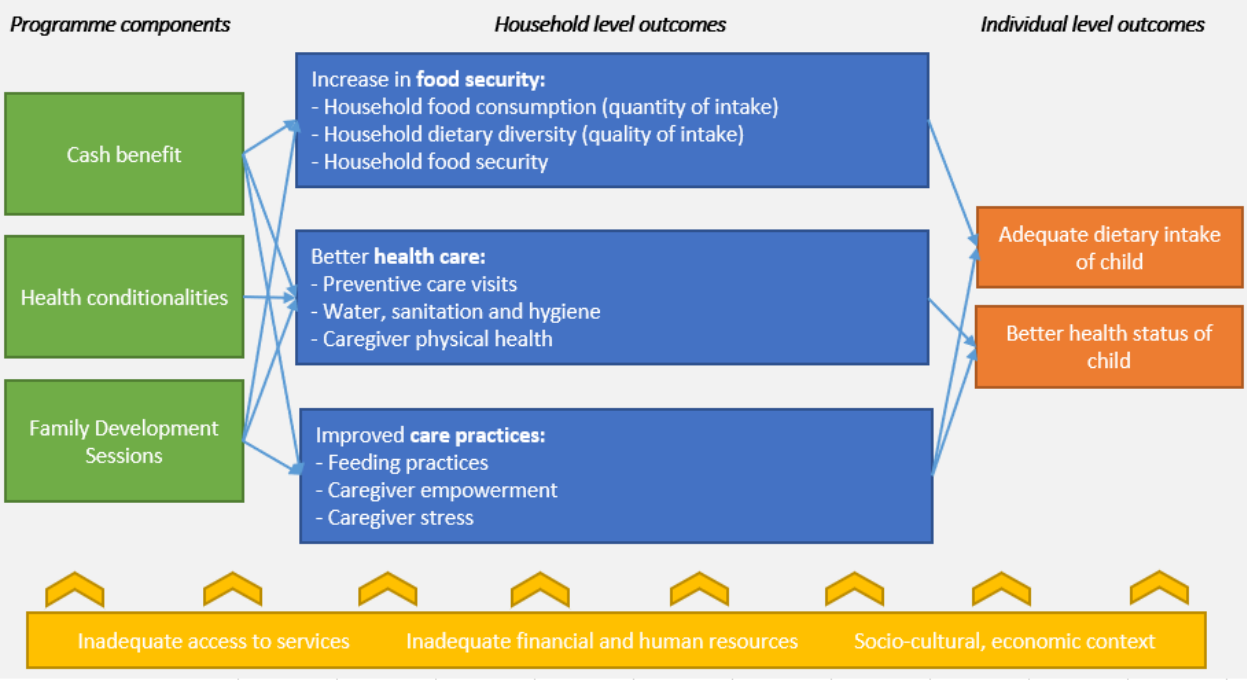

Figure 2. Assessment framework: Nutritional impacts of the 4PS

Box 7425. *Underlying assumptions and potential risks to achieving nutritional outcomes*

Assumptions:

- 4Ps' programme design contributes to addressing the challenges of malnourished children and their families.
  - 4Ps' beneficiaries need financial support to increase their overall food consumption;
  - 4Ps' beneficiaries need financial support to increase overall improve dietary diversity;
  - 4Ps' programme conditions encourage beneficiaries to utilise health services; and
  - 4Ps' FDS improve beneficiaries' knowledge, attitude and behaviour regarding determinants of nutrition, such as child care, feeding and sanitation practices.
- 4Ps' is adequately implemented and resourced at all relevant levels.

Risks:

- Programme design is not adequate to positively impact food security, health care and care practices at household level, in turn, not improving child health status and dietary intake.
- Inadequate programme implementation, for instance through insufficient human and/or financial resources.
- Access to and/or quality of basic services inhibit the programme's effectiveness to achieve possible nutritional impacts.
- Basic socio-cultural and economic factors prevent the programme from achieving behavioural changes at household level.

3.2. Research questions

Following findings from the desk review and discussions with DSWD, UNICEF and other partners during the inception mission, the framework and research questions to guide this assessment were developed. This research was guided by UNICEF's conceptual framework on malnutrition, which is also reflected in the PPAN, as displayed above. Based on the framework and in line with the assessment's objective to create an understanding of the factors that drive nutrition impacts in 4Ps beneficiaries under which circumstances, the following research questions were developed:

- In how far has the 4Ps impacted the food security, health care and care practices in 4Ps beneficiary households in selected municipalities and in how far were these translated into outcomes at child-level? (Green to blue to orange)
- Under which circumstances has the programme achieved impacts? (Taking implementation of programme components, household-level dynamics and basic factors into consideration)
- What are the main barriers to achieving these outcomes? (Exploring how design and implementation of programme components and basic factors obstruct outcomes)

3.3. Methods

The study employed a combination of different research methods to assess the impacts of 4Ps on nutrition outcomes in selected municipalities and answer the above-listed research questions. Next to a structured desk review and analysis of existing secondary sources and data, the assessment relied on participatory research to collect and analyse primary data. A triangulation of

findings through these different methods helped to capture the multiple dimensions of the factors driving and inhibiting nutritional outcomes of the 4Ps programme and hence helped to safeguard the comprehensiveness and robustness of findings.

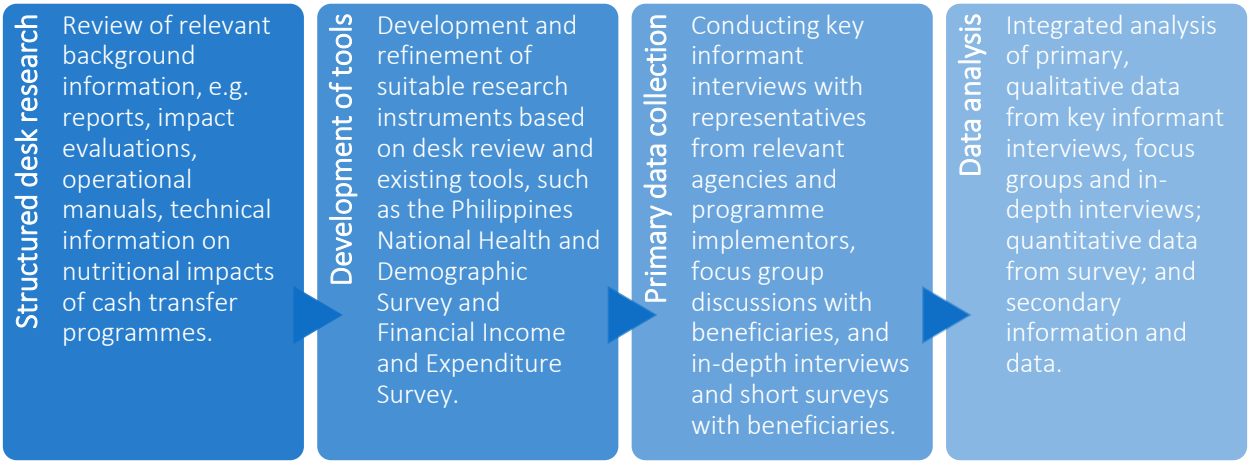

Figure 3. *Overview of study methodology*

3.3.1. *Structured desk research*

EPRI has conducted a comprehensive review of relevant background information on the linkages between cash transfers, and more broadly social protection, and nutrition and the potential pathways of achieving nutritional impacts through the provision of cash. In addition to the theoretical mapping of these impact trajectories, available programmatic evidence on cash transfers and child nutrition outcomes was reviewed to supplement theoretical pathways. Identifying the pathways of achieving nutritional impacts served to define a framework to guide the research and assess the factors potentially hindering successful achievement of impacts in the 4Ps. In addition, EPRI carried out a review of 4Ps programme-specific documents, including the 4Ps manual of operations, programme design documents, the results framework, both 4Ps impact evaluations, and other relevant research pieces, zooming in on the 4Ps impacts, particularly on nutrition and underlying drivers of nutritional impacts – health, food security and care practices. In addition, EPRI analysed relevant policy documents, such as the Philippine Development Plan and the Philippine Plan of Action on Nutrition, to get a profound understanding of the policy context within which the 4Ps operates and to recognise the government's priorities in the areas of child protection, social protection and nutrition.

3.3.2. *Primary data collection*

Primary data collection activities took place at national level and sub-national level, comprising of key informant interviews, focus group discussions and an in-depth interview and short survey with selected beneficiaries from the FGDs.

Key informant interviews

Key informant interviews at **national level** served to gather insights into the implementation of 4Ps and the nutrition impacts it might achieve, as well as factors that might contribute to and/or inhibit the achievement of such impacts. Moreover, the interviews guided the development of the research framework, refined research questions and were used to identify relevant implementors at the municipal level. As summarised in **Error! Reference source not found.** below, representatives from government ministries, national non-governmental partners and international organisations were met for key informant interviews.

Table 1. Interviewees at national level

Method	Designation	# per location
Key informant interviews[21]	UNICEF Philippines Country Office	4
	Asian Development Bank (ADB)	1
	World Bank	1
	Department of Social Welfare and Development (DSWD)	2
	Department of Health (DOH)	1
	Department of Education (DepEd)	1
	National Nutrition Council (NNC)	1
	Philippine Institute for Development Studies (PIDS)	1
	Food and Nutrition Research Institute (FNRI)	1
	University of the Philippines	1
	Philippine's Women University	1
	Total	**15**

At **sub-national level**, KIIs were carried out with 4Ps implementers and personnel involved in the implementation of health and nutrition activities, all of whom are regularly in contact with 4Ps beneficiaries. The KIIs served to shed light on practical questions regarding the overall implementation of 4Ps in the selected municipality/cities, the impacts of 4Ps on overall beneficiary well-being, and on food security, health care, sanitation and hygiene, and care practices in 4Ps beneficiary households overall. The KIIs were also conducted to understand the circumstances in which the programme achieved outcomes and impacts and to identify some of the main barriers to achieving outcomes, including structural factors such as access and quality to basic services.

Table 2. List of key informant interviews at sub-national level

Method	Designation
Key informant interviews	Municipal/City Links
	Nutrition Action Officer
	Rural Health Unit staff
	Barangay Nutrition Scholar
	Barangay Health Worker

Focus group discussions

Next to the KIIs, focus group discussions were conducted with 4Ps beneficiaries in each of the six selected municipalities to collect first-hand information from programme beneficiaries about the

[21] Most of the KIIs included multiple representatives from the partner organisation.

impacts 4Ps has on their well-being and to discuss the extent to which the 4Ps impacts the nutrition status and health seeking behaviour among 4Ps beneficiary households. Moreover, beneficiaries were asked about persistent challenges they might face in meeting the nutritional needs of their children, their attitudes, believes, knowledge and behaviour on practices related to child nutrition, their care practices, perceptions around food security, and a range of other factors that may explain heterogeneity in nutritional outcomes. The FGDs also served to identify beneficiaries for additional individualised data collection through in-depth interviews and a short household survey.

In-depth interviews and surveys

Upon completion of the FGDs, two to three participants whose answers appeared particularly interesting or revealing were approached to assess their willingness to participate in an in-depth interview. These interviews served to contextualize some of the answers given during the FGD, but also ask more in-depth questions, typically not asked and answered in group setting. Prior to the in-depth interview, a short household questionnaire was administered to the household. The objective of this quantitative component was not to gather representative statistics for the sample – certainly as the sample might suffer from selection bias – but rather to collect some key characteristics of the sample population, including demographic household characteristics, but also household's access to basic services, which might help shed light on factors potentially driving differences within the sample.

3.4. Sampling for data collection

For participatory data collection activities at sub-national level, DSWD selected six provinces, with one municipality within each province, using the results of the National Nutrition Survey 2015. *Table 3* lists the chosen provinces, municipalities and barangays. Whereas provinces two to six were chosen due to their a high prevalence of stunting, as based on the NNS 2015 results, the first province – Bulacan – was chosen to represent a rather well-performing province, with a low prevalence of stunting.[22] In adding a well-performing province to the sample, the study aimed to reveal potential differences in nutritional impacts that might be driven by basic socio-economic drivers of nutritional impacts at location level, instead of household level, such as access to services and cultural factors and norms. The chosen six provinces equally represent the three major islands groupings of the country (Luzon, Visayas and Mindanao), with two sample provinces located in each. Additionally, the number of 4Ps beneficiaries living within the provinces was taken into consideration when selecting the provinces.

Within the provinces, municipalities were randomly selected; however, accounting for the urban-rural distribution of 4Ps beneficiaries. Two urban municipalities and four rural municipalities were

[22] See graphs on rates of stunting and wasting in the selected provinces in ***Annex B***.

randomly selected, approximating the distribution of the 4Ps households living in urban areas (30 per cent) and rural areas (70 per cent). Finally, within each municipality, different barangays were selected for primary data collection based on DSWD's recommendations. The specific barangays were selected based on a range of factors, among others the number of 4Ps beneficiaries under the age of five years and the accessibility and proximity to other barangays for data collection.

For the FGDs with 4Ps beneficiaries, a purposive sampling approach was adopted, in that individuals were selected by Municipal/City Links based on their willingness and availability to participate in FGDs. Subsequently, two to three FGD participants, whose answers were particularly interesting or revealing, were invited for an in-depth interview and a short survey form to discuss their households' experience with the 4Ps in more detail and gather quantitative data on select indicators.

Table 3. *List of sub-national level fieldwork locations and activities*

Province	Municipality/City	# of KIIs	Barangays	# of FGDs	# of FGD participants	# of HH survey & in-depth interv.
1. Bulacan	City of San Jose del Monte	4	Muzon	3	57	9
			San Pedro	3	47	6
2. Catanduanes	Caramoran	5	Supang	3	61	5
			Toytoy	3	52	7
3. Lanao del Sur	Ganassi	4	Tabuan	3	58	6
			Pindolonan	3	60	6
4. Negros Occidental	Hinigaran	3	Barangay IV	3	50	7
			Cambugsa	3	51	6
5. Samar	San Jorge	4	Lapaz	3	64	7
			Erenas	3	59	6
6. Zamboanga del Norte	Dipolog City	5	Turno	3	32	7
			Galas	3	41	6
	TOTAL	**25**		**36**	**632**	**78**

3.5. Ethical considerations

The study's data collection activities were guided by ethical and moral principles in line with the *Norms and Standards for Evaluation* (2016), developed by the UN Evaluation Group (UNEG), as well as the UNICEF *Procedures for Ethical Standards in Research, Evaluation, Data Collection and Analysis*.[23] Strict adherence to a high set of ethical standards was of importance, given the subject matter of the study and its focus on vulnerable children. As such, the participatory data gathering approach was designed to avoid stigmatisation, exposure to secondary trauma, discrimination, and any form of harm to children, their parents, caregivers.

Prior to interviews and FGDs, **informed consent** of all potential participants and interviewees was gathered, and thoroughly explained to them the purpose of the evaluation, their role within the

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

evaluation, and what information will be asked from them. A consent script was read out prior to the commencement of research and potential participants were asked to provide their consent to join in the research. For the participation of minors, an informed consent form was signed by the parent/caregiver and an informed assent form was signed by the child, if the case management agency had not gathered informed consent and assent as part of their procedures.

At the outset of data collection, all participants were informed that their answers will be kept confidential. Responses and comments were summarised in this research report, but on no occasion, respondents are identified by name or any other identifying characteristics aside from approximate age and gender. For the focus group discussions, the participants' real names were not recorded, instead they were assigned numbers.

All potential participants and interviewees were assured of the confidentiality and voluntariness of their answers. If at any point a participant felt uncomfortable, he or she was not obliged to provide requested information. In the event that a participant wished to leave the discussion before its conclusion the researcher thanked the participant for his/her participation and linked the participant to case management personnel on site, if desired. Appropriately responding to and managing emotional responses from participants during the course of an interview was the researcher's responsibility and formed part of risk mitigation.

Lastly, members of the research team were bound by ethical research principles of impartiality, independence, credibility, conflicts of interest, accountability. Researchers remained as impartial and objective as possible and allowed participants to express their own views and opinions without interruptions, making suggestions or engaging in personal debates about the views expressed. Researchers committed to independent review, safeguarded through the obtainment of ethical approval from an independent review panel, and ongoing checks on the quality and ethics of this study from the researchers themselves, and through inputs and feedback from UNICEF and partners. Moreover, researchers were responsible to safeguard the credibility of the study by acting fair and credible towards research subjects, providing an accurate and transparent description of the potential risks or discomforts and the anticipated benefits derived from the study; as well as ensuring a fair selection of research respondents, representing diverse age ranges, varying levels of exposure to explicitly defined vulnerability factors, and other social factors. Researchers also accounted for the conflict of interest arising from the concern for individual rights and potential harm to research objects and the benefits of knowledge and learnings generated on the impacts of the response on children's lives by avoiding insensitive questions or probing for information, when it is clear that participants would prefer not to answer. Finally, to safeguard the accountability, information of all research team members' names, positions, and relevant trainings and qualifications was submitted as part of the ethical review process, offering an estimate of competence together with a chain of responsibility and accountability for all those holding responsible positions and in direct contact with subjects.

3.6. Limitations

The generalisability and representativeness of the findings of this assessment findings are limited by the geographic scope of the assessment. The six municipalities were purposively chosen to participate in the assessment and hence the findings are not representative of the 4Ps programme's impacts on nutrition outcomes across the country. Nevertheless, to partially ameliorate this limitation, the distribution of urban and rural municipalities in this assessment was proportionate to the number of 4Ps beneficiaries living in urban versus rural areas.

Additionally, it should be noted that the quantitative household survey is not representative on its own, and as part of this assessment merely serves to support and triangulate qualitative findings and to sketch key characteristics of the households included in the sample. Likewise, one must apply caution when interpreting the information on children's nutrition status and caregiver's health status. The information for both indicators stems from caregiver's self-assessment and might hence suffer from perception bias.

4. Findings

This section presents the findings of the rapid assessment of the impact of 4Ps' on nutrition outcomes in beneficiary households in selected municipalities. The first sub-section commences by introducing the 4Ps beneficiary households that participated in this assessment, and particularly the households that participated in the in-depth interview and household survey. Subsequently, sub-sections ***4.2.*** *4Ps design and implementation*, ***4.3.*** *Underlying causes of malnutrition and 4Ps impact*, and ***4.4.*** *Immediate causes of malnutrition and 4Ps' impact* will answer the first research question: "In how far has the 4Ps impacted the food security, health care and care practices in 4Ps beneficiary households in selected municipalities and in how far were these translated to outcomes at child-level?". Then, by way of consolidating and integrating findings, sub-section ***4.5*** *4Ps' impact on nutrition outcomes in assessed 4Ps households* focuses on the research questions "Under which circumstances has the programme achieved impacts?" and "What are the main barriers to achieving these outcomes?".

4.1. Characteristics of the sample

Overall, 625 household representatives participated in the focus group discussions organised for this assessment and carried out across twelve barangays in six municipalities. (***Annex B.*** presents a breakdown of the number of FGD participants per barangay and municipality). The vast majority of these households were represented by the female primary child caregiver during these focus groups. From all focus group participants, two to three participants were chosen per location to participate in an in-depth interview and a brief household survey. The in-depth interview and short survey were conducted among 78 households in the six selected municipalities. The table below shows the percentage share of interviews and household surveys carried out in each municipality.

Table 4. Overview of sample size

Municipality	# of in-depth interviews and survey	Percentage share
Caramoran	12	15%
Dipolog	13	17%
Ganassi	12	15%
Hinigaran	14	18%
San Jorge	13	17%
San Jose del Monte (SJDM)	14	18%
Total	**78**	**100%**

Based on the sample of 78 household, a total sample size of 560 individuals was attained, with 241 observations for adult household members (128 female and 115 male) and 319 for children. The mean household size of the sample is just over 7, with an average of 4 children. Over 92 per cent of primary caregivers are female, and almost 8 per cent male. In the sample, 22 per cent are female-headed households, with the highest share of female-headed households in Hinigaran (31 per cent) and the lowest in Caramoran (6 per cent). The mean age of the adults in the sample is 39 years.

Out of 319 children living in the sampled households, 173 are enrolled in the 4Ps. The mean number of children in 4Ps per household is 2.24. The youngest child enrolled in the 4Ps is five years old and the oldest child enrolled is 19 years old. The majority of enrolled children is between ten and 19 years old (92 per cent) and the average age of beneficiary children is 14 years. The average age of children excluded from 4Ps is 9 years.

Finally, 6 per cent of households have a child who lives with a disability. There are no reported children with disabilities in SJDM and Caramoran, most children with a disability live in San Jorge (15 per cent.) Finally, 15 per cent of all households interviewed reported to be part of an indigenous community; all of them in Ganassi.

Box 10241. *Self-assessed nutrition status*

As part of the in-depth interview respondents were asked to recall the **birthweight** of their children. While most respondents were able to recall the birthweight – often presenting relevant documentation – a few caregivers were not able to provide the information. Based on the available data, the mean weight at birth of children in the sample is 6.16 lbs., with the minimum and maximum weight being 1.6 lbs. and 11.2 lbs., respectively.

Additionally, respondents were asked to assess the **weight** of their children. Since no anthropometric measures were taken as part of this rapid assessment, caregivers were asked to classify their child(ren) into 'normal', 'overweight' or 'underweight', based on the information they might have received during growth monitoring at the health centre, for example. Based on their caregivers' assessment, 70 per cent of children are considered of normal weight, 6 per cent overweight, and 24 per cent underweight. In Hinigaran (29 per cent), Caramoran (33 per cent) and San Jorge (46 per cent) more children are assessed as underweight, compared to the other municipalities. The least number of underweight children was reported for Dipolog with 8 per cent.

Furthermore, caregivers were asked to assess their children's **height** and categorise it into 'normal', 'short', or 'tall'. Based on the caretakers' self-assessment, 72 per cent of children are of normal height, while 15 per cent and 13 per cent, respectively, were reported as shorter or taller compared to other children of the same age. The highest shares of short children were reported in Caramoran (33 per cent) and Hinigaran (21 per cent).

4.2. 4Ps design and implementation

In this section, the 4Ps' design and its implementation in the six selected municipalities is analysed. This allows for the development of an understanding of the effectiveness of the design and implementation of programme components (the green boxes in the assessment framework) in influencing the underlying and immediate causes of malnutrition in these municipalities (the blue and orange boxes in the assessment framework) in the following sections.

4.2.1. *Reaching vulnerable households*

Evidence has shown that the likelihood that social protection programmes find positive nutrition impacts increases when poor and vulnerable households and individuals are reached. All FGD participants reported that there are vulnerable households in the barangays that are currently not included in the 4Ps, however, live in an equally desperate situation or are sometimes even considered more vulnerable. In Caramoran, for example, FGD participants explicated that "They are poorer than us. They always get jealous about the cash we receive".

Key informants further confirmed that "The poorest of the poor are not in 4Ps." A key informant mentions that the excluded households are oftentimes young families, that did not have a pregnant household member or children when the first round of the *Listahanan* was administered in 2009, however, have several young children now, and would thus be eligible for the 4Ps. Key informants across locations supported this finding, with one Barangay Health Worker indicating that only about half the households that would be eligible are currently reached by the programme. Key informants in Hinigaran, San Jorge and SJDM, for example, estimated that almost all poor were covered by the 4Ps, however, not all.

In addition to not reaching all poor and vulnerable households, the 4Ps programme currently also does not formally capture any children born since 2010. This means that the youngest children living in 4Ps beneficiary households are excluded from the benefits. However, there seem to be options for replacing beneficiary children within one household, if an older child reaches the upper eligibility threshold and is replaced on the beneficiary registry with a younger sibling. With a limit on the education grant for a maximum of three children per household, the old children in the household tend to be enrolled in the 4Ps programme. And again, younger children living in 4Ps households might not have been born at the time of the first wave of the *Listahanan*. Data from the brief household survey supports this impression as the average age of children excluded from 4Ps is 7.9 years and the average age of beneficiary children is 13.8 years.

While the cash transfer is typically shared among all children living in the household or even all household members, the lack of enrolment of younger children in the household, means that the education and health conditions are not monitored for these children.

4.2.1. *Health conditions*

The receipt of the 4Ps health grant (PHP 500 monthly per household) is linked to a set of conditions that the household must comply with, entailing that: (i) all children younger than five years and pregnant women must visit the health centre or rural health unit regularly, and (ii) all school-aged children (6 to 18 years old) must comply with the Department of Health's de-worming protocol at schools. Most beneficiaries agreed that compliance with the health conditions is not stressful and most beneficiaries would go to the health facility, even without the receipt of the cash transfer and the attached health conditions, they would go and visit the health facility. They explained that even if the transfer ended, they would still visit the facility to check on their children's well-being.

Nevertheless, few beneficiaries named difficulties in complying with the health conditions. One beneficiary from San Jorge elucidated that "[…] sometimes it is stressful, if the conditions are in conflict with our daily jobs in the farm." A Barangay Health Worker from Palumbanes Island, in Caramoran further mentioned that in the past, it was difficult for the household to comply with the health conditions, as there was no health centre on the island and the households had to cross the sea to comply with the health conditionalities. Now that there is a health centre and a midwife visits regularly, monitoring and compliance of conditions is easier. A Barangay Nutrition Scholar further elaborated that non-compliance with the health conditions is typically due to a lack of money for transportation to the health facility. FGDs across all locations confirmed that beneficiaries often spend their health grant on transportation costs to the health facility, and at times, these costs can also constitute a barrier to accessing health care.

Lastly, rural health unit staff and Barangay Health Workers in some locations criticised that at times compliance with health conditions is not properly monitored, and hence beneficiaries do not take the conditions seriously, as ultimately no benefit reduction follows. A key informant pointed out

that "[…] even if members missed out some of the conditionalities, they still get the full grant, so some are not taking the conditionalities seriously."

4.2.2. *Family development sessions*

Responses on the quality and usefulness of the FDS are mixed across 4Ps beneficiaries and key informants. Across all locations, the majority of beneficiaries indicated that they find the FDS helpful and informative. They mention that they apply the knowledge acquired from the FDS for example on backyard gardening; how to deal with children and how to take care of their health; and disaster preparedness. Beneficiaries also confirmed that the FDS are for their own good and hence do not mind attending FDS as part of the 4Ps' conditions. Moreover, beneficiaries said that:

> "We are excited to learn new topics and excited to apply the new lessons. We are excited to meet our friends in FDS. We are already comfortable. Before, we were shy. We were just staying in our house most of the time, so we were not confident. When asked during FDS, we were just quiet, we did not care to participate. Now, we learned how to interact with people."

This attitude also indicates that while beneficiaries seem to enjoy the sessions; the FDS might rather be considered social activities and gatherings than places to learn. One FGD emphasised improvements in their overall mental attitude which they experienced in the course of their membership in the 4Ps: "We were ashamed that we are 4Ps beneficiaries because they [the community] will know we are poor. But now the perception of being in the program is different because of the improvements in our lives. [It is] not difficult to comply. Responsibility is forever."

The FDS are often conducted in surroundings not conducive for learning and discussions among all participants. Beneficiaries from Caramoran and Ganassi, for example mentioned that oftentimes FDS are very crowded – in Caramoran around 150 beneficiaries attend the FDS – so that it gets noisy in the venue and focusing on the discussion is difficult. We are so crowded during FDS we cannot hear the municipal link." Some beneficiaries also thought the FDS were not particularly helpful and the sessions were often conducted in a lecture-like setting without much interaction between the speaker and the participants.

Key informants support these finding and point out that the quality of the session delivery could be further improved, rendering these sessions more participatory, for instance. A Municipal Link confirmed that usually the FDS are conducted in open areas, where there is no microphone and no sound system. Hence, it is difficult for the beneficiaries to hear and understand the speaker. Additionally, resources for visual aids and other supplies to facilitate the FDS are usually not available. Moreover, one key informant mentioned that especially the FDS on health and nutrition are rather brief and should be revised to provide more detailed information. Moreover, a Barangay Nutrition Scholar mentioned that parents should be further informed and educated on the positive outcomes that a balanced diet can have.

Finally, there seems to be mixed evidence on which practices taught during the FDS were actually taken on; for example, when asked to recall some of the learning from the FDS, some beneficiaries could not remember the last FDS topics. Still, overall there seem to be positive behavioural changes associated with FDS attendance. The actual application of learnings from the FDS ultimately depends on the situation of the single family and also its financial ability to do so. "Yes, I can see some of the mothers or families that really follow, obey and comply with the 4Ps requirements. I can see improvements on the reports especially on wasting. But still there are some of them that do not internalize the learnings." KII also reported that the FDS modules on nutrition and health should be updated and made more concrete to provide holistic in-depth information on how nutrition and food impact child development.

4.2.3. *Cash benefit and usage*

During the FGDs, beneficiaries indicate that they primarily spend the cash benefit on expenses related to schooling of children, such as school supplies, school uniforms, school allowance and fare, school projects and activities; transportation to health facilities and medicines not available in the health centre; vitamins for children; food for all household members; and to a lesser extent household items and investments and improvements to their housing situation for instance fixing the roof, making general repairs and purchasing livestock to improve their livelihoods. These FGD findings were further corroborated by the key informants interviewed in all locations.

Still, most beneficiaries agreed that the cash benefit is too low, and the value would have to be increased to adequately augment household income. Inflation, and a resulting increase in the cost of living, was cited as a major reason for the corroding value of the cash transfer. In addition, particularly in bigger households, where the cash grant is ultimately shared between all household members, the value is considered too low. As a beneficiary from Caramoran put it "I have five children. Only three are enrolled in 4Ps. All of them are attending school, so cash transfer is shared by all. It's not enough." Some key informants echoed the beneficiaries view on a need to increase the cash grant. They believe that a higher cash transfer might also result in more meaningful impacts, particularly in the area of nutrition, as food prices have risen substantially in line with inflation. A key informant from SJDM explained that "Yes, the cash transfer can help, but is not enough to meet the needs of the whole family. It still depends on the number of their children. If the programme would cover more children, the impact could be meaningful."

Other key informants argued that the grant is high enough, as it is only supposed to serve as an income supplement to households. Indeed, the few households that report to be okay with the cash transfer, rely on it only as additional income and at least one of the household members has a permanent source of income. Beneficiaries explained that "For me, it is enough. I have 4 children. My husband has a job."; and "I have a job, so the cash transfer is good enough to augment for the expenses of the whole family." However, a substantial share of the 4Ps beneficiaries interviewed

work as seasonal labourer in agriculture and fishery, or do not have a stable source of income at all; in turn, increasing their dependency on the cash transfer.

***Box 10753.** Additional 4Ps benefits and linkages*

In addition to the education and health grant, beneficiaries are entitled to some other benefits, as part of their 4Ps status. In 2017, a **rice subsidy** was added to the cash grants. The rice subsidy amounts to PHP 600 per household a month and is given in the form of cash and treated as an additional cash grant. The rice subsidy is delivered to beneficiaries using the same payment mechanisms and according to the same schedule as the education and health cash grants. Additionally, as part of their 4Ps status, beneficiaries get **PhilHealth** health insurance coverage. As sponsored members, 4Ps beneficiaries are entitled to full PhilHealth benefits, including primary care benefits (consultations, regular blood pressure measurements, breastfeeding programme education, etc.), diagnostic examinations as recommended by the doctor, selected free drugs and medicines, and in-patient benefits, among others.

Next to these benefits, the 4Ps further links beneficiaries to other activities and programmes, most of which are localised initiatives, oftentimes encouraged by barangay captains. Examples include for instance the cleaning up of barangays and waste removal and linking beneficiaries to free toilet bowl initiatives. Moreover, the Technical Education and Skills Development Authority (TESDA) has been invited to family development sessions and the Department of Agriculture supports beneficiaries' backyard gardening through provision of seedlings.

Likewise, there has been a move towards more integration and **convergence** between DSWD's three major programmes – the 4Ps, Sustainable Livelihoods Programme (SLP) and Kapit-Bisig Laban sa Kahirapan-Comprehensive and Integrated Delivery of Social Services (Kalahi-CIDSS), a community development programme – to provide poor households with a more comprehensive range of services.

Sources: (Department of Social Welfare, 2017), (PhilHealth, 2019)

4.2.4. *Payment timeliness, frequency and delivery mechanism*

The responses on timeliness of the receipt of cash were mixed, largely dependent on the payment modality and the specific location. In the municipalities of San Jose del Monte, Caramoran and Dipolog, the 4Ps beneficiaries that participated in the FGDs all receive their money through over-the-counter (OTC) payments every two months. The majority of beneficiaries reported that the payments were typically made on time, and only on few occasions have been delayed for a few days. This regularity enables beneficiaries to plan their purchases and expenditures accordingly. Beneficiaries interviewed in Hinigaran also receive their payments over-the-counter, however, after having received their payments regularly every two months, recently the payments have been delayed. One peculiar challenge faced by 4Ps beneficiaries living on Palumbanes Island, Caramoran, is reaching the pay point. Beneficiaries have to cross the sea to reach the pay point, which can be perilous when weather conditions are bad.

> "There are times when we have to cross the rough seas. There were occasions when some boat would drown because of overloading. We cannot leave people behind, and of course, nobody died. When we arrived there, we were the last in line because we were late. In the late afternoon, when we returned [back], the sea was more turbulent."

In the municipality of Ganassi the payment modality was switched from cash cards to OTC payments in 2018. With the switch in modality, the frequency of payments also changed.

Beneficiaries and key informants from Ganassi reported that payments are delivered every eight to ten months now, instead of every two months. Beneficiaries also seem to be less aware of the exact payment day, and simply await announcements from the municipal link. Additionally, it is more difficult for beneficiaries to monitor whether they receive the correct cash transfer amount. One focus group participant pointed out that "[…] we cannot monitor the cash transfer amount, since it is given every ten months".

By contrast, in San Jorge a switch from bi-monthly over-the-counter payments to less frequent cash card payments, was made. The switch to cash cards apparently created problems for beneficiaries in San Jorge, as one beneficiary explained: "We didn't use ATMs for many years, because they were giving it [the cash transfer] out via over-the-counter. Then by 2017 they said it will be received through the ATM, but the PIN numbers we got are not working." Furthermore, the switch in payment modalities and the less frequent pay-outs have resulted in less comprehension on the payment schedule among beneficiaries, some complaining that pay-outs are late and incomplete. "Most of the time when we get money from cash card, we are not informed what months this corresponds to."

More generally, less frequent pay-outs and delayed pay-out make it more difficult for beneficiaries to plan their purchases and expenditures. Without knowing when the next cash transfer will be paid out, beneficiary households cannot plan their expenditures and often have to resort to borrowing money from lenders, in order to smooth their consumption until the next payment. Beneficiaries mention that because they are 4Ps beneficiaries, it is easier for them to borrow money from lenders, compared the non-4Ps beneficiaries, as the programme is perceived as a form of guarantee for payback. Particularly in locations with less frequent payments, beneficiaries need to borrow money to bridge the gap between payments. One beneficiary from Ganassi explained that "Since pay-out is given yearly or every ten months, our cash transfers would just go to (re)payment of loans or borrowed money."

4.3. Underlying causes of malnutrition and 4Ps impact

The preceding sub-section served to create a better understanding of how the 4Ps is implemented in the six municipalities, how beneficiaries use the cash grant and assess the other benefits related to 4Ps, and what type of challenges beneficiaries might face. This sub-section further explores in how far the implementation of 4Ps impacts the underlying causes of malnutrition within beneficiary households – food security, health care and care practices.

4.3.1. *Food security*

For the household level outcome of food security, the study investigated what the food security situation of the beneficiary households is, how beneficiaries learn about nutrition and what role information and knowledge play for them in this context.

Food consumption (quantity)

4Ps beneficiaries participating in the FGDs and in-depth interviews were asked about their food consumption, that is, the quantity of the food intake by children and adults living in the household. More specifically, interviewees were asked how many meals the household consumed the day preceding the interview. Below, ***Table 5*** provides and overview of the average number of meals consumed for the whole sample, as well as disaggregated by municipality. It becomes evident that 88 per cent of all respondents reported to have had three meals on the day preceding the interview, relatively consistently across all municipalities. 6 per cent had only eaten two meals, and 3 per cent had four or five meals respectively. It must be considered that respondents answered the question based on their own interpretation of what constitutes a meal, which is subjective and likely to differ across respondents.

Table 5. *Number of meals consumed by households per municipality*

# of meals	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
2	6.4	0	0	16.7	7.1	7.7	7.1
3	88.5	66.7	100	83.3	92.8	92.3	92.9
4	2.6	16.7	0	0	0	0	0
5	2.6	16.7	0	0	0	0	0

Across locations, the vast majority of 4Ps beneficiaries agreed that the cash transfer positively impacts their food consumption, i.e. the quantity of foods that they can buy. Next to simply having more money available, households also point to their ability to purchase foods in higher quantities, in turn reducing the unit cost of the single foods. FGD participants from Caramoran and Dipolog for example stated that "[…] before, when there was no 4Ps, we could not buy rice in bulk. But now, with the cash transfer, we buy more rice than we used to" and "[…] if we have cash, we can buy bulk. With monthly income only, can buy small amounts only."

Households' ability to purchase goods in higher volumes and at lower cost is also linked to their ability to better plan household expenditures, as the cash transfer constitutes a regular and reliable income support to the household. Beneficiaries in the City of San Jose del Monte and Caramoran mentioned that, knowing the cash transfer will be paid out every two months, enables them to plan expenditures accordingly. 4Ps beneficiaries would even prefer a monthly pay-out, to be able to better plan food purchases and smooth consumption. The other way around, less frequent pay-outs seem to render it more difficult for beneficiaries to plan their purchases and expenditures, as explained by beneficiaries in Ganassi and San Jorge, for example. Beneficiaries cannot rely on the money from the cash transfers in the planning of their daily and weekly food expenditure. This infrequent pay-out has also contributed to the development of local cash lending and borrowing mechanisms, most notably reported in Ganassi.

Next to infrequent pay-outs of the cash transfer, inflation and increasing food prices were cited as critical factors inhibiting the cash transfer's impacts on food consumption. Beneficiaries in all municipalities explained that the cost of basic foods, including rice, fruits, fish and meats, have

increased. As the cash transfer amount has not increased in line with inflation, beneficiaries cannot afford to buy the same quantity of foods they used to. A key informant from Hinigaran echoed the concerns of beneficiaries: "Due to inflation, I think there is a need to increase the grant. Based on field observations, the grant is not adequate anymore." And although not part of this assessment, beneficiaries repeatedly mentioned that the rice subsidy of PHP 600 per month is not sufficient to buy a sack of rice, which now costs PHP 2,500.

When asked for expenditure on food over the past seven days, the mean average expenditure as reported by beneficiaries was PHP 1,745. Disaggregating this information by municipality reveals that beneficiaries from San Jose del Monte and San Jorge have higher reported food expenditures than the other municipalities, as shown in ***Table 6*** below.

Table 6. *Average household food expenditure over the past seven days by municipality (in PHP)*

All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
1,745.0	1,745.8	1,607.7	1,720.0	1,315.6	2,028.5	2,060.7

Next to the cash transfer, the FDS and backyard gardening seem to positively influence and contribute to household's food consumption. As part of the FGDs, households learn to do backyard gardening for vegetable and fruit supply. This seems to be supported by most beneficiaries and strongly monitored by parent leaders and Municipal/City Links, as some beneficiaries report to send pictures to the Municipal/City Links for proof of gardening. "We are required to have a garden at home. It is inspected and monitored by the municipal links.", beneficiaries from Dipolog explained. Moreover, beneficiaries and interviewees in Dipolog, Caramoran, Hinigaran, and San Jose del Monte mentioned that the Department of Agriculture (DA) initially provided seeds for backyard gardening. Some beneficiaries in San Jose del Monte feel that their homestead gardens might alleviate some of the financial losses they would experience, if the 4Ps programme ended.

And even though the backyard gardening of fruits and vegetables might provide additional food supplies to the household, the vast majority of beneficiaries expressed that the food quantity they currently buy will be negatively affected, if the 4Ps stops. Respondents agree that they would not be able to purchase the same quantity of foods anymore. Below, **Error! Reference source not found.** illustrates the share of interviewees that report that their quantity of food would be reduced, if the cash transfer stopped, versus the share that does not think their food intake would change. Overall, three-quarter of all FGD participants across all six municipalities reported that the quantity of foods they are able to consume would be affected, if the cash transfer of the 4Ps ended. The disaggregation into municipalities shows that only 42 per cent of respondents in Caramoran and only 57 per cent in San Jose del Monte stated that they would feel an effect on the quantity. On the other hand, all beneficiaries from San Jorge say their quantity consumed would be affected and over 90 per cent from Ganassi reported that they would have to cut food consumption without the cash transfer.

Table 7. *4Ps effects on household food quantity by municipality*

Would the household's quantity of food be affected, if 4Ps stopped now?							
	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
Yes	75.6	41.7	76.9	91.7	85.7	100	57.1
No	24.4	58.2	23.1	8.3	14.3	0	42.9

Food diversity (quality)

In addition to the quantity of food intake, 4Ps beneficiaries were also asked about the types of foods they typically eat, as well as their preferred preparation methods, in order to assess the food diversity and quality. Beneficiaries were asked to recall the types of food that the household had eaten the day preceding the interview. The results are reflected in ***Table 8***. Overall, almost all households reported to have eaten grains, roots or tube vegetables in their past meals, while only 3 per cent had eaten legumes or nuts. Dairy products where included in less than 60 per cent of households' meals, with as few as 8 per cent in Ganassi and as many as 79 per cent in San Jose del Monte. Moreover, 87 per cent of all respondents indicated to have eaten meat or fish in their last meal, wherein in Ganassi only 50 per cent of households had fish or meat, and all respondents from Dipolog had fish or meat. Eggs were included in almost 70 per cent of households' meals, or as many as 93 per cent in San Jose del Monte and Dipolog, compared to 42 per cent in Caramoran and Ganassi. Fruit and vegetables were included in 92 per cent of households' meals, with relatively little regional variation; the lowest share reported was in San Jorge with 85 per cent.

Table 8. *Types of food included in the past meals*

What types of food were included in the meals you consumed yesterday? (tick all applicable)							
	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
Grains, roots, tubers	98.7	100	100	100	92.9	100	100
Legumes, nuts	2.6	8.3	0	0	0	0	0
Milk, milk products	59	75	69.2	8.3	64.3	53.9	78.6
Meat, fish	87.2	83.3	100	50	100	92.3	92.9
Eggs	69.2	41.7	92.3	41.7	85.7	53.9	92.9
Fruits, vegetables	92.3	100	92.3	91.7	85.7	84.6	100

During the interviews, respondents were also asked about their preferred food preparation method. The most common answers across municipalities were fried foods and soup-based dishes, followed by *adobo* (stew). Less commonly cited were grilled foods and sautéed foods, and only one respondent mentioned that the household commonly prepared steamed foods – one of the most nutritious methods to prepare food.

The majority of beneficiaries indicated that the cash transfer allows them to buy more diverse foods. FGD participants in Caramoran, for example, reported that: "Before 4Ps, we only used to buy dried fish most of the time. But with the cash transfer now, we can buy a variety of foods." Still, most beneficiaries also explained that they would like to buy more fresh foods, which is currently not possible. Moreover, food items such as meat still remain a luxury, and many

respondents pointed out that they cannot afford to buy meat for the household regularly, instead households often resort to sardines and dried fish.

Box 11328. *Role of fast food in Filipino diet*

Fast food seems to play a special role within the households participating in this assessment, and more generally in broader Filipino society. As part of the FGDs and in-depth interviews, caregivers oftentimes mentioned that on pay-day, they like to treat their children to fast food restaurants as a way of family bonding. Moreover, for many beneficiaries, fast foods are considered a luxury and linked to certain status. When asked about foods that they would like to eat, but cannot eat, one beneficiary explained: "Food that rich people eat that we see in television." Generally, there seems to be a discrepancy between what beneficiaries like to buy, know they should buy and can afford. Nearly all caregivers indicated to know that fast foods are unhealthy, but still identify it as the main treat for family and children to afford on pay-days. Thus, inaccessibility of these food options due to financial constraints seems to drive the appeal that is associated with eating out in fast food restaurants and the decision to overlook a more nutritious option.

More broadly, the fast food industry has been thriving in the Philippines and has transformed the landscape of Filipinos' diet and culture. Improved purchasing power pushed for higher spending on food and the increasingly busy lifestyles of Filipinos, especially for the emerging middle class, heightened the demand for more convenience, which fast food restaurants and chains could take advantage of. Buying fast food has now become an everyday routine for most people, especially for middle class earners engaged in productive activities, living in urban areas.

Source: (Institute for Development and Econometric Analysis, University of the Philippines, 2012)

Without the cash transfer, beneficiaries explained that they will have more difficulties in purchasing foods for a balanced diet on regular basis. Consequently, not only the quantity of beneficiaries' food intake would change without the cash grant, but also the diversity and type of foods consumed. For instance, a beneficiary explains that cassava or sweet potatoes would be used to replace rice as a carbohydrate, and that they would not be able to afford a protein like fish and only consume vegetables as a main course. As shown in ***Table 9*** below, 72 per cent of all respondents reported that the quality of food would be affected, if the cash transfer stopped. Again, San Jorge respondents unanimously report that the quality of their food consumed will be affected and respondents from the San Jose del Monte anticipated to be affected less, compared to respondents from all other municipalities.

Table 9. *4Ps effects on household food quality by municipality*

Would the household's quality of food be affected, if 4Ps stopped now?							
	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
Yes	71.8	58.3	69.2	91.7	92.8	100	21.4
No	28.2	41.7	30.8	8.3	7.1	0	78.6

Next to the cash transfer itself, the FDS also seem to have an impact on beneficiary households' food diversity. Most beneficiaries recall the learnings they take from the FDS in terms of balanced diet and food preparation. Examples they give include which type of fish and vegetables are more nutritious than others. One FGD participant explained that: "We eat *dilis* and cassava. We learned that these are healthy foods, very nutritious." The acquired knowledge also seems to empower beneficiaries to convince other household members and particularly their children to eat more

fresh foods. “Before 4Ps, my second child was malnourished, probably because I was not aware of the proper way to feed them and they did not eat vegetables. But with help of the FDS, I was able to tell the children that vegetables are really healthy. So now some vegetables became their favourite dish.”, a beneficiary explicated. Beneficiaries particularly liked the FDS modules explaining how to cook healthy foods economically and with ingredients that most beneficiaries have available and can afford to buy.

> “We learned a lot from FDS, like how to save money, how to maintain vegetable gardens to save expenses for food, because you do not have to buy these vegetables. We also learned how to prepare nutritious food for children, and we learned that a meal should have *go-grow-glow foods* so that it will be balanced.”, beneficiaries elaborated.

One beneficiary from San Jose del Monte even stated that with the knowledge from the FDS she would be able to continue preparing nutritious, yet even economical meals, even if the 4Ps stopped. However, some other mothers reported that they cannot always apply what they learned in the FDS, mostly due to financial stress and their inability to purchase nutritious foods. A beneficiary from Caramoran said that “[…] even with the cash transfer, […] we still have difficulty buying balanced foods.” Barangay Nutrition Scholars, Barangay Health Workers and Nutrition Action Officers across locations all confirmed that the majority of caregivers is aware of the relation between nutrition and child development; however, a Barangay Health Worker from Ganassi summarised the challenges a lot of households face as follows: “They are aware or know the value of nutrition, but many cannot afford a balanced diet. I think they can see the relevance. Some mothers admit that they don’t have proper meals at home. They are helpless because of poverty.”

Food security

Food security can be defined as the availability of food and households’ access to it. Hence, a household is considered food secure when its occupants do not live in hunger or fear of starvation. Thus, 4Ps beneficiaries were asked whether they currently experience hunger or have done so in the past as part of this assessment. Across all six municipalities, 23 per cent reported to have experienced hunger in the past, wherein households in Dipolog (39 per cent) and San Jose del Monte (36 per cent) reported higher levels of hunger in the past than others. Further 27 per cent said to have not experienced hunger, however, had to ration food at some point, with the highest share of households reporting food rationing in Caramoran (42 per cent). However, a total of 62 per cent of respondents from San Jorge confirm to having experienced hunger recently, while only 18 per cent of all respondents in the municipalities said so. Finally, 32 per cent of households said they had not experienced hunger in the past and are not experiencing it currently, with more than the majority of households in Dipolog never having experienced hunger. The overall experience of hunger is shown in the Figure below.

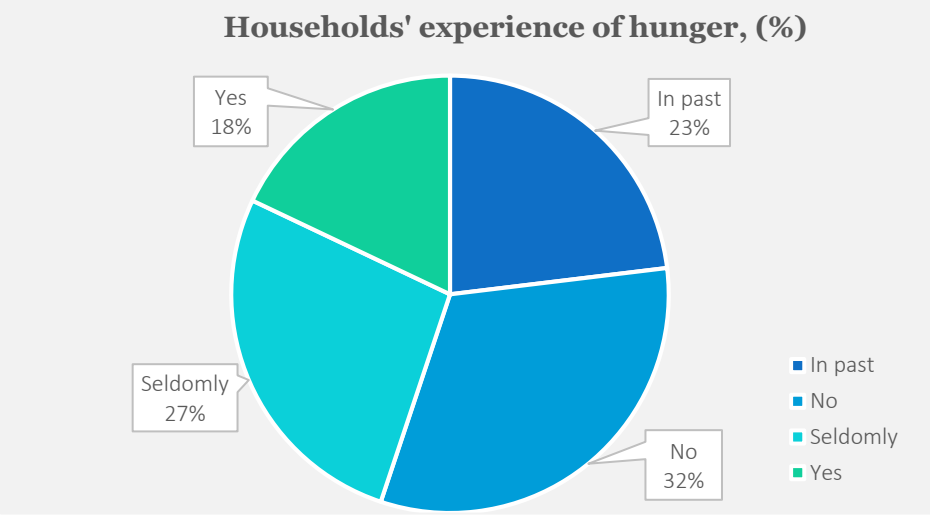

Figure 4. Experience of hunger as reported by study sample

During the in-depth interviews, 4Ps beneficiaries further explained the reasons behind having to ration food or even skipping meals and going hungry. Households are most likely to find themselves in such situations, when there is no permanent household income. Employment of one or more adult household members, or more generally income generating activities in households, seems to be the key driver of food security for the 4Ps households included in this assessment. In Caramoran, for example, households' food security is largely dependent on the ability to go out and fish, which is why more households report having to ration food and/or borrow money and/or food from other people during rough seas, when fishing is not possible. "Fishing and abaca farming are the only source of income here. And it is seasonal", one FGD participant explains. Likewise, in Hinigaran, beneficiaries indicated that they have no income during the off-season on the sugarcane plantations between June and September. Beneficiaries report that during these times, when income generating activities are more restricted, the dependence and reliance on the 4Ps cash transfer to purchase foods is higher. Similarly, an in-depth interviewee from Dipolog, explained that in the past she had to ration food during her pregnancy; however, the situation improved when her husband found a job. The other way around, the impact of the 4Ps cash transfer on food security seems to be less pronounced for households in which one or more adults in the household have a secure income.

Additionally, bigger households, with a higher dependency ratio tend to be more food insecure. As the cash transfer is shared between more household members, its potential for impact on the children is limited further. Disaggregating the respondents' answers on whether they experience hunger or must ration food according to household size reveals that as soon as households reach a size of up to four members, the past experience of hunger is more present, and households respond 'yes' more often when asked if they have to ration food. Larger households also seem to currently experience hunger more frequently than small households.

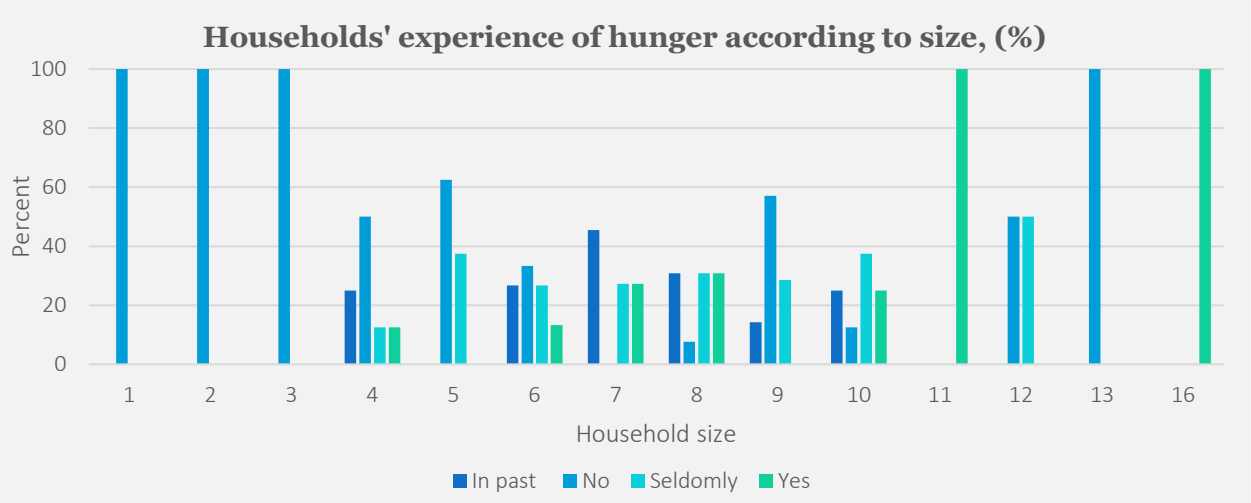

Figure 5. *Experience of hunger by household size*

Payment frequency also seems to play a role on the impact that 4Ps has on the food security of households. While most households across locations stress their dependency on the 4Ps cash transfer to purchase foods, in Ganassi, one beneficiary reported that the impact of 4Ps on their food security is less pronounced, as they cannot plan the use of cash transfer because it is only paid out every eight to ten months.

Lastly, the subjectivity of households' food security and diversity must be kept in mind. While information suggests that most households perceive themselves as more food secure with the cash grant as prior to receiving it and also described their diet as relatively balanced, during the FGDs some participants mentioned that their household resorted to eating rice only or not being able to provide balanced, nutritious meals as taught in the FDS. Likewise, the information and data collected in the household questionnaire does not allow for conclusive statements regarding adequate composition of meals, for instance how much protein-rich foods children actually consume. Consequently, although subjective food security increased among households, there might not be a real impact on nutrient intake and objectively measurable quantity of foods consumed among children, and generally all household members.

4.3.2. *Health care*

For the household level outcome of health and health care, the study investigated beneficiaries' health care seeking behaviour, what health care practices are like among the beneficiary households and to draw a holistic picture of caregiver health.

Preventive health care

All beneficiaries indicated that they visit the barangay health centre regularly for check-ups and for treatment of illnesses. Focus group participants mentioned vaccinations, growth monitoring, and getting vitamins and supplementation for children as the most commonly availed services

from the health facilities. In addition, most caregivers also get check-ups for themselves when at the health facility, including for example blood pressure and blood sugar check-ups. Furthermore, one of the main reasons for beneficiaries to go to the health facility is to check on the availability of free medicines. Oftentimes there is a shortage of free medicine supply though, so that beneficiaries must buy medicines, oftentimes at the nearest hospital. Some beneficiaries even mention to skip the health centre and go to the hospital immediately, in case of illness. This health care seeking behaviour is most notable in Dipolog, where beneficiaries mentioned that "We go directly to the hospital so the process will not be repetitive. If we go to health centre, they will refer us to the hospital anyway."

While most households go to a health facility for preventive care visits, a minority of households explained that transportation costs to the nearest health facility constitute a barrier to accessing health care. "There are times that we don't go to the rural health unit, even if we are sick, because travel expenses to the mainland are costly.", a beneficiary from Caramoran clarified. More generally, transportation costs were mentioned as a major item that households spend their health grant on, aside from medicines. A Barangay Nutrition Scholar from Hinigaran confirmed that "Before 4Ps, some mothers did not go to health centres because they didn't have money for the fare. But since they have a cash transfer, they have more motivation in bringing their children to health centres."

Even though the cash transfer facilitates access to preventive health care by providing resources for transportation costs to the health facility and medicines, beneficiaries unanimously stated that they will continue to visit the health centre, even if the cash transfer would stop, as they feel that their children's and their own health is their responsibility. This also explains why most beneficiaries do not find it difficult to comply with the health conditions, as outlined in ***sub-section*** *Error! Reference source not found.**1. Error! Reference source not found.**.*

Water, sanitation and hygiene

To get an indication of the household's WASH situation, the in-depth interviewees were asked about the household's main source of drinking water, the type of toilet facility used and the respondents' hand washing behaviour. In terms of their main source of drinking water, 14 per cent of beneficiaries said to be using piped water, 4 per cent use water from a tube well/borehole or dug well, respectively, and the remaining 78 per cent reported to use other sources of drinking water, such as buying mineral water (two-thirds) and using spring water (one-third). The regional breakdown presented in ***Table 10*** below shows that in all municipalities but San Jose del Monte, the majority of beneficiaries indicated to use an 'other' source for drinking water. All respondents from Ganassi and Caramoran who indicated 'other' source, reported to use spring water, while all respondents from Hinigaran, San Jorge and Dipolog buy mineral water, as do most beneficiaries from San Jose del Monte, who indicated use of an 'other' source. Only in Hinigaran did beneficiaries report to use water from dug wells, with few respondents elaborating that these

wells were near septic tanks of their own or their neighbour's toilet. No respondent said to use surface water.

Table 10. Main source of drinking water, as share of total (%)

Source	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
Piped water	14.1	0	7.7	0	0.0	0	71.4
Tube well or borehole	3.9	0	33.3	0	14.3	0	0
Dug well	3.9	0	0	0	21.4	0	0
Surface water	0	0	0	0	0.0	0	0
Other	78.2	100	84.6	100	64.3	100	28.6

Based on the focus group discussions and in-depth interviews, beneficiaries seem to be well aware of the linkages between using improved toilet facilities and well-being. "There are so many of them staying in one small dilapidated house. They don't have toilet either.", a beneficiary from Caramoran described, when talking about a poor household in the area. When asked for their own toilet facility, 90 per cent of households indicated to have a pour/flush toilet, 2 per cent each reported to have a pit latrine or use a public toilet, no household reported using a composting toilet and 4 per cent reported to practice open defecation. The remaining 4 per cent reported to use an 'other' type of toilet, which was not further specified. A total of 28 per cent of respondents said they share their toilet, wherein 25 per cent share their toilet with one other household, 35 per cent share with two other households, 20 per cent with three households and five per cent said to share with four, seven, ten and 'too many to count'. The sharing of toilet facilities is also encouraged by Barangay Health Workers: "Yes, we monitor households without a toilet. We encourage them to use their neighbour's toilet if they do not have one."

Table 11. Type of toilet facility and sharing of facility, as share of total (%)

	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
Type of toilet facility							
Flush/pour toilet	89.7	66.7	100	75	92.9	100	100
Pit latrine	1.3	0	0	8.3	0	0	0
Composting toilet	0	0	0	0	0	0	0
Public toilet	1.3	0	0	8.3	0	0	0
Open defecation	3.9	8.3	0	33.3	0	0	0
Other	3.9	25	0	0	7.1	0	0
Sharing of facilities							
Shared	27.6	27.3	15.4	75	23.1	23.1	7.1
Average number shared	3.6	3	2	6.3	2.3	1.3	3

A significant share of beneficiaries reported having used the 4Ps cash transfer money to construct their own toilet facility. Beneficiaries learned about sanitation and having their own toilet facility during the FDS, as multiple beneficiaries across locations stated that they were reminded during the FDS to build their own toilet facility. Some beneficiaries indicated that they benefitted from the distribution of free toilet bowls at the barangay level. The City Link in Dipolog explained that the 4Ps beneficiaries who did not have a toilet bowl were linked to the city health office to receive free toilet bowls. Moreover, in Dipolog the Sanitary Inspector has been invited to provide expert information during the FDS. "Our toilet was built from cash grants. Our children agreed to spend the cash grants for the construction of our toilet. The mayor provided for the toilet bowl. To avoid sickness, we knew from FDS that we need to have a proper toilet.", a beneficiary from Hinigaran confirmed.

Additionally, some households mentioned to buy hygiene and sanitary items and toiletries with the cash transfer. Again, the regularity of the transfer enables them to buy goods in bulk, reducing the unit price of the goods and making the purchase more economical. The FDS also seem to have played a role in educating caregivers about personal hygiene and hygiene practices for their children. Focus group participants recalled FDS on food preparation and hygiene practices, including for example hand washing before food preparation, cleaning of breast before breastfeeding, and covering of water containers for storage. Moreover, key informants across locations confirmed that a lot of caregivers take on personal hygiene practices taught in the FDS, as caregivers looked less stressed. "It could be due to good nutrition and proper hygiene.", noted a Nutrition Action Officer in Caramoran. However, this behaviour might also be a response to appeals from Municipal/City Links, rather than a profound change in attitudes and behaviours of caregivers. It became evident that Municipal/City Links strongly advise beneficiaries to look "[…] presentable and clean, when going to the FDS and during pay-out. They should take a bath and avoid *nganga* (betel nut)."

While all respondents indicated to wash their hands with soap regularly, a Barangay Health Worker in Ganassi also spoke about the challenge of parents not taking the information provided seriously, especially with regards to hand washing procedures. Oftentimes caregivers were not open to take on new information and translate it into behaviour changes. Likewise, close to 4 per cent of all households participating in this assessment still practice open defecation, with as much as one in every three households in Ganassi, even though FDS strongly encourage households to build improved toilet facilities.

Overall, the 4Ps has significantly contributed to the building of improved toilet facilities for many households by providing them with the necessary cash or linking beneficiaries to ongoing initiatives of free toilet bowl distribution, and also by reminding them of the crucial role that improved sanitation plays during the FDS. In terms of permanently changing beneficiaries' attitudes and behaviours towards handwashing procedures and personal hygiene, however, the

4Ps' effects are less obvious and pronounced, as caregivers seem to take on personal hygiene practices largely to comply with demands to look 'presentable' during pay-outs and FDS.

Caregiver physical health

As caregivers' own physical health constitutes a vital factor in children's health and development, the assessment asked caregivers to give a self-assessment of their own health status. The study therefore asked to assess their own health on a scale from 1 (lowest) to 5 (highest). Of all respondents, 37 per cent rated their own health with 4 and 36 per cent even described it as 5. About a quarter of the respondents rated their health with 3 and only 3 per cent rated it 2 out of 5. All respondents who rated their own health with 2 out of 5 are from Dipolog.

Disaggregating the data by municipality, it becomes evident that in Caramoran caregivers assessed themselves the healthiest, with 75 per cent rating their health as 5 out of 5, while in San Jorge overall caregivers gave themselves the lowest rating, with 46 per cent describing their health as 3 out of 5. During the FGDs and in-depth interviews caregivers revealed some of the reasons for not giving themselves the highest rating. Some caregivers mentioned serious physical illnesses, such as cancer and asthma affecting them, others emphasized the stress and physical burden of being a mother and symptoms of other forms of stress, including fatigue and high blood pressure. One mother from San Jorge described her own physical health as:

> "Rated 3 out of 5. Sometimes, I cannot find time for myself. I always work, for example, do laundry. My blood pressure is okay, but sometimes I feel numbness due to the laundry job and household chores in my employer's house. However, I still can go home to take care of my children; I still have time for the children before going to my employer's house."

Table 12. Self-rated physical health of caregiver

Rating	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
1	2.6	0	15.4	0	0	0	0
2	24.4	0	15.4	33.3	21.4	46.2	28.6
3	37.2	25	46.2	33.3	42.9	15.4	57.1
4	35.9	75	23.1	33.3	35.7	38.5	14.3
5	2.6	0	15.4	0	0	0	0

While the 4Ps health conditions stipulate regular health check-ups for children, no corresponding condition exist for caregivers. Nevertheless, the majority of caregivers mentioned to go to the health facility and get their blood pressure checked anyway. The major impact of 4Ps' on caregivers' health might thus be that caregivers go to the health facilities anyway to get their children checked-up and while there also get their own health checked. Furthermore, a few caregivers explained that they use the cash grant to buy medicines that they require. One mother in Hinigaran explained that she needed to take medicine for ten months, costing PHP 33 per day. The 4Ps cash grant helped her to pay for a share of the required medication.

4.3.3. *Care practices*

The study investigated beneficiaries' feeding and childcare practices, caregiver empowerment as well as their level of stress and resilience to stress.

Caring practices

Beneficiaries indicated that doing household chores related to child care and preparing their food were the child-care practices that occupied most of their time. Only few beneficiaries mentioned that spending active time with their children, for instance through playing and other interactions, occupied much of their time in the FGD. However, based on the data from the survey, almost half of respondents spend more than five hours per day with their children for play, feeding, reading and bathing them (37 per cent spend one to three hours). Only 4 per cent of respondents said to spend less than one hour on those activities. Breaking this information down to the municipal level shows that between 7 and 8 per cent of respondents from Ganassi, Hinigaran and San Jorge spend only one hour with their children. In contrast, none of the respondents from the City of San Jose del Monte, Caramoran and Dipolog say to spend less than one hour with their children per day.

Table 13. Time spent with children

Time	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
< 1 hour	3.9	0.0	0.0	8.3	7.1	7.7	0.0
1-3 hours	37.2	25.0	53.9	16.7	21.4	53.9	50.0
4-5 hours	11.5	8.3	7.7	0.0	28.6	15.4	7.1
5+ hours	47.4	66.7	38.5	75.0	42.8	23.1	42.9

Although most mothers mention values such as respect for authority and good conduct, good manners, religion and responsible behaviour (such as coming home directly after school, set times for watching TV, doing homework and household chores) as priorities for their child care, they also emphasise the need and importance to show their children they are loved and cared for. Concrete actions mentioned to show such affection are kissing them goodbye in the morning or taking them to bed at night, as well as dropping them off at school or picking them up after class. Caretakers also mention that they want to support their children's talents and encourage their positive development. Across all locations, beneficiaries frequently used the term 'for the sake of the children' when discussing their own ability to fulfil their duties and deal with stress. Over 90 per cent of caretakers also reported to take their children to a health facility, if they are sick.

The majority of beneficiaries interviewed as part of this assessment identify other female members of the family (typically mother, mother-in-law, aunt, etc.) as the main information source about care practices. Some also described the FDS or 4Ps staff as a source of information in this context, but also made reference to digital source such as social media. Beneficiaries mentioned that they learned a lot of the care practices they apply during the FDS and that "In fact, child care practices and 4Ps conditionalities complement each other for the good of your family." They agreed that it is easy to apply the care practices and to care for their children. When asked about one topics of the care practices they applied to their children, one mother from San Jose del Monte

responded that she stresses the relevance of hand washing to them: “Before eating, wash hands; after eating, after using the toilet, wash hands. I told them that they should wash their hands because it is the source of dirt, so they should always wash their hands to avoid sickness.”

However, with regards to applying knowledge and the implicit goal to take the best care possible of their children, a big source of frustration and stress mentioned by beneficiaries is that sometimes explanations or methods do not work, and that financial insecurity is a constant worry. One mother in an FGD in San Jose del Monte stated that “We get used to our poverty, day in and day out, money is always the problem.”

One key informant interviewed in Hinigaran indicated that s/he observes a strong link between the children’s nutritional status and the care they receive. The key informant reported that their feeding programme, which provides milk, rice, micro-supplements and appetite enhancers to affected households, does not tag 4Ps households. Instead, s/he explained that caregivers of all 15 severely malnourished children in Hinigaran who are being monitored and fed, are perceived as less knowledgeable in terms of care practices and less caring of their children and themselves. One Nutrition Action Officer said “Mothers do not practice proper hygiene. We gave out nail cutters hoping that cleanliness of the body can start from there. Proper hygiene can combat malnutrition.”

Feeding practices

As important part of care practices, the study looked at feeding practices in more detail. When asked about relevant care and feeding practices, only a minority of mothers mentioned breastfeeding during the FGDs. Only one mother pointed towards the relevance of communicating with the child during breastfeeding, but when talking about important care practices, a few mothers mentioned the relevance of breastfeeding for emotional bonding between mother and child. However, in the in-depth interview and survey the mean length of time that mothers reported to have breastfed their infants after birth is 20 months and 84 per cent of mothers said to have initiated breastfeeding immediately after birth. The interviews further showed that some mothers were not able to breastfeed their children because they had too little milk or were working and thus had no time or resources to organise breastfeeding.

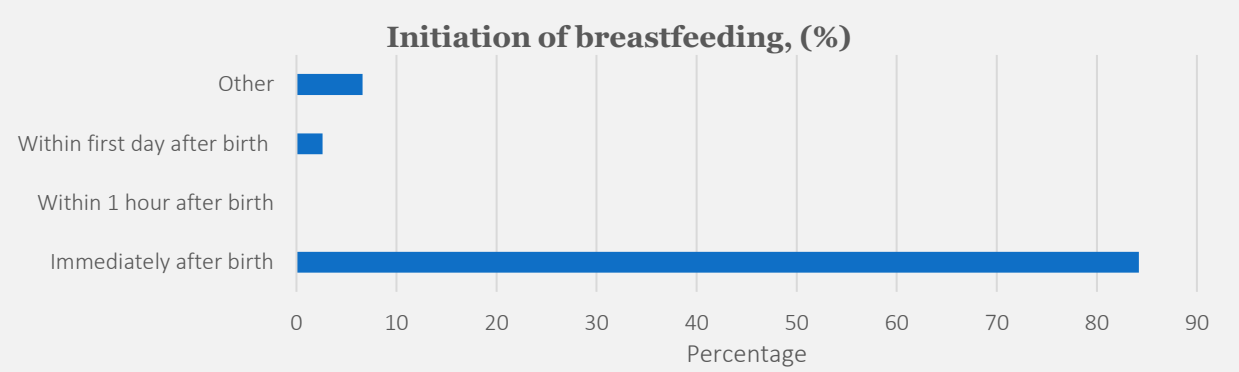

Figure 6. *Time of initiation of breastfeeding for last child*

In line with this, only few mothers explained the need to take into consideration the different ages of children and related food preferences and needs, when preparing food. Although only one mother made explicit mention of complementary feeding practices and introduction of solid foods, the data from the in-depth interview and survey shows that 80 per cent of mothers said to have introduced solid foods to their infants' meals after six months. In the FGD, when beneficiaries discussed care practices, beneficiaries said they focus on ensuring that children are fed during appropriate feeding times and they frequently mention the importance of having regular meal times, preparing breakfast for them before school and packing lunches for their children when they attend school. The data further indicates that there seems to be the overall perception that a good appetite of children is considered an indication of good health.

Key informants at all levels in Caramoran observed that attitude and behaviour of parents are decisive for their children's health "Nutrition and health status of children depend on the parents, whether 4Ps or not. Malnourishment is based on parents' attitude." A Municipal Link shared this view and raised the question as to why the high prevalence of malnutrition in the municipality has not seen reductions, although mothers show a keen interest for health and nutrition during the FDS and report that they prepare nutritious meals, including vegetables, for their children. He further described that some grantees are encouraged to prepare colourful vegetable dishes for their children and that they provide mothers with supplemental food. He also pointed out that it is a missed opportunity to not monitor, who receives the supplements.

Across all municipalities, key informants emphasized the important role of vegetables for child nutrition and also mentioned frequently that recipes and methods are discussed during FDS. Beneficiaries described the FDS as valuable and pleasant source for information about health and care practices: "We learned how to take care of the whole family, also particularly learned about health and care practices, also learnt how to cook there." Key informants, for instance Barangay Nutrition Scholars, reported that they do observe positive impacts of the FDS and that the participants usually achieve changes in attitude and learn healthier behaviours. But they also said, that there are 'sluggish' or 'stubborn' beneficiaries, who do not seem willing to adopt new behaviours and attitudes.

Even though a range of mothers explained that they learned about nutritious foods to feed their children and junk foods not to feed their children, all beneficiaries agree that fast and fried foods are desirable, and they want to buy more of it. One main reason for this that is frequently mentioned is family bonding and because it makes the children happy to eat such foods.

Caregiver empowerment and emotional well-being

Only three households in the sample are female-headed households, the remaining 75 are headed by men. Still, women almost always are the primary caregivers in the household. When asked about who supports them in caring for the children, 33 per cent of all female caregivers reported that no one supports them. Hence, they indicated to receive no help from their husband, other household members, extended family or neighbours. The highest share of female caregivers reporting to not receive any support in child caring live in Hinigaran (43 per cent) and San Jorge (54 per cent).

Table 14. Support with childcare

	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
Yes	66.7	66.7	69.2	75	57.1	46.2	85.7
No	33.3	33.3	30.1	25	42.9	53.9	14.3

Of the female caregivers that stated to receive help with childcare, 50 per cent mentioned their husband as the person, who helps them raise their children. In Dipolog and San Jose del Monte about two-thirds of all female caregivers that receive support in childcare, pointed out to be supported by their husbands. By contrast, fewer husbands engage with childcare practices in Hinigaran and San Jorge.

Table 15. Husband helps with childcare

	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
Yes	50.0	41.7	69.2	58.3	35.7	30.8	64.3
No	50.0	58.3	30.7	41.7	64.3	69.2	35.7

In Ganassi, the male caregiver is the purse keeper whereas in most locations the mother/female caregiver is the purse keeper. Partners usually divide the work into buying food and cooking it, where the husband is responsible for making the purchases and the wife prepares the food. This is also visible in the data from the in-depth interviews; with regards to household decision-making, all respondents (100 per cent) indicated that they are involved in decisions pertaining to their own health, their children's health, food purchases, as well as major household purchases. Only 3 per cent are not involved in decisions pertaining to family visits.

In FGDs beneficiaries discussed the positive impact of the FDS on their emotional well-being and improved ability to engage with society. One group stated "Before, we were shy. We were just staying in our house most of the time, so we were not confident. When asked during FDS, we were just quiet, we did not care to participate. Now, we learned how to interact with people." They described the FDS as an opportunity for exchanging experiences and learning. Some municipalities use the FDS as a stage for communal cooking classes where beneficiaries bring ingredients to the

FDS and practice “economical and nutritious recipes” together. Beneficiaries also mentioned that, as a result of the FDS, they understand the ‘true definition of family development’ better.

Nonetheless, as main information source for care practices almost all beneficiaries pointed to other female members of the family (typically mother, mother-in-law, aunt, etc.). Thus, even though FDS seem to enjoyable to most caregivers, they are not considered a viable source of information with regards to care practices. In this context, a Nutrition Action Officer pointed to the importance of barangay captains for engaging beneficiary parents and ensuring that they attend the FDS.

Stress and resilience to stress

During the in-depth interviews, parents indicated that their main stress factor is their financial situation and the worry to not being able to afford sufficient food for the household and the transportation fare for school children. This financial stress was also reported to be the main reason for discussions and arguments between spouses. Additionally, during FGDs beneficiaries frequently mentioned their children as a source of stress for them. Issues pertaining to rearing children, which cause stress, mentioned by mothers are for instance disobedient children, children with special needs who need more care or sometimes teenage pregnancies. Single parents in particular emphasized the stress of raising children, as they are solely responsible for the household and often indicate to have no one to talk to and discuss their concerns. One of the most frequently made points is that children do not fulfil their household chores, which requires themselves, usually the mother, to fulfil their chores on top of the regular household work, even if they have a job. This is described as extremely stressful. Some respondents also mentioned in their in-depth interviews that they feel guilty after getting angry, irritated or frustrated with their children. Beneficiary mothers also elaborated that they experience health issues or signs of stress, such as yelling, occasionally not being able to control their stress or frustration, reacting emotionally or feeling symptoms such as stomach ache because of stress.

Key informants also highlighted the relevance of the community for exchanging information and knowledge among beneficiaries. In terms of changing behaviour of caretakers, key informants mentioned that they observed mothers improving their vocabulary, not swearing in front of their children and stopping physical punishment of the children. In Dipolog, it is reported that external agencies are sometimes invited to conduct FDS to provide beneficiaries with expert knowledge. One key informant clearly stated that s/he observed a strong improvement among beneficiaries’ living situation: “They have felt the pain of poverty. Also, today, some mothers look presentable, less stressed. It could be due to good nutrition and proper hygiene.”

In addition to the FDS playing a role in alleviating some of the stress that caregivers face by empowering them and teaching them ways of dealing with stressful situations, the 4Ps cash benefit also seemed to have contributed to lowering stress levels within the household, by (partially) reducing the financial stress and pressure that caregivers face. One beneficiary from San

Jose del Monte explained during an FGD: "In our case, when we became 4Ps beneficiaries, our family relationship improved. Before 4Ps, my husband and I used to frequently quarrel over financial problems. But these eased out when the cash grant was there. It is easy now to borrow money, so we are able to address our family needs hence there is more harmony at home."

4.4. Immediate causes of malnutrition and 4Ps' impact

As expounded above, the 4Ps influences the underlying causes of malnutrition at household level through different avenues. These underlying causes in turn, directly influence the immediate causes of malnutrition at the individual child level – the child's dietary intake and the health status of the child. With the 4Ps targeting households and the cash typically being shared among household members, the pathways to impact on these underlying causes are rather straightforward, however, the 4Ps impacts on the immediate causes of malnutrition at the individual level are less obvious and more difficult to point out.

4.4.1. *Dietary intake of child*

The dietary intake of the child is the result of the household's food security and care practices the child is subject to. Thus, the way that the 4Ps impacts the food security and care practices within a household, ultimately reflects in the dietary intake of children living in the household. As expounded in ***sub-section 4.3.1.*** *Food security*, the 4Ps cash transfer enables most households to enhance their food quantity and quality by providing additional income, which can be spent on food purchases. In turn, most 4Ps beneficiaries confirmed that the dietary intake of their children has changed with the availability of more cash. This is not just true for children in the household that are enrolled in the 4Ps, but for all children living in the household. As indicated by 4Ps beneficiaries, the cash transfer is typically shared among all household members; hence all children in the household, regardless of their 4Ps beneficiary status, have benefitted from foods purchased through the cash transfer.

In addition to buying foods, some caregivers mentioned during the FGDs that they buy milk, vitamins and other supplements for the children with the help of the 4Ps cash transfer. A Barangay Health Worker from Caramoran confirmed that "4Ps families can buy vitamins and milk for the children. They can buy rice and have better food compared to non-4Ps. So 4Ps children are better off than non-4Ps."

Moreover, the FDS seem to have played a role in teaching caregivers about nutritious and healthy foods that can positively impact their children's development. During the focus group discussions, caregivers kept referring to 'go-grow-glow foods', which they had learned about in the FDS. According to the caregivers, they now see a clear link between the foods they feed their children, and the children's nutritional status and overall well-being and development. A Barangay Nutrition Scholar from Dipolog agreed with the beneficiaries' statements and explained that "Yes, they have

applied what they learned in the FDS. Like not eating junk foods and soft drinks. I can see mothers who let their children eat vegetables and other nutritious foods." On the contrary, however, the 4Ps cash transfer also enables households to buy desired foods that they usually cannot afford – most of which would be considered unhealthy foods. A substantial share of all focus group discussants stated that they like to take their children to a fast food restaurant on payday, as a special treat and a way of family bonding.

Nevertheless, overall the 4Ps seems to positively impact the dietary intake of beneficiary children, with the increased availability of cash in the household, as well as enhanced knowledge of parents on what types of foods foster a healthy development of their children. Still, the same challenges as for the 4Ps impacts on food security and care practices apply here – most prominently infrequent pay-outs limiting the ability to plan food purchases, cash benefits not adjusted to inflation and household size going beyond three children, as well as mixed evidence on the application of learnings on care and feeding practices from the FDS.

4.4.2. *Health status of child*

The same way that a child's dietary intake depends on household-level factors, the health status of a child is the result of the household's health care seeking behaviour, as well as the care practices the child is subject to. When asked about their children's health status, most caregivers assessed their children as healthy during the focus groups and in-depth interviews. To further substantiate their statements, many caregivers offered evidence such as "They don't get sick easily. They are into sports." and "They are energetic, have a good appetite." Nevertheless, when asked whether one of their children was sick during the past 14 days, almost half of all survey respondents answered 'yes'. The most common diseases were fever (53 per cent) and cough or respiratory issues (32 per cent), with only a minority reporting diarrhoea (3 per cent) and other diseases (13 per cent).

When the respondents were further asked whether they went to seek advice and/or treatment for the illness from a medical professional, over 90 per cent responded with 'yes'. This point supports the 4Ps beneficiaries' explications about their health care seeking behaviour. Not only do households regularly go to the health facility for preventive care and check-ups, as elaborated upon in ***sub-section 4.3.2****. Health care*, but the vast majority also seeks advice and/or treatment in cases of illness.

Within the small sample, no relation between the caregivers' self-assessed health and children's illness could be found. Nevertheless, caregivers seemed to be aware about the effects that their own health has on their children's health. During focus groups and in-depth interviews many caregivers pointed towards the link between their own health and their children's health. A beneficiary explained that "When we are healthy, they are healthy!".

Key informants confirmed that parents are aware of the linkages between their own health and their children's health. Moreover, they explained that there is higher awareness among caregivers now, that the care practices they apply do affect their children's health and well-being. A beneficiary from Ganassi highlighted that "[During FDS, we] learned how to take care of the children well. They teach us many topics. Yes. Even it is difficult to comply, I really do it for my children's sake and well-being."

Consequently, as for the health care seeking behaviour at household level, 4Ps primarily seems to impact the health status of the individual child by ensuring that households avail health care regularly, for preventive care and check-ups, as well as in cases of illness. Households have available resources to cover the transportation cost to the nearest health facility, where caregivers and children are provided with free check-ups and free medicine, if available. Likewise, the FDS seem to have played a role in strengthening awareness on relevant care practices and how these can impact a child's well-being and health status. FGD participants across locations did also mention the FDS as a main source of health-related advice, next to the health centre and barangay officials. As elaborated upon above, evidence on whether caregivers regularly apply these practices, however, is more difficult to establish. Nevertheless, the FDS have played a role in creating awareness and building knowledge.

4.5. 4Ps' impact on nutrition outcomes in assessed 4Ps households

The previous sections assessed the 4Ps' impacts on the underlying causes of malnutrition – food security, health care and care practices – and immediate causes of malnutrition – dietary intake and health status of the child. Across the sections, evidence on how the 4Ps programmes has influenced these underlying and immediate causes in the six municipalities, is presented. As a way consolidating and integrating the findings, the following sub-sections explore the factors that have promoted 4Ps' impacts, and what main barriers prevail and prevent impacts. It must be noted that the assessment draws mainly on qualitative research findings and supplements these by indications given through a short household questionnaire. Thus, none of the findings elaborated upon below indicates correlation and/or causation, but merely constitutes a factor that repeatedly came out as promoting or inhibiting nutritional impacts within the households participating in the assessment. Likewise, the assessment did not take anthropometric measurements of the children living in these households and only asked caregivers for a self-assessment of their children's height and weight.

4.5.1. *Factors promoting nutrition impacts*

Subsequently some of the factors that consistently emerged as promoting nutrition impacts across the six locations are elaborated upon.

4Ps cash transfer to strengthen food security

Overall, the 4Ps cash transfer has strengthened the food security of beneficiary households. The transfer constitutes a (more or less) regular form of household income, which allows households to plan their food expenditure accordingly. As a result, for the majority of households the 4Ps cash grant positively impacts the quantity of foods that they buy, as well as the quality or diversity of foods. The specific ways in which the cash transfer impacts the households, are largely defined by the household's economic situation and the income generating activities of adults living in the household. In households where no adult earns a regular income, or income is only seasonally earned, the cash transfer plays a bigger role in impacting the availability and quantity of food. Especially in times when no other regular income is earned, households heavily depend on the cash transfer to purchase basic foods such as rice, fruits and eggs.

By contrast, in households where at least one adult earns a steady income, the reliance on the 4Ps cash transfer to purchase basic foods is lower. Households indicated instead to spend the money on foods that they otherwise would not be able to purchase regularly, for example meats or milk, effectively diversifying their diet. Some of these households even stated that they would buy vitamins, supplements and milk for children, thereby directly influencing the dietary intake of the children.

Family development sessions to empower caregivers

The family development sessions seem to have played a major role in empowering caregivers, particularly female caregivers, who are the main attendees of these events. By providing caregivers with knowledge on a range of topics, particularly relevant in this context are caring and feeding practices, they felt empowered and better equipped to handle their children in different situations – some of which might cause stress for them – and overall learned to be more confident in their interactions with children and other household and community members. In bringing together caregivers from different households to learn and discuss together, the FDS have also played a vital role in creating a feeling of community among caregivers. By addressing caregiver stress, empowering them and overall enhancing their well-being, the FDS thus, at least partially, addressed underlying cases of malnutrition resulting from inadequate care practices.

Information on self-reported caregiver well-being and malnourishment of children supports these findings. Caregivers that positively assessed their own well-being (rating 4 out of 5, or higher) also assessed the nutritional status of their children as higher – 91 per cent assessed their children as normal in terms of height and weight. Caregivers that assessed their own well-being lower (rating below 4 out of 5) assessed the nutritional status of their children worse – only 80 per cent thought their children would be normal. Again, it must be kept in mind that these are self-reported indicators of well-being, height and weight of caregivers and might hence suffer from perception bias.

4Ps as a platform to link beneficiaries to other initiatives

Through its linkages to other initiatives, 4Ps has shown to be able to promote impacts on household's food security and also sanitary environment, which ultimately impact the health of children and other household members. By providing FDS participants with seedlings from the Department of Agriculture, the 4Ps enabled household to start backyard gardening, which now plays a vital role in providing households with fresh fruit and vegetables, as pointed out by many beneficiaries. Likewise, using the FDS as a platform to link the 4Ps beneficiaries to free toilet bowls initiatives carried out at local level has supported many 4Ps households in building their own, improved toilet facility. Hence, such linkages have contributed to promoting nutrition impacts by addressing underlying drivers of malnutrition at household level.

4.5.1. *Barriers to achieving nutrition impacts*

While the factors listed above have contributed to the 4Ps' ability to realise nutritional impacts within beneficiary households, a range of factors persists, currently inhibiting impacts. These barriers to achieving nutritional impacts are related to different design and implementation components of the 4Ps.

Benefit structure and payments

The 4Ps cash benefit level has not been adjusted to inflation since the programme roll out in 2008 and for beneficiary households across all six municipalities this decrease in the real value of the transfer constitutes a substantial challenge. With increasing prices of foods, including rice, fruits and meat, beneficiary households cannot purchase the same amount of foods as they used to. Likewise, the limitation of the education grant to three beneficiary children per household has limited the cash transfer's potential to enhance household's food security. The average household size in the sample is 7.13, with 4.14 children; however, on average, only 2.24 children per household are included in the 4Ps programme. Since the 4Ps cash grant is shared among all children, or even household members, the effective per capita grant is relatively low, particularly for bigger households, in turn reducing the cash transfers' ability to achieve meaningful impacts.

Furthermore, the irregularity and infrequency of payments in some locations, usually linked to a change in the payment modality, constitutes a barrier for the cash transfer to achieve more profound impacts. Not knowing when the next payment comes, reduces beneficiaries' ability to plan their food purchases and expenditure. In locations with less frequent pay-outs, beneficiaries frequently borrow money and/or food to bridge the gap between payments and once the 4Ps cash transfer is paid out, the money is used to pay back the borrowed money plus interest.

Reaching vulnerable households and children

The reliance on the 2009 wave of the Listahanan for targeting of the cash transfer means that all newly poor families and families that did not have children in 2009 yet, are excluded from the 4Ps programme. In addition to not reaching all poor and vulnerable households, the 4Ps programme

currently also does not cover the youngest children living in 4Ps beneficiary households. With a limit on the education grant for a maximum of three children per household, the older children in the household tend to be enrolled in the 4Ps programme. And again, younger children living in 4Ps households might not have been born at the time of the first wave of the *Listahanan*. While the cash transfer is typically shared among all children living in the household or even all household members, the lack of enrolment of younger children in the household, means that the education and health conditions are not monitored for these children. With the first 1,000 days constituting the primary window to achieve nutritional outcomes for children, the 4Ps thus misses a major opportunity to positively impact the nutrition outcomes of its beneficiary children due to shortcomings in its targeting approach.

Format of family development sessions

Whereas the FDS are a popular activity among the beneficiaries and the sessions seem to have significantly contributed to the empowerment of female caregivers and made them more confident in interactions with children, household members and the wider community; the transmission of knowledge and information to beneficiaries to induce behavioural change seems to be falling short. A major challenge to more effectively transfer knowledge and induce permanent change seems to be the format that the FDS are currently conducted in. The spaces are often too crowded and loud, and presenters do not make use of microphones and visual aids to better engage the beneficiaries. Moreover, the modules on health and nutrition are rather brief and do not provide detailed enough information.

Monitoring of outcomes

Likewise, there is limited monitoring as to whether beneficiaries apply knowledge acquired during the FDS. For some initiatives, such as backyard gardening, Municipal/City Links seem to play a vital role in monitoring whether 4Ps beneficiaries set up and maintain gardens; however, for most sessions, no monitoring activities are carried out, as also indicated by some beneficiaries not being able to recall topics covered during the last FDS. Together with the non-conducive learning environment that FDS are conducted in, the lack of monitoring likely also contributed to limited behavioural change at household level.

4.5.2. *Beyond 4Ps: Basic factors hampering nutrition impacts*

As also reflected in the assessment framework, there are basic factors that can influence the nutrition status of children and hamper the positive effects that the 4Ps could have on nutritional outcomes of beneficiaries. Such basic factors include for example the access to and quality of services, available human and financial resources, and broader socio-cultural, economic and political factors. And while the 4Ps programme does not aspire to directly impact these factors, the latter can still play a significant role in determining the 4Ps success in positively impacting the nutrition status of its beneficiaries, as these factors shape the environment within which the

programme operates. Subsequently, the role that these basic factors play in defining the environment that the assessed households live in, is briefly explored.

Access to and quality of health facilities

As beneficiaries indicated that the 4Ps health grant is oftentimes spent on transportation costs to health facilitates, beneficiaries were asked about the average travel time to the nearest facility, as well as their overall satisfaction with the quality of services received. Almost two-thirds of all respondents across locations indicated that they travel less than 15 minutes to the nearest facility, and 28 per cent travel between 15 and 30 minutes. Only the minority of respondents travels up to 60 minutes (6 per cent) and no respondent travels more than one hour. In Caramoran, Ganassi, Hinigaran, San Jorge and SJDM more than half or half of all respondents need less than 15 minutes, whereas in Dipolog the majority (54 per cent) takes between 15 and 30 minutes to reach the nearest facility. Thus, overall, across all six locations, access to health facilities seems largely secured, as the vast majority of beneficiaries can reach health facilities in under 30 minutes.

Table 16. Travel time to health facilities

Travel time	All	Caramoran	Dipolog	Ganassi	Hinigaran	San Jorge	SJDM
Less than 15 minutes	65.4	66.7	46.2	66.7	50	100	64.3
15-30 minutes	28.2	16.7	53.9	33.3	35.7	0	28.6
Up to 60 minutes	6.4	16.7		0	14.3	0	7.1
More than 60 minutes	0	0	0	0	0	0	0

Asked about the quality of services in the health facilities, almost half of all respondents rated the services as 'satisfactory' and over one-third as 'highly satisfactory'. Eighteen per cent said the services were fair and only 1 per cent rated the services as 'unsatisfactory'. Most beneficiaries elaborated that they perceive the barangay health officers and midwives as highly knowledgeable on health and health care. They were also reported to be kind, caring and always approachable. Across all six municipalities, the main reason for not giving the highest rating is the shortage of free medicine supplies within the health centres to treat common illnesses, such as cough and fever. Due to lacking supplies, beneficiaries must travel to other health facilities and/or pay for medicines. Likewise, some beneficiaries mentioned that that the equipment within the health centre needs updating.

Economic environment

Most beneficiaries participating in this assessment mentioned that their household does not have a stable source of income. The majority of beneficiaries who participated in the FGDs and subsequent interviews live in rural areas. Hence, most of the households live in communities that are dependent on seasonal income generating activities in fishing and farming. Most notably, beneficiaries form Caramoran explained that they are dependent on their husband's income from

fishing. When seas are rough during rainy season, however, they are unable to go fishing and thus cannot generate income. Likewise, in Hinigaran beneficiaries explained that working on the sugar cane plantations is seasonal, while in San Jorge, beneficiaries pointed out that typhoons and floods increasingly destroy their livelihoods and income generating activities in farming. These challenges faced by households in Caramoran and San Jorge, particularly, also correspond with the self-assessment of the children's nutritional status. In Caramoran, two-thirds of all caregivers assessed their children as malnourished – the highest share in the sample. The second highest share of children assessed as malnourished comes from San Jorgen, with 54 per cent.

These same beneficiaries also explained that during off-seasons they are oftentimes fully dependent on the 4Ps programme to provide them with income, as no other opportunities exist. However, as reflected in the poor performance in children's nutritional status, it becomes evident again, that the 4Ps can only act as income support to households with an existing income, as the benefit value is too low to replace a stable income and meaningfully contribute to strengthened food security of the household.

The economic environment that beneficiaries live in not only reflects in their livelihood opportunities, but also in their access to markets and ultimately availability of goods. FGD participants in Ganassi, for example, explained that they live in an uphill area, which is why at times it is more difficult for them to buy fresh foods. Moreover, beneficiaries in Caramoran pointed out that during the rainy season not only their livelihoods are affected, due to the inability to fish the availability of fresh fish is also limited. One caregiver stated during an FGD that "If there is a typhoon and the sea is strong, we only have salt as dish with rice." The division between more connected and less connected areas also reflects when disaggregating the nutrition status assessment by rural and urban areas. In rural areas over 50 per cent of all caregivers assessed their children as malnourished, while only 30 per cent did so in urban areas.

Socio-cultural factors

Prevailing socio-cultural believes and perceptions around (mal)nutrition seem to significantly influence beneficiaries' and also implementers' views on the urgency of the problem. While key informants at national level indicated that in the Philippines shortness is considered normal and simply related to genetics, a Barangay Health Worker interviewed as part of this assessment confirmed that these perceptions are still prevailing, even among experts. The interviewee explained that "I don't think stunting is a problem, I think it is just genetics." The other way around, overweight children are considered healthy by a fair share of caregivers and 'having a good appetite' was mentioned by the majority of caregivers in relation to what signifies a healthy child. One beneficiary from Ganassi explained that "My child is very healthy, as it looks overweight."

Moreover, most beneficiaries reported that during pay-day they like to do family bonding and treat their children to special foods – typically fast food. Even though FGD participants explained that they learned about healthy foods during FDS and that they should not give their children fast

food to eat, their mindset has not changed. Many beneficiaries mentioned that they want to eat the food they see on TV or hear about, even though they know it is unhealthy. One respondent expressed it in this way: “It is the food of rich people.” These perceptions around indicators of well-nourished children and desirable foods further stress that the FDS and other activities focused on providing caregivers with information on nutritious and healthy foods, have not yet achieved the desired mentality and behaviour changes.

Available resources

In terms of available resources, the assessment looked at the wider nutrition response at municipal and barangay levels, and in how far human and financial resources are available to plan and implement activities. When asked about nutrition plans, all key informants within the municipalities confirmed that Municipal Nutrition Action Plans were recently developed, most of which were described as quite comprehensive, covering lots of different activities. The barangays were then tasked with translating and implementing these plans at the barangay level. As a key challenge to the implementation of these plans, resource constraints were mentioned. A key informant explained that there is no nutrition-specific financing for activities, as the budgets of nutrition plans often have not come through. A frequently cited challenge in the work of Barangay Nutrition Scholars, for example, is the lack of resources for transportation to conduct house-to-house visits, which can play a major role in ensuring that mothers apply the learnings from FDS and nutrition classes. The shortage of funding also reflects on the human resources available to implement nutrition-related activities, most notably the training and renumeration of staff and implementors. Some functions in programme delivery are given to volunteers, which may limit the motivation and expertise some of the staff are able to provide an input to good quality of services.

5. Conclusions

Findings suggest that the 4Ps programme positively influences beneficiary households’ overall situation, food security and also mental well-being. Although most households indicated that the cash transfer itself was too low, beneficiaries still agreed that the 4Ps does support their livelihoods and that, without the cash grants, their situation would be worse. The data indicates that the potential and observed influence of the intervention goes beyond financial perils, as respondents from beneficiary households rather consistently confirm their improved self-confidence and identification in society.

Relevant aspects that support the achievement of nutrition outcomes in beneficiary households were identified in design and implementation of programme components, household-level dynamics, as well as basic factors that characterise the environment within which the 4Ps operates. With regards to implementation of the programme, positive outcomes were observed more, when the payment cycle was **frequent, timely and reliable**. In such scenarios, the 4Ps enables households to smooth consumption, make more economical decisions during grocery shopping

and comprehend fully how their compliance behaviour affects the pay-outs they receive. In contrast, unreliable and infrequent payment cycles render it nearly impossible for households to plan their expenditures and as a result, beneficiaries often have to resort to borrowing money from lenders to be able to pay for staple foods and meals, as well as transport to health facilities.

Most households largely depend on the 4Ps cash grant, because they do not have a regular income. Only for a minority of households the cash grant is a supplement to a regular income. For these beneficiaries, the cash grant is perceived as an 'ok' addition to their household budget, allowing for consumption smoothing and purchasing goods in bulk. Most households however perceive the benefit level of the grant as inadequate. This economic backdrop strongly defines the outcomes experienced and described by beneficiaries and by the key informant interviewees. This shows that the 4Ps programme contributes to achieving outcomes, if it is a supplementary income as per its design but cannot provide for all needs of a family.

An additional factor among household level dynamics, the size of the household, plays a role for better outcomes, as smaller households report fewer periods of hunger for instance. The education grant is paid on an individual level for a maximum number of up to three beneficiary children per household; however, the average number of children per household is 4.14, which means that, in most cases not all children in a household receive the grant. Consequently, the overall amount received under the education grant is likely to be shared at least among all children in a household and is most likely also used to cover other expenditures, not directly linked to the benefit of a child. This shows that positive changes for children are more likely to be achieved where adequate amount of financial support per child is available.

A further aspect of programme implementation which was observed in context with households' improved outcomes are linkages between different, mutually reinforcing interventions. One example is the free toilet bowl initiative which provides households without improved sanitation facilities with a toilet bowl at no cost. In combination with additional information on improved sanitation practices and persistent awareness raising campaigns by various actors including barangay captains, municipal links and sanitation experts, beneficiaries were sensitised and encouraged to change behaviour and received financial support to undertake necessary changes, if they were unable to afford the needed improvement by themselves. These cases show that linkages between different interventions contribute towards programme outcomes because increased fluency in the public realm encourage positive programme outcomes. With strengthened awareness for the need of improved sanitation practices in FDS and in the barangays, households' attitude and behaviour seem to have positively and sustainably been changed, shaping expenditure prioritisation.

With regards to household level dynamics, household priorities are decisive for programme outcomes. Beneficiaries indicate that they would still seek health services regularly, even if the cash grant stopped, which suggests that their own and their children's health is a household

priority. Although it is not a programme condition of the 4Ps programme that caretakers use preventive health services, as a side-effect of them taking their children to the facility for required check-ups, beneficiaries report to also use services such as blood pressure check-ups, for instance. The mixed impact of the FDS further supports the role of household prioritisation and the need for them to take something seriously for change to be achieved sustainably.

Although beneficiaries consistently indicate that they enjoy the FDS, they might not consider them a viable source of information with regards to care practices. Care practices still largely seem to be passed on intergenerationally between female members of a household or family. This might also explain the focus areas of child care practices that the majority report, namely respect, faith and good conduct and fulfilling household chores. Household chores and child care are reported by parents as most relevant stressors, for single parents in particular. Key informants also report that they observe a link between caretaker well-being, including mental and physical appearance. Caretakers willingness to reflect on and change their attitude and behaviour, as well as household prioritisation as a result, seems to vary dependent on topics. Households in which caretakers' own well-being and self-care practices are good also show outcomes on children's nutritional status and less malnourishment. However, differences in willingness and preparedness to accept and apply newly acquired knowledge and adjust behaviours exist, as it was observed that many households seem incapable to apply new learnings. Topics such as sanitation practices or curbing the popularity of fast food seem more challenging to communicate and change than regular health seeking behaviour or underlying values for child nurturing to be more encompassing of emotional bonding, love and play.

In addition to the above factors that have shown to support outcomes, main barriers to achieving more pronounced outcomes were also identified. Firstly, the 4Ps' targeting approach, which still relies on the 2009 data of the *Listahanan*, presents the main barrier to access the programme benefits for a significant number of vulnerable households and children born after the initial enrolment. The current age cohort covered by the programme is nearly entirely born before 2009 and nearly all respondents in the FGD know equally or even more vulnerable households, who are excluded from the programme due to the targeting approach. As a result, the intervention misses the window of opportunity to improve beneficiary children's developmental outcomes of the first 1,000 days. In this time period, the foundations for positive development are laid and will be consolidated for the rest of the child's live.

At household level, financial constraints play a large role in preventing beneficiaries from fully reaping the benefits of the 4Ps programme. In all municipalities, beneficiaries criticise the cost of basic foods continuously increasing compared to the non-inflation adjustment of their cash transfer. This effectively reduces the amount of goods there are able to buy from the transfer. As most beneficiaries have limited livelihood opportunities and live in environments of scare economic opportunity, their access to markets and goods is also limited.

In addition, while the FDS are provided for free and are perceived as popular, beneficiaries feel unable to replicate some of the learnings in nutrition and food, as required ingredients are still too costly for them. Incomplete or varying willingness to change behaviour also prevents beneficiaries from experiencing stronger positive outcomes from the 4Ps. This can be observed in FGD participants' reporting that they learned about healthy foods during FDS and that they should not give their children fast food to eat. Despite the theoretical knowledge about its poor nutritional values, beneficiaries mention that they want to eat the food they see in advertisements or TV.

Although information is provided in FDS and also non-4Ps interventions exist which promote these topics, beneficiaries struggle more to implement changes because of a variety of factors, predominantly because of a lack of financial resources or incongruent household priorities. This becomes evident in the difference between known healthy foods and the desire to reward children with fast foods for instance. In this context, the reinforcing character of cross-programmatic awareness raising campaigns and education becomes evident. A related aspect is the quality of FDS, which are mostly carried out with poor equipment and suffer from overcrowding, all of which were identified as barriers to achieve better outcomes.

Finally, basic factors might also affect the 4Ps. While overall beneficiaries are satisfied with the quality of health services provided in the nearest facility and would assess these services conducive to achieving good outcomes, shortage of medical supplies and free medicines remains a challenge across all six locations. As a result of lacking supplies, beneficiaries travel to other health facilities and/or pay for medicines despite their PhilHealth membership. Additionally, the limited availability of resources for the wider nutrition response, including lack of budgets for activities and also training and remuneration of staff and implementors, hampers implementation processes and quality of planned activities and services.

6. Recommendations

Based on the research findings and conclusions drawn, and in consideration of the five factors for nutrition-sensitive cash transfers discussed in ***Box 1***, a range of recommendations are proposed, focusing around how to strengthen and enhance the response, further harmonise and integrate it, and render it more sustainable and coherent over the long-term, while addressing some of the most pressing challenges currently experienced by programme beneficiaries which hamper nutritional outcomes. In the following, these recommendations are presented.

6.1. Enhancing existing components

Periodically retarget the 4Ps programme to ensure that vulnerable children and households are covered. Crucial in this is the updating of the National Household Targeting System for Poverty Reduction (*Listahanan*). For 2019, DSWD has planned an updating of the latter, aiming to cover about 16 million households, or 70 per cent of the country's household population. Based on

Executive Order 867 *Providing for the Adoption of the National Targeting System for Poverty Reduction as the Mechanism for Identifying Poor Households Who Shall Be Recipients of Social Protection Programs Nationwide*[24] DSWD is required to update the NHTS-PR every four years, which, if implemented regularly and adequately, could be a crucial step in including pregnant women and children below the age of five years, a prime target group, if nutritional impacts are to be achieved as envisioned by the PPAN.[25] Supportive evidence comes for example from Peru's *Juntos* cash transfer programme, which achieved nutrition outcomes (measured in height-for-age) for children who benefitted from the programme between the ages of 0 to 3 years, however, did not achieve these outcomes for children exposed to the programme between 5 to 7 years of age.[26]

Both factors, age and targeting, are identified in ***Box 1*** for rendering cash transfers nutrition-sensitive because they speak to the fact that most damage to child development happens in the first the 1,000 days of life. It is therefore crucial to reach pregnant mothers and young children at the earliest point in time possible. This can be assured by up-to-date targeting methods and beneficiary data. Retargeting also contributes to improve beneficiaries' perception of programme fairness and willingness to change behaviour.

Revise the benefit structure and regularly adjust the benefit level to inflation. This is a crucial step to ensure that benefits reach households and beneficiaries as designed and counters dilution of the benefit level. To achieve that 4P beneficiary households and children do receive the benefit amounts as intended by design, it should be assessed whether the limit of three children per households can be lifted and/or whether the health grant could be provided on an individual per child level, instead of per household basis. This would allow households to invest more in health and nutrition and prevent dilution of outcomes for individuals. Global evidence shows that higher benefits are usually associated with stronger impacts on food expenditure as well as education, health and nutrition outcomes. Recent research on cash transfers points to a gold standard of providing a benefit level of about 15 to 20 per cent of household food consumption, in order to ensure that the cash transfer meaningfully contributes to changes in food consumption, as well as economic/productive impacts. Providing substantially less will dilute the value of the transfer for the household and will thus result in limited or no changes in food consumption. The evidence also stresses the relevance of adjusting the benefit level according to household size. The example of Kenya's Cash Transfer for Orphans and Vulnerable Children (CT-OVC) shows that the cash transfer achieved significant changes in the food consumption of households with less than three

[24] (Government of the Philippines, 2010)
[25] (Department of Health , 2016)
[26] (Sanchez, Melendez, & Behrman, 2016)

children, however, failed to do so for households with three children or more, because the benefit size was not adjusted accordingly.[27]

Harmonise the pay-out schedules to be on bi-monthly basis as is already practiced in some locations. Higher frequency of pay-outs has several advantages for beneficiaries, not only can they rely on regularly receiving the cash grant and hence plan their expenditures accordingly. They are also enabled to better understand the payment patterns, which can contribute to strengthened financial literacy and responsibility among beneficiaries. Evidence from around the world, for instance for Lesotho's Child Grant Programme, shows that poor impacts are often associated with poor frequency, predictability and understanding of payment patterns among beneficiaries.[28] Likewise, in Ghana, where cash transfer payments were provided in a lump sum because of internal administrative delays, the irregularity of payments did not allow beneficiary households to smooth their permanent consumption, meaning there was no effect on food consumption.[29]

It should further be assessed whether 4Ps payment modalities could be streamlined or if the introduction of choice models for beneficiaries would be feasible. While streamlining payment modalities across locations will contribute to regularity of payments, facilitate administration and allow for cost savings, choice models serve beneficiaries better as they can chose the payment channel most convenient to them.

Strengthen the quality of the family development sessions by improving the infrastructure of locations, as well as the relevance of modules. Relatively straightforward steps, such as providing microphones and visual aids to the speakers during FDS, could go a long way in establishing a more conducive environment to provide participants with relevant information and also engage them better in an interactive discussion, as opposed to a one-way lecture that FDS currently resemble. With interactive modules, for example cooking demonstrations as carried out in some municipalities, being especially popular with beneficiaries, these should be further applied and encouraged. Complementing cash grants with knowledge and information for caregivers, mothers in particular, is a decisive component of successful nutrition and health focused conditional cash transfer programmes around the world. The *Integrated Community Child Health* Programme in Honduras, *Nutrition and Early Childhood Development Project* in Uganda, *Seecaline* Programme in Madagascar, and Colombia's *Familias en Accion* Programme all use community-based, interactive learning sessions or courses to incentivise behaviour change. For all programmes, positive impacts on care and feeding practices and caretaker knowledge were found.

[27] (UNICEF-ESARO/Transfer Project, 2015)
[28] (Pellerano, Jakobsen, Moratti, Bajgar, & Barca, 2014)
[29] (UNICEF-ESARO/Transfer Project, 2015)

6.2. Fostering integration and harmonisation

Linking the 4Ps more explicitly to nutrition-specific activities and nutrition-related outcomes. As of now, the 4Ps is not explicitly linked to nutrition-related outcomes, which also reflects in beneficiaries' perceptions of the programme. With the primary objectives of school enrolment and attendance and health check-ups, as also stressed by the related conditions, beneficiaries perceive nutrition as a secondary objective, if at all. Linking the 4Ps to ongoing nutrition activities, such as Operation Timbang Plus (OTP) – the annual weighing and height measurement of pre-schoolers – or the feeding programme for malnourished children, could generate more awareness among caregivers. Currently, the anthropometric measurements for 4Ps children are captured during visits to health facilities but not integrated into the programme MIS, neither recorded in the compliance verification forms or used for compliance tracking. By integrating these indicators into in the programme MIS, implementing staff would be enabled to continuously track the status of beneficiary children at any given point in time and monitor progress (or lack thereof) more effectively. The silo structure of the different programmes and activities results in obstacles to effective data management, as implementers operate independently of 4Ps. For instance, the midwife, Barangay Health Worker and Barangay Nutrition Scholar for the OTP, often do not know which of the children assessed as malnourished are 4Ps children. Tagging 4Ps children in the OTP and feeding programme, for example, could help to create more evidence on the nutrition status of 4Ps children, enable monitoring of their status, and also create more awareness among 4Ps caregivers, that the nutrition status is relevant and being monitored. In Colombia for example, the cash transfer *Familias en Acción* has supported an improvement in the nutritional status of beneficiary children aged 0 to 6 years by linking the receipt of the cash to regular growth monitoring and health check-ups.[30]

Further formalise and structure linkages of 4Ps to other initiatives and programmes, especially in the realm of livelihoods development and income generating opportunities. As a cash transfer programme, the 4Ps can provide income support to households, however, cannot replace income generating and livelihood opportunities for households. Hence, there is a need to better link and formalise linkages from 4Ps to livelihood programmes and employment opportunities for beneficiaries. With existing plans to more structurally link the 4Ps, SLP and Kalahi-CIDSS, for example, DSWD envisions higher integration and coordination between different existing programmes and services, which in turn can tackle different vulnerabilities – something that one programme typically cannot achieve on its own. Similarly, in light of a dedicated programme to engage local government units actively under the PPAN 2017-2022, local governments are presented with the opportunity to take on a key role in delivering nutritional outcomes and actively linking beneficiaries to different programmes. More broadly, global evidence suggests

[30] (Attanasio, Battistin, Fitzsimons, Mesnard, & Vera-Hernández, 2005)

that, instead of expecting social protection to eradicate poverty, food insecurity and malnutrition on its own, it is vital to build systems and strengthen coordination between social protection, productive sectors, and social services (e.g. health, education, nutrition and child protection).[31]

Link the 4Ps programme to a more elaborate case management mechanism to facilitate integration and coordination and effectively support and monitor outcomes at household- and child-level. Nutrition outcomes are complex to achieve and depend on a myriad of factors at household- and child-level, and hence, households might require support tailored to their specific needs. Case management can support this approach by assessing the individual household's situation and linking the household to relevant services, for example in the area of nutrition-specific interventions or livelihoods, as described above. Through regular contact with the household, case management can also support monitoring and follow-up at local level and ensure that caregivers take up the information they are taught in the FDS and other classes (for example nutrition classes). Case management can play a role in encouraging caregivers to take learnings seriously, adopt new behaviours and change their attitudes sustainably. Adding systemic check-ups can take advantage of the popularity of the FDS among beneficiaries and replicate the successful method applied in the backyard gardening initiative, where beneficiaries are encouraged to track their progress and report it to the 4Ps implementing staff. Evidence from Brazil's Bolsa Familia programme, which has a strong case management component linked to its compliance monitoring unit, shows that families who struggle to comply with conditions and sustainable behaviour change, benefit strongly if they are identified early and can be provided with additional support.[32]

[31] (Devereux & Nzabamwita, 2018)
[32] (Brollo, Kaufmann, & La Ferrara, 2017)

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Annex A. List of activities and participants by region

Research method	*Participant group*	*Level*	*# of activities*	*# of participants*	*Total*
National-level inception mission					
Key informant interview	UNICEF Philippines Country Office	National	4	2	8
Key informant interview	Asian Development Bank (ADB)	National	1	2	2
Key informant interview	World Bank	National	1	1	1
Key informant interview	Department of Social Welfare and Development (DSWD)	National	2	2	4
Key informant interview	Department of Health (DOH)	National	1	1	1
Key informant interview	Department of Education (DepEd)	National	1	1	1
Key informant interview	National Nutrition Council (NNC)	National	1	1	1
Key informant interview	Philippine Institute for Development Studies (PIDS)	National	1	2	2
Key informant interview	Food and Nutrition Research Institute (FNRI)	National	1	1	1
Key informant interview	University of the Philippines	National	1	1	1
Key informant interview	Philippine's Women University	National	1	2	2
TOTAL			15	16	24
Bulacan, San Jose del Monte					
Key informant interview	Barangay Health Worker		1	1	1
Key informant interview	Barangay Nutrition Scholar		1	1	1
Key informant interview	City Link		1	1	1
Key informant interview	Rural Health Unit staff		1	1	1
Focus group discussion 1	4Ps beneficiaries	Muzon	1	16	16
Focus group discussion 2	4Ps beneficiaries	Muzon	1	23	23
Focus group discussion 3	4Ps beneficiaries	Muzon	1	18	18
Focus group discussion 1	4Ps beneficiaries	San Pedro	1	15	15
Focus group discussion 2	4Ps beneficiaries	San Pedro	1	16	16
Focus group discussion 3	4Ps beneficiaries	San Pedro	1	16	16
In-depth interviews	Selected 4Ps beneficiaries	Muzon	9	1	9

In-depth interviews	Selected 4Ps beneficiaries	San Pedro	6	1	6
TOTAL			25	110	123

Catanduanes, Caramoran

Key informant interview	Barangay Health Worker		1	1	1
Key informant interview	Barangay Nutrition Scholar		1	1	1
Key informant interview	Municipal Link		1	1	1
Key informant interview	Nutrition Action Officer		1	1	1
Key informant interview	Rural Health Unit staff		1	1	1
Focus group discussion 1	4Ps beneficiaries	Supang	1	23	23
Focus group discussion 2	4Ps beneficiaries	Supang	1	22	22
Focus group discussion 3	4Ps beneficiaries	Supang	1	16	16
Focus group discussion 1	4Ps beneficiaries	Toytoy	1	13	13
Focus group discussion 2	4Ps beneficiaries	Toytoy	1	19	19
Focus group discussion 3	4Ps beneficiaries	Toytoy	1	20	20
In-depth interviews	Selected 4Ps beneficiaries	Supang	5	1	5
In-depth interviews	Selected 4Ps beneficiaries	Toytoy	7	1	7
TOTAL			23	120	130

Lanao del Sur, Ganassi

Key informant interview	Barangay Health Worker		1	1	1
Key informant interview	Barangay Nutrition Scholar		1	1	1
Key informant interview	Municipal Link		1	1	1
Key informant interview	Rural Health Unit staff		1	1	1
Focus group discussion 1	4Ps beneficiaries	Pindolonan	1	19	19
Focus group discussion 2	4Ps beneficiaries	Pindolonan	1	19	19
Focus group discussion 3	4Ps beneficiaries	Pindolonan	1	22	22
Focus group discussion 1	4Ps beneficiaries	Tabuan	1	19	19
Focus group discussion 2	4Ps beneficiaries	Tabuan	1	22	22
Focus group discussion 3	4Ps beneficiaries	Tabuan	1	17	17
In-depth interviews	Selected 4Ps beneficiaries	Pindolonan	6	1	6
In-depth interviews	Selected 4Ps beneficiaries	Tabuan	6	1	6

TOTAL			22	124	134

Negros Occidental, Hinigaran

Key informant interview	Barangay Health Worker		1	1	1
Key informant interview	Barangay Nutrition Scholar		1	1	1
Key informant interview	Municipal Link		1	1	1
Key informant interview	Nutrition Action Officer		1	1	1
Focus group discussion 1	4Ps beneficiaries	Brgy IV	1	19	19
Focus group discussion 2	4Ps beneficiaries	Brgy IV	1	17	17
Focus group discussion 3	4Ps beneficiaries	Brgy IV	1	14	14
Focus group discussion 1	4Ps beneficiaries	Cambugsa	1	19	19
Focus group discussion 2	4Ps beneficiaries	Cambugsa	1	16	16
Focus group discussion 3	4Ps beneficiaries	Cambugsa	1	16	16
In-depth interviews	Selected 4Ps beneficiaries	Brgy IV	7	1	7
In-depth interviews	Selected 4Ps beneficiaries	Cambugsa	7	1	7
TOTAL			24	107	119

Samar, San Jorge

Key informant interview	Nutrition Action Officer		1	1	1
Key informant interview	Rural Health Unit staff		1	1	1
Key informant interview	Barangay Health Worker		1	1	1
Key informant interview	Barangay Nutrition Scholar		1	1	1
Key informant interview	Municipal Link		1	1	1
Focus group discussion 1	4Ps beneficiaries	Erenas	1	18	18
Focus group discussion 2	4Ps beneficiaries	Erenas	1	17	17
Focus group discussion 3	4Ps beneficiaries	Erenas	1	24	24
Focus group discussion 1	4Ps beneficiaries	Lapaz	1	21	21
Focus group discussion 2	4Ps beneficiaries	Lapaz	1	19	19
Focus group discussion 3	4Ps beneficiaries	Lapaz	1	16	16
In-depth interviews	Selected 4Ps beneficiaries	Erenas	6	1	6
In-depth interviews	Selected 4Ps beneficiaries	Lapaz	7	1	7
TOTAL			24	122	133

Zamboanga del Norte, Dipolog

Key informant interview	Barangay Health Worker		1	1	1
Key informant interview	Barangay Nutrition Scholar		1	1	1
Key informant interview	City Link		1	1	1
Key informant interview	Nutrition Action Officer		1	1	1
Key informant interview	Rural Health Unit staff		1	1	1
Focus group discussion 1	4Ps beneficiaries	Galas	1	15	15
Focus group discussion 2	4Ps beneficiaries	Galas	1	14	14
Focus group discussion 3	4Ps beneficiaries	Galas	1	13	13
Focus group discussion 1	4Ps beneficiaries	Turno	1	9	9
Focus group discussion 2	4Ps beneficiaries	Turno	1	11	11
Focus group discussion 3	4Ps beneficiaries	Turno	1	12	12
In-depth interviews	Selected 4Ps beneficiaries	Galas	6	1	6
In-depth interviews	Selected 4Ps beneficiaries	Turno	7	1	7
TOTAL			24	81	92

Annex B. Prevalence rates of stunting and wasting in selected provinces

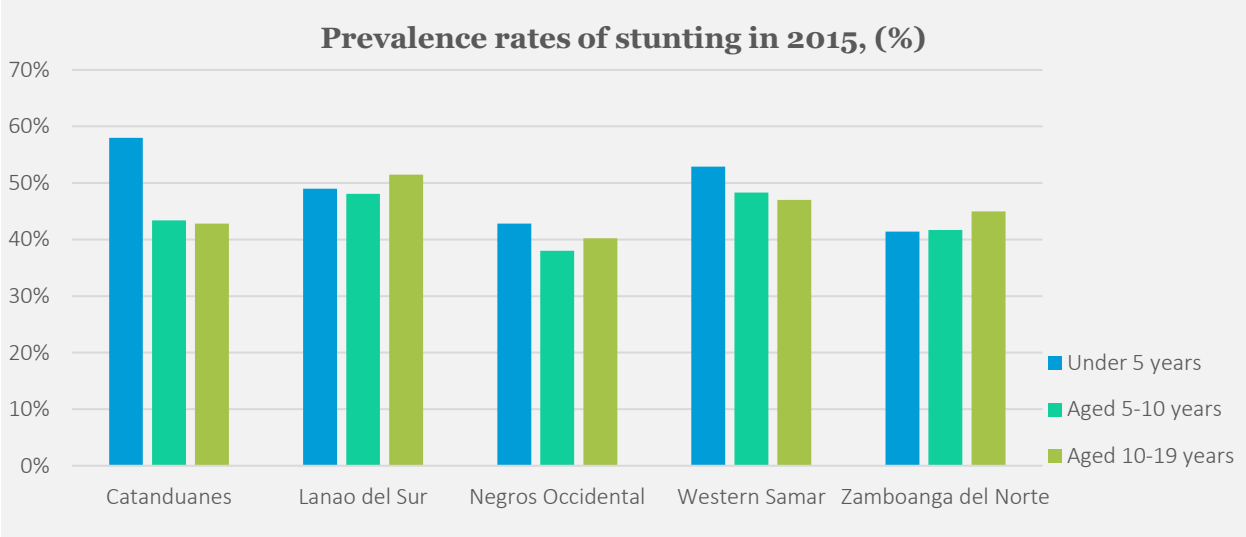

Figure 7. Prevalence rates of stunting per age group and province, NNS 2015

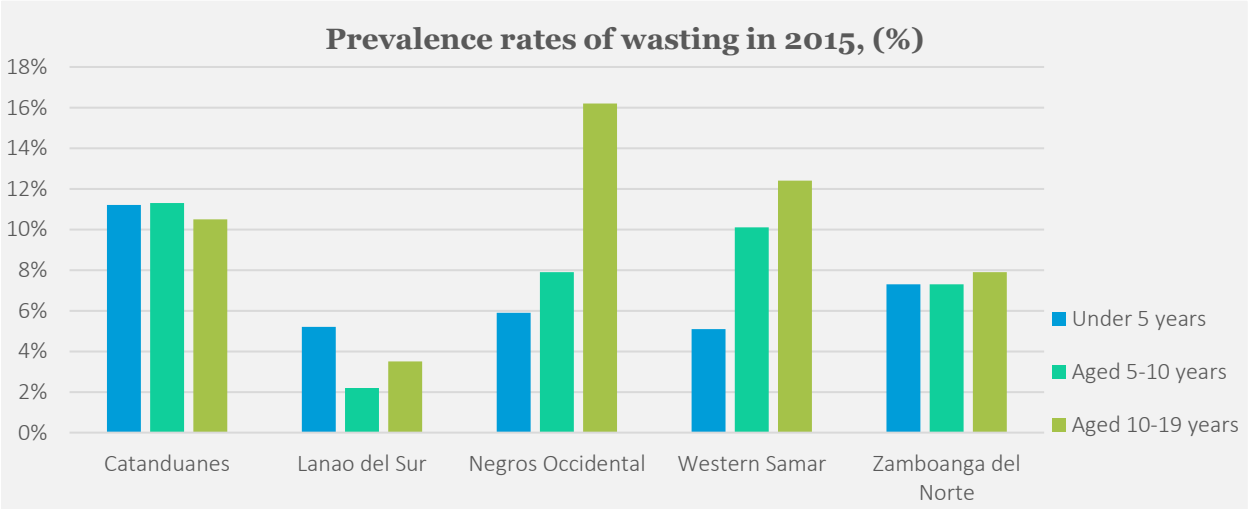

Figure 8. Prevalence rates of wasting per age group and province, NNS 2015