PHILIPPINES

Expanding the Evidence Base on Cash, Protection, GBV and Health in Humanitarian Settings

Cash to Increase Facility-Based Deliveries in the Philippines

EVALUATION OVERVIEW

In 2021-2022, the United Nation Population Fund (UNFPA) in the Philippines introduced Cash for Maternal Health - Emergency Fund in the conflict-affected Maguindanao province. The Cash for Maternal Health project was designed to facilitate safe pregnancy and delivery. Cash was provided after delivery in a health facility to 850 women as a means of encouraging facility delivery, most often at a rural primary level health facility. Cash for deliveries was part of a holistic emergency response that also supported maternal health programming via numerous interventions including the provision of equipment and kits to facilities, the conduct of medical missions, and the provision of community-based maternal health information sessions.

To assess the impacts of the maternal cash transfer program, UNFPA and the Johns Hopkins Center for Humanitarian Health collaborated to conduct a mixed-methods evaluation from December 2021 to June 2022. A total of 330 Cash for Maternal Health cash transfer recipients were compared to 316 pregnant women and adolescents who were registered to deliver in facilities but did not receive cash assistance in six different municipalities. The evaluation included questionnaire-based interviews pre-delivery (baseline) and post-delivery (end line) for all participants in addition to qualitative interviews with 20 women who received the cash assistance. The evaluation is intended to provide new evidence to inform planning of maternal health programmes with cash components, both in the Philippines and beyond.

Key findings were as follows:

- Women and adolescents who received cash assistance were significantly more likely than the

comparison group to have a facility-based delivery (86.4% vs.58.7%) and reported that they did so because it was safer for themselves and the baby (85.7%). They were also significantly more satisfied (98.1% vs. 83.9%) and more likely to plan for future pregnancies to be delivered in the facility (95.8% vs. 64.0%) than the women in the comparison group.

- Almost all recipients reported that their husband and/or family members were aware of the assistance (95.4%) and supported receipt of the cash (95.5%). Women either independently (46.3%) or collaboratively (27.9%) decided with their husband how to use the cash, though 25% reported they did not have primary decision-making power. Cash was primarily used to meet household's food needs.

- Cash did not pose safety risks within the household, and most women (78.5%) reported no change (neither better nor worse) in their relationship after receiving the cash. Nearly all women (99.4%) reported they felt safe receiving the assistance.

- There was a preference for future assistance to be provided as cash (59.5%) or through a combination of cash and in-kind assistance (35.1%) and that it be provided directly to women (78.8%).

The findings of this evaluation on the integration of cash assistance into UNFPA Philippines maternal health programming within the Maguindanao emergency response shows that the use of CVA can help strengthen uptake of health services. The cash incentive contributes to women and adolescents visiting health facilities more often throughout their pregnancies, becoming more comfortable doing so, sharing their intention to return to the facilities for subsequent pregnancies, and encouraging other women to do the same.

INTRODUCTION

Beyond frequent environmental disasters, the Philippines has faced an ongoing conflict between the Armed Forces of the Philippines (AFP) and armed groups, particularly on the island of Mindanao. Conflict in Maguindanao province, on the island of Mindanao, has been increasingly pervasive since March 2021, leading to widespread displacement and disrupted access to essential services. As of May 2022, more than 3,300 were displaced due to conflict and more than 540 were displaced by flooding in Maguindanao Province.[1] The poverty rate in Maguindano is well above the national average (38.0% vs. 18.1% in 2021)[2,3] and COVID-19 exacerbated already limited access to maternal health services, limiting efforts to increase facility-based deliveries in order to reduce maternal and infant mortality. In 2017, antenatal care (ANC), postnatal care (PNC), and facility-based delivery (FBD) coverage in the now defunct Autonomous Region in Muslim Mindanao (ARMM) were at 68.6%, 63.6%, and 28.4%, respectively (more recent data is not available).[4]

The use of cash and voucher assistance (CVA) has rapidly expanded worldwide and is widely used across a range of sectors to meet varied objectives. Globally, approximately US$5.3 billion in CVA was provided in 2021, an increase of 3.9% from 2020 and 141% from 2016, with CVA accounting for 21% of total international humanitarian assistance in 2021.[5] Cash-based approaches to providing assistance to populations affected by disaster and conflict can be more efficient than in-kind assistance and more supportive of local economies, human agency, and recipients' dignity.[6] CVA can be provided as cash or vouchers (the latter restricting spending to certain items/services, and the former providing full flexibility in its use) and as conditional or unconditional depending on whether or not a prerequisite must be fulfilled in order to receive the transfer (e.g., attending a medical visit).[7]

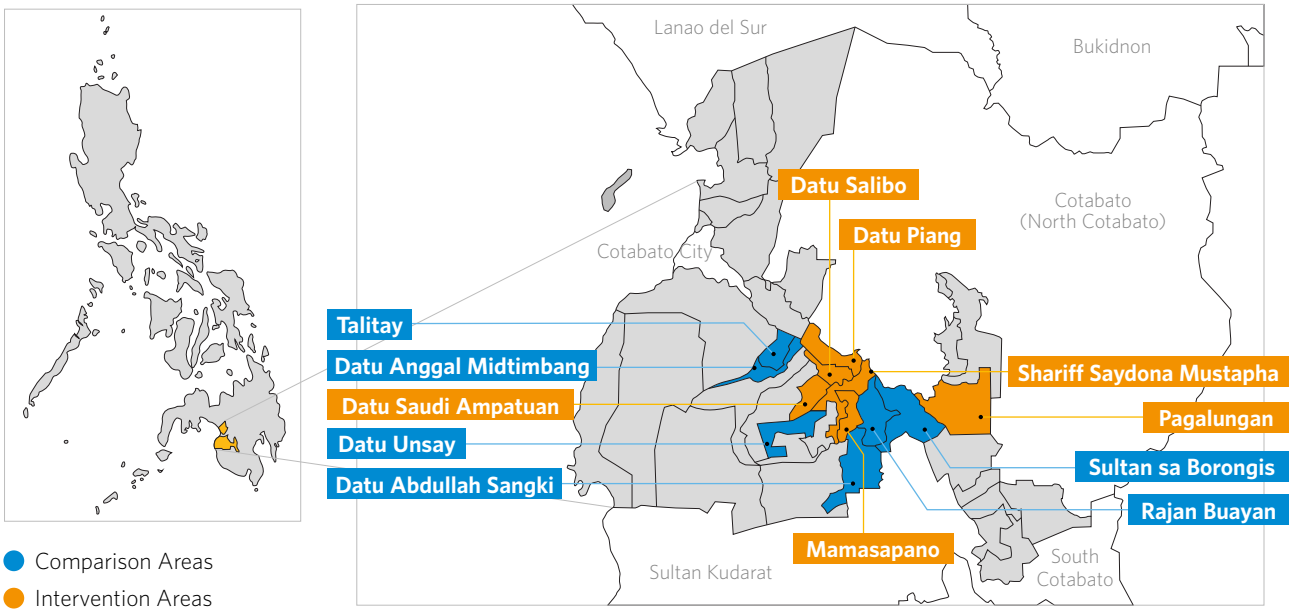
As part of 2021 programming in the Philippines, UNFPA, its implementing partner the Mindanao Organization for Social and Economic Progress, Inc. (MOSEP), and financial service providers (FSPs) Palawan Express Pera Padala and M Lhuillier provided 850 registered pregnant women in Maguindanao province a one-time cash transfer of US$46.40 after they delivered in health facilities between October and December 2021.

The objectives of the Cash for Maternal Health program were:

- To promote safer pregnancies and delivery.
- To increase adolescents' and women's self-determination over their health and well-being.
- To support the local health system to recover from multifaceted challenges, including COVID-19.
- To support the local economy in recovery from the economic impact of COVID-19.

This evaluation was conducted to complement ongoing monitoring of maternal, infant, and child programming. In addition, this report seeks to expand program learnings to provide a more comprehensive understanding of the impacts of Cash for Maternal Health in the context of the Philippines and understand whether financial incentives can help change attitudes and behaviors.

Figure 1: Evaluation Locations



METHODS

UNFPA and the Johns Hopkins Center for Humanitarian Health collaborated to conduct a mixed-methods evaluation of UNFPA's cash assistance program to support women delivering in health facilities in order to improve outcomes for pregnant and lactating women and adolescents (PLW&A) in the Philippines. This evaluation work was conducted from December 2021 to June 2022 in six municipalities (Datu Piang, Datu Salibo, Datu Saudi Ampatuan, Mamasapano, Pagalungan, and Shariff Saydona) in Maguindanao province situated in the mainland Bangamoro Autonomous Region in Muslim Mindanao (BARMM). An overview of evaluation locations is presented in Figure 1.

The evaluation employed a pre-post design with a comparison group. Participants consisted of PLW&A (ages 15-49) in targeted municipalities registered in the Cash for Maternal Health program with a delivery date in December 2021 (cash for maternal health/intervention group) in addition to PLW&A (ages 15-49) registered for facility delivery in adjacent municipalities with a delivery date in December 2021 (comparison group). Using the Technique for Order Preference by Similarity to Ideal Solution (TOPSIS) methodology, the comparison areas were determined through ranking of municipalities based on existing ANC, PNC, and Facility-Based Delivery coverage data. An overview of planned and analyzed sample sizes for each group is presented in Table 1. The comparison group allowed for examination of the magnitude of change observed between the intervention group and the comparison group on key outcomes including: 1) attendance to antenatal care visits; 2) facility-based delivery; 3) attendance to postpartum care visits; 4) satisfaction of care; 5) well-being; and 6) safety. In addition, qualitative data was collected with a sub-sample of Cash for Maternal Health recipients with a focus on the use of cash and satisfaction with facility-based care. All participants were asked to complete a pre-delivery survey prior to their delivery and a post-delivery survey one month after their delivery.

Surveys were facilitated by trained enumerators in a private and safe location at a time determined in agreement with the woman/adolescent. At the end of the pre-survey, the enumerator verified safe contact information and informed participants that they would be contacted one month after delivery to complete the post-survey. Pre-surveys were completed in an average of 20 minutes and post-surveys in approximately 20-40 minutes due to extra questions on the use and perceptions of cash assistance for PLW&A registered in

Table 1: Planned and Analyzed Sample by Location and Evaluation Group

Group	Area	Target PLW&A Recipients	Planned Sample	Analyzed Sample	Qualitative Interviews
Intervention (Cash Recipients)	Datu Piang	150	83	86	4
	Datu Salibo	100	55	53	3
	Datu Saudi Ampatuan	150	47	50	4
	Mamasapano	150	47	51	3
	Pagalungan	150	35	37	3
	Shariff Saydona	150	45	53	3
	Intervention Group Total	**850**	**312**	**330**	**20**
Group	**Area**	**Eligible PLW&A (Avg 2017-19)**	**Planned Sample**	**Analyzed Sample**	
Comparison	Datu Abdullah Sangki	553	23	23	
	Datu Anggal Midtimbang	465	78	67	
	Datu Unsay	314	37	36	
	Rajah Buayan	604	59	55	
	Sultan sa Barongis	727	81	80	
	Talitay	354	56	55	
	Comparison Group Total	**3,017**	**335**	**316**	

the Cash for Maternal Health program. At the conclusion of the post-delivery survey, cash recipients were asked if they could be contacted to participate in an additional qualitative interview to explore in more depth their participation in and experience with cash assistance, facility-based delivery and care, health and safety outcomes, and their knowledge and use of referrals for services. All women and adolescents who consented to participate in either group provided their name and phone number at the pre-survey to allow for follow-up contact to complete the post-survey. PLW&As' existing registration codes were linked to the pre-post surveys and the information was securely stored in a separate file; their information was used only by the field team to contact women for the post-survey or qualitative interview. The pre-post surveys were conducted using a digital application (Kobo) on a secure tablet and completed only after the women and adolescents provided consent.

To add depth to the survey findings and provide information to strengthen cash assistance programs, qualitative data were also collected from a subset of 20 women (see Table 1) in the Cash for Maternal Health program after the post-delivery survey. Qualitative interviews used a semi-structured interview guide and were conducted within two months of the facility-based delivery. All interviews were conducted in-person in a safe and private location by a female enumerator from Moropreneur Inc. with training in qualitative methods. Interviews were conducted after receiving participants' consent. Enumerators took notes during interviews, which were used to summarize each interview. The summaries were then translated to English by Moropreneur Inc. To protect confidentiality, names were not recorded on notes or transcripts. The transcripts were securely transferred to the Johns Hopkins Center for Humanitarian Health for coding and analysis of key themes on Cash for Maternal Health, facility-based care and delivery, satisfaction, health, and safety outcomes.

De-identified quantitative and qualitative data were provided to Johns Hopkins Center for Humanitarian Health for analysis using a secure data sharing workspace. Quantitative analysis was conducted in Stata 13 and included descriptive statistics to summarize data (e.g., means, median, standard deviations) and examine patterns of change from pre- to post- for both groups. Chi-squared tests for comparison of proportions and t-tests for comparison of means were used in analysis, with p-values <0.05 considered statistically significant. Qualitative analysis was conducted by reading the interview summaries to organize, code, and analyze content for key themes associated with cash assistance.

LIMITATIONS

A primary limitation of the evaluation is that some information from final interviews is missing, such as whether a participant was living with a husband/partner and details on ANC visits (perceptions, education received, likely of use in future pregnancies, etc.). Additionally, the qualitative interviews did not include questions on sensitive topics such as mental health, safety in the household and relationship changes. Qualitative interviews were also limited to notes and summaries rather than full transcripts. These limitations prevented in-depth analysis of some thematic areas and the comprehensiveness of findings and would benefit from additional exploration in future research.

Table 2: Household Demographic and Economic Characteristics and Receipt of Humanitarian Assistance

		Overall (N=646)			Comparison Group (n=316)		Cash Recipients (n=330)		p-value
		N	Point	(95% CI)	Point	(95% CI)	Point	(95% CI)	
Demographic Characteristics									
Women's age (mean years)		645	27.1	(26.6-27.6)	26.4	(25.7-27.1)	27.8	(27.1-28.5)	0.007
Household size (mean)		642	6.2	(5.9- 6.4)	5.5	(5.2- 5.8)	6.8	(6.4- 7.1)	<0.001
Female headed households		72	11.1%	(8.7-13.6%)	8.9%	(5.7-12.0%)	13.3%	(9.6-17.0%)	0.071
Living Conditions									
Time in current location	< 10 years	284	44.1%	(40.3-47.9%)	39.8%	(34.4-45.3%)	48.2%	(42.8-53.6%)	0.098
	10-20 years	130	20.2%	(17.1-23.3%)	21.3%	(16.8-25.9%)	19.1%	(14.8-23.4%)	
	20+ years	230	35.7%	(32.0-39.4%)	38.9%	(33.4-44.3%)	32.7%	(27.6-37.8%)	
Household Economic Characteristics									
Monthly Income (USD)[1]	Median	642	49.5	--	39.6	--	59.4	--	
	Mean		74.8	(67.0-82.6)	53.5	(47.4-59.5)	95.3	(81.5-109.1)	<0.001
Bottom Quartile (<30)		226	35.2%	(31.5-38.9%)	45.4%	(39.9-50.9%)	25.4%	(20.6-30.1%)	<0.001
2nd Quartile (30-50)		109	17.0%	(14.1-19.9%)	20.0%	(15.6-24.4%)	14.1%	(10.3-17.9%)	
3rdd Quartile (50-90)		156	24.3%	(21.0-27.6%)	17.5%	(13.2-21.7%)	30.9%	(25.9-35.9%)	
Top Quartile (>90)		151	23.5%	(20.2-26.8%)	17.1%	(13.0-21.3%)	29.7%	(24.7-34.6%)	
Number of HH members earning income	Median	641	1	--	1	--	1	--	---
	Mean		1.5	(1.4- 1.6)	1.4	(1.3- 1.5)	1.6	(1.5- 1.8)	0.001
HH income past month vs. typical									
More than usual		46	7.1%	(5.1-9.1%)	4.7%	(2.4-7.1%)	9.4%	(6.2-12.6%)	<0.001
About the same as usual		152	23.5%	(20.2-26.8%)	23.4%	(18.7-28.1%)	23.6%	(19.0-28.2%)	
Less than usual		383	59.3%	(55.5-63.1%)	54.7%	(49.2-60.3%)	63.6%	(58.4-68.9%)	
Income is irregular		65	10.1%	(7.7-12.4%)	17.1%	(12.9-21.3%)	3.3%	(1.4-5.3%)	
Humanitarian Assistance									
Receipt of assistance (past month)[2]									
Any assistance		365	57.0%	(53.2-60.9%)	27.4%	(22.4-32.3%)	85.6%	(81.7-89.4%)	<0.001
Cash		259	40.5%	(36.7-44.3%)	4.1%	(1.9-6.4%)	75.5%	(70.8-80.2%)	<0.001
In-kind food		139	21.7%	(18.5-24.9%)	23.9%	(19.1-28.6%)	19.6%	(15.3-24.0%)	0.192
Non-food items		46	7.2%	(5.2-9.2%)	5.7%	(3.1-8.3%)	8.6%	(5.5-11.6%)	0.162
Cash transfer value (USD)	Median	252	46.1	--	39.6	--	46.1	--	---
	Mean		52.5	(43.0-62.1)	54.9	(34.9-74.9)	52.4	(42.5-62.4)	0.917

1 Amounts are in USD, using a conversion rate of 1 USD = 50.50 PHP

2 Less than 5% of households reported receiving assistance in: shelter, health, water and sanitation, hygiene, livelihoods, education, or 'other'

RESULTS

BASELINE DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS

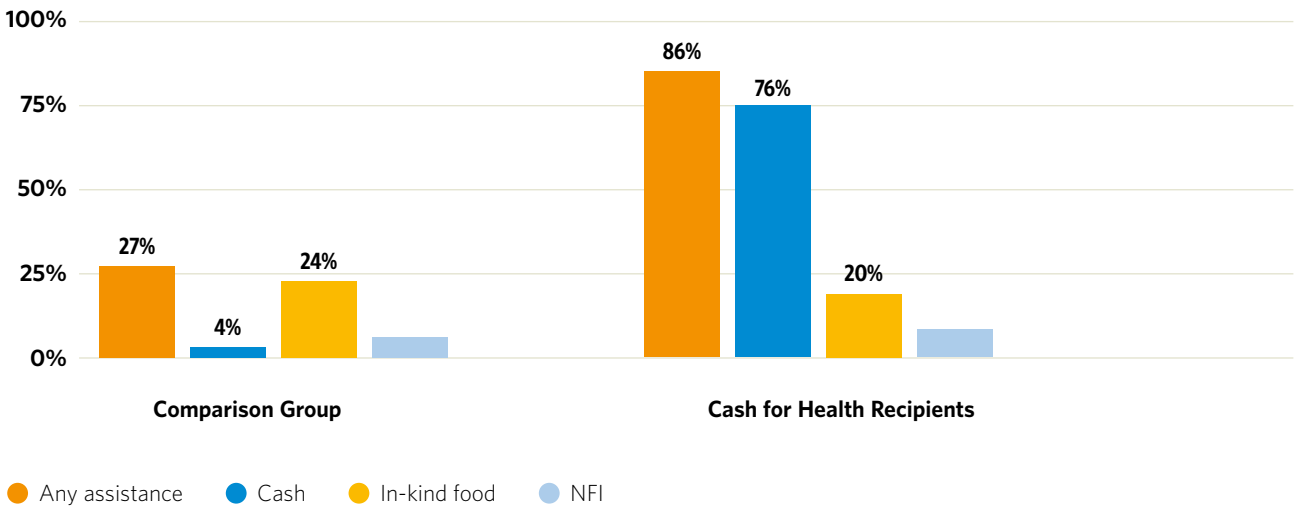
Baseline information collected included participant demographics, income, and humanitarian assistance received in the prior month (Table 2). Significant differences were noted at baseline between intervention and comparison groups for recipient age, household size, monthly income, number of household members earning income, and receipt of humanitarian assistance. Cash recipients were significantly older than comparison group PLW&A (mean age 27.8 vs. 26.4, p=0.007) and had a significantly larger average household size (mean 6.8 members vs. 5.5, p<0.001). Both groups were similar in terms of household head sex with 13.3% of cash recipient households and 8.9% of comparison group households reporting having a female head. Length of time in the current location was also similar between groups (p=0.149), with 35.7% of participants in their current location for more than 20 years and an average of 14.3 years in their current location.

Cash recipients had significantly higher monthly income (mean US$95.3 vs US$53.5, p<0.001) than PLW&A in the comparison group; however, average income in both groups fall under "poor" based on the latest Philippines income classification.* Based on 2018 poverty incidence data, the mean poverty incidence in the intervention group was 62.3 compared to 68.8 in the comparison group. The monthly income of the two groups was almost half less than the monthly poverty threshold.

The average household income in the prior month was US$74.8 (CI: 67.0-82.6) and was significantly higher in the intervention group (mean US$95.3, CI: 81.5-109.1) than in the comparison group (UC$53.5, CI: 47.4-59.5; p<0.001), however as mentioned above, both groups were largely under the national poverty threshold. More than half of the participants in each group reported their income in the past month was lower than in a typical month. Overall, nearly all households reported at least one household member, including children, currently working and earning income, with a median of 1 and a mean of 1.5 income-earning household members.

Cash recipients reported higher levels of humanitarian assistance receipt in the preceding month, with 85.6% of cash recipients reporting having received humanitarian assistance compared to 27.4% of comparison group PLW&A (p<0.001) (Figure 2). Overall, the most common types of assistance received were cash (40.5%) and in-kind food aid (21.7%). Cash assistance receipt was significantly different between the two comparison groups – Cash for Maternal Health recipients were significantly more likely than comparison group PLW&A to report receiving any cash assistance (75.5% vs. 4.1%, p<0.001).

Figure 2: Humanitarian Assistance Receipt



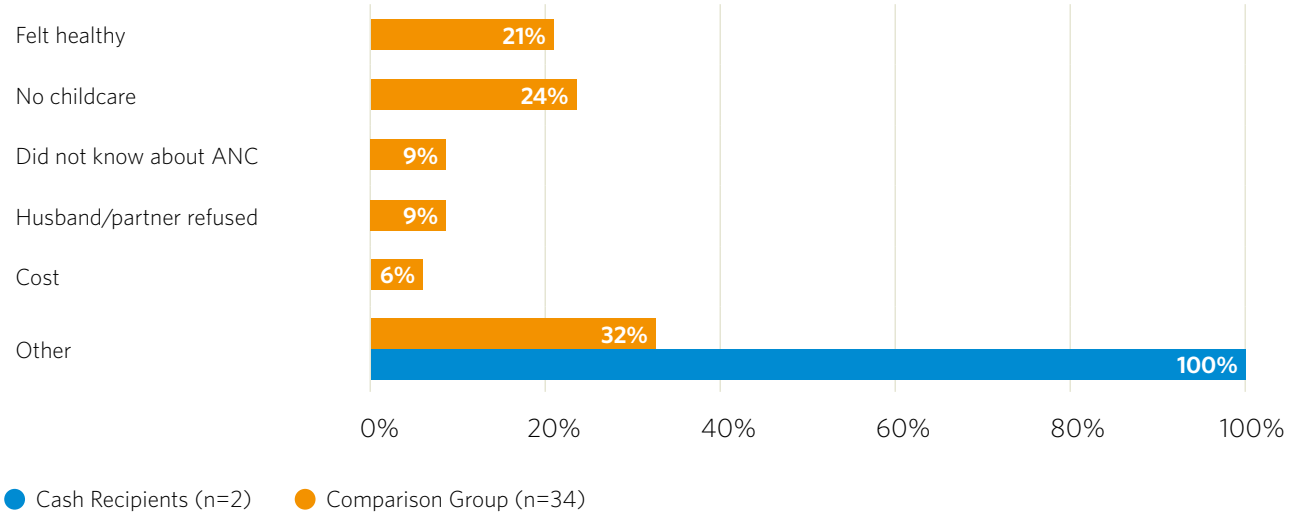
* There are seven PIDS income classifications,[8] with poor households having a monthly income less than P10,957 (US$195.8).

PREGNANCY AND ANTENATAL CARE

Previous births were common among women in both groups, with all Cash for Maternal Health recipients and 79.0% of comparison group PLW&A reporting having given birth before their current pregnancy. Women in the cash group reported a significantly greater number of times previously giving birth (mean=3.1) compared to those in the comparison group (mean=2.3) ($p<0.001$). Antenatal care visit attendance was relatively high overall with 92.6% of all women reporting currently attending antenatal care visits at the facility where they were registered; this was higher in the cash group (99.1%) than in the comparison group (84.1%) ($p<0.001$). More than half (58.7%) of women overall reported attending four or more ANC visits at the facility; this was again higher in the cash group (69.6%) than in the comparison group (41.2%) ($p<0.001$).

Women in qualitative interviews described the benefits of ANC visits as *"learning about their pregnancy and getting free vitamins and medicines."* Among the 43 women not attending ANC visits, 36 provided reasons for not doing so–the largest proportion (36.1%) reported assorted reasons such as not having time or being afraid to go to the health center; the next most frequently reported reasons were not having childcare (22.2%) and feeling healthy (19.4%) (Figure 3). Of the two women receiving Cash for Health who provided reasons for not attending ANC visits, one reported that she did so because "it was 45 days before you can register" and the other because she was "a cesarean case."

Figure 3: Reasons for Not Attending ANC Visits



FACILITY-BASED DELIVERY

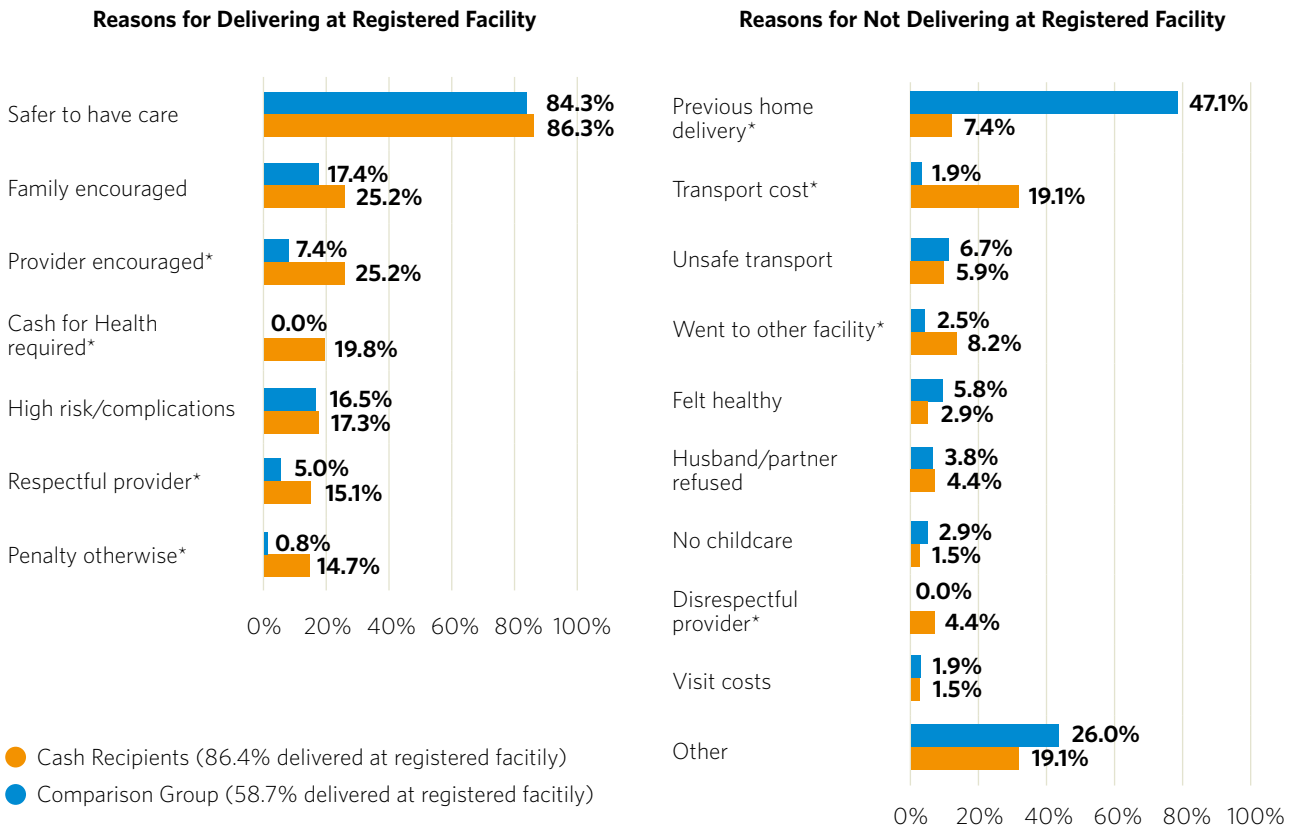
Most women (75.4%) delivered at the health facility where they registered; however, women in the cash group (86.4%) were significantly more likely to deliver at the health facility compared to those in the comparison group (58.7%, $p<0.001$). One woman interviewed shared that she did not deliver in the health facility where she was registered because she was referred to the hospital since she had a high-risk pregnancy and eventually had a cesarean delivery. Women who delivered at the health facility most frequently reported doing so because it was safer for the mother and baby (85.7%); fewer women delivered at their registered facility because their family (23.1%) or health provider (19.8%) encouraged them to do so. Cash recipients were significantly more likely to deliver at the health facility because their medical facility provider encouraged it (25.2% vs 7.4% of comparison PLW&A) or because the provider was respectful (15.1% vs. 5.0%) (Figure 4).

One woman described her decision to deliver at the facility by saying, *"I heard from my in-law who gave birth in the health center that it is good and the midwives are generous. So when I was about to give birth, my husband and I decided to go to health centers for myself and my child's safety."*

Another woman added, *"I heard that it is really good to give birth in the health facility to avoid any complications that I could have if I deliver in our house. It is really recommended to deliver in a health clinic or hospital for safety."* **Another one stressed,** *"in the facility, you can be sure that you are safe because there are many people who will assist you."*

Another woman noted in the interview, "*Even my mother who is a 'walyan' or a traditional healer convinced me to deliver in the facility, which was the best decision I made. I will definitely recommend the facility to other mothers because they can ensure that the pregnancy is*

Figure 4: Delivery at Health Facility Where Registered and Reasons



* Statistically significant difference between groups in indicated reason

safe and well taken care of. I can visit the facility frequently because the cash assistance helps me with my fare."

Some cash recipients also reported delivering at the facility because there was a penalty** for not doing so (14.7%) or because their cash assistance required facility-based delivery (19.8%). Among women who did not deliver at the health facility, most did so because their prior deliveries were at home (31.4%) or for varied other reasons (23.3%). Not having money for transportation was more commonly reported by cash recipients (19.1% vs. 1.9% in the comparison group) while prior home delivery was reported by a greater proportion of women in the comparison group (47.1% vs. 7.4% of cash recipients) (Figure 4).

Women were asked to report their satisfaction with the way they were treated by the midwife/medical providers during their delivery and their overall satisfaction with the care received during their delivery at the health facility. Women were largely satisfied with the way they were treated by the midwife/medical providers during their facility delivery, with 92.5% of all women reporting being either somewhat or very satisfied. **As one cash for health recipient said,** *"I have realized that it is safer to give birth in the health center and there are a lot of benefits we can receive. Yes, if I am pregnant again, I will give birth in the health center."*

Women in the cash group were significantly more satisfied than those in the comparison group as 98.1% of cash recipients reported being either somewhat or very satisfied compared to 83.8% of women in the comparison group ($p<0.001$). Women in both groups were similarly satisfied with the overall care they received during their facility deliveries with 98.1% of women in the cash group and 83.9% of women in the comparison group reporting being either somewhat or very satisfied ($p<0.001$). Most women (82.1%) said they plan to deliver future pregnancies in a health facility. Significantly more women in the cash group (95.8%) planned to deliver in a health facility in the future

** Local policies stipulate that it is not permitted to deliver at home; however, UNFPA Philippines was unable to confirm if there is ever an actual penalty for those delivering at home as it has not heard of it being acted upon by local authorities. The recipients' answers are linked to these local policies.

compared to women in the comparison group (64.0%; p<0.001). Most women (96.9%) also said they would recommend facility delivery to their pregnant friends and/or family members and significantly more women in the cash group would recommend facility-based delivery (98.8%) than women in the comparison group (94.3%).

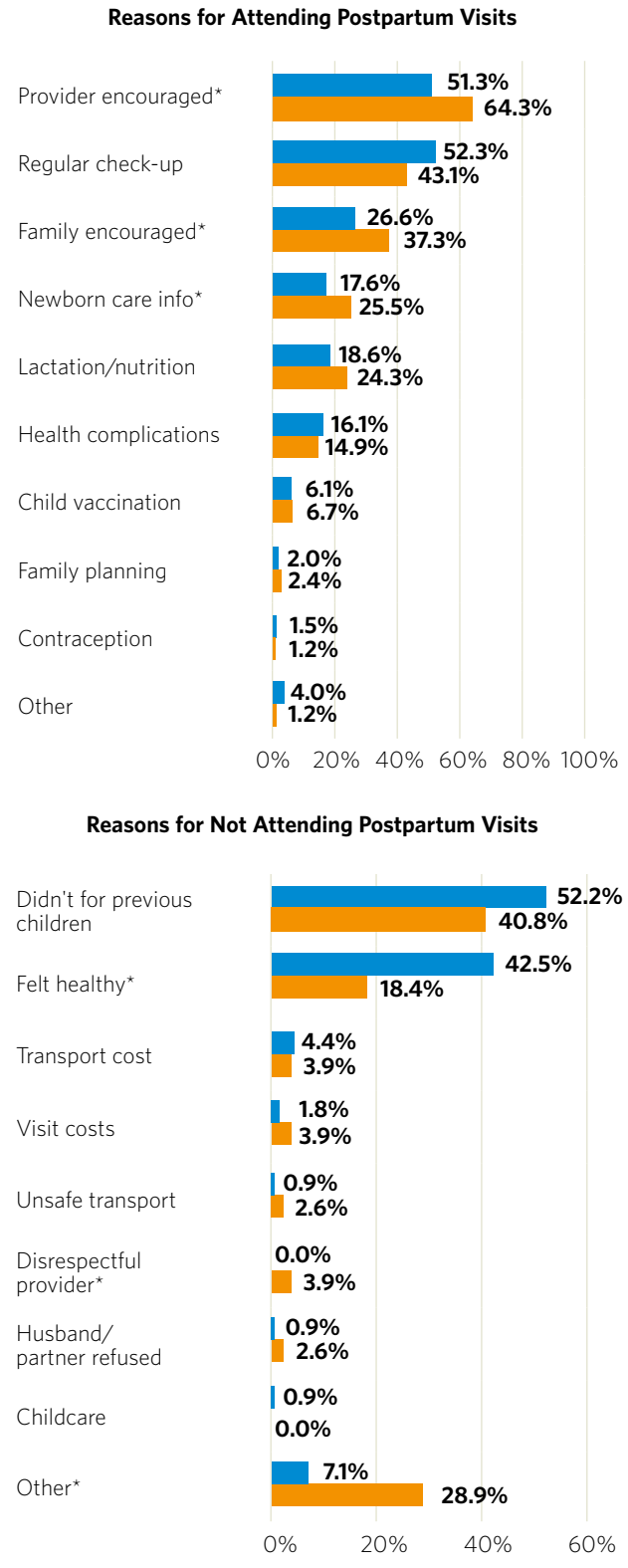
One woman interviewed described how she learned about the cash for health program, her decision to have a facility-based birth, and her satisfaction with care, saying, *"When we went to the health center for some check-up and immunization while we were pregnant, our midwife informed us about the program. We also learned that it is safe to deliver in a health facility because it is safer for the mom and the newborn because they also have equipment for us. The midwives were also kind and accommodating to us. We can recommend to our family and friends to deliver in a health facility but it is still up to them if they are going to do it."* With this, a few women mentioned that the cash assistance program was a very timely program for mothers like them given that they really needed support in their pregnancy. Because of this, they said that they had recommended the program to others.

POSTPARTUM CARE

Postpartum care was relatively common, with 69.4% of women reporting having attended the recommended visits since their delivery. More women in the cash group (76.2%) reported postpartum care compared to women in the comparison group (62.3%); this difference was statistically significant (p=0.001). Women attending postpartum visits reported an average of 2.6 visits at the facility; this was higher in the cash group (2.9) than in the comparison group (2.3) (p<0.001). Most women attending postpartum visits did so because their medical provider encouraged them to do so (58.6%), because it was a regular check-up (47.1%), or because their family encouraged it (32.6%). More women in the cash group reported attending postpartum because they were encouraged by their medical provider (64.3%) compared to those in the comparison group (51.3%) (p=0.005), whereas comparison group PLW&A more commonly attended postpartum visits because it was a regular check-up (52.3% vs 43.1% of cash group, p=0.053) (Figure 5).

Women in the qualitative interviews reiterated that they attended postpartum care visits for *"check-ups and screenings and assessments of the baby's health."* **One woman described the quality of her ANC and postpartum care by stating,** *"I was given the best pre- and post-natal care. I was checked frequently, informed about the state of my pregnancy, and given the right vitamins to take. Then after my pregnancy, I was checked again and the baby was screened."*

Figure 5: Postpartum Care Utilization and Reasons



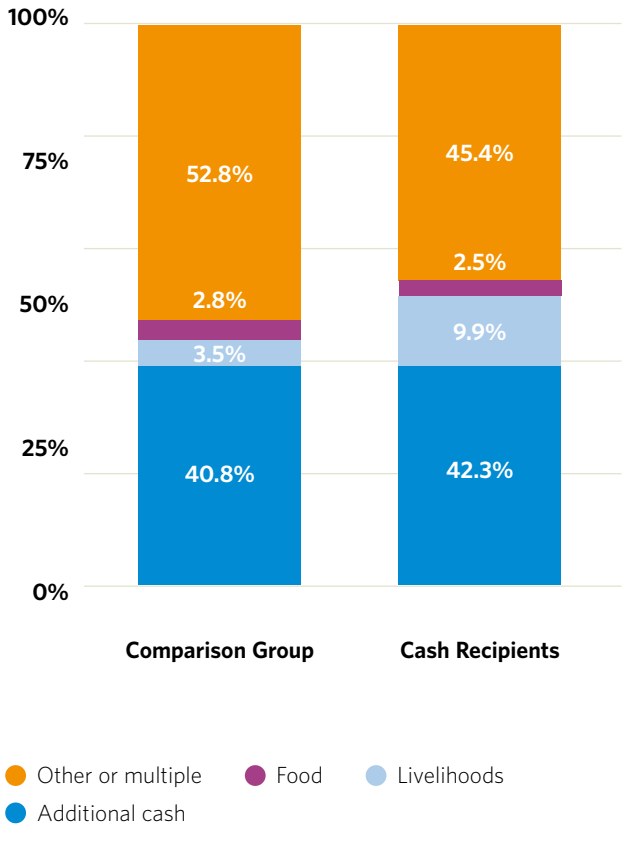
* Statistically significant difference between groups in indicated reason

Among women not attending postpartum visits, the most common reason was because they never attended with other pregnancies (47.6%), followed by because they felt healthy (32.8%). Not attending with previous pregnancies deterred a larger proportion of women in the comparison group (52.2%) than those in the cash group (40.8%), as did feeling healthy (42.5% in the comparison group vs. 18.4% in the cash group) (Figure 5). Most women (95.5%) said they plan to attend postpartum visits in a health facility in the future. Significantly more women in the cash group (98.7%) planned to attend postpartum visits than did women in the comparison group (91.8%; p<0.001), showing how the cash incentive may reduce financial access barriers for PNC visits.

REFERRALS FOR SERVICES

Information or referrals to other services were similar between groups before receipt of assistance and during postpartum visits. In the pre-survey, 99.1% of Cash for Health recipients and all comparison group PLW&A reported receiving a referral to other services. The types of services for which women received referrals are provided in Figure 6. PLW&A were most commonly referred for other or multiple services (45.4% of cash group and 52.8% of comparison) before receiving assistance, followed by additional cash assistance (42.3% of cash group and 40.8% of comparison). Fewer women were referred for livelihoods (9.9% of cash group and 3.5% of comparison), and food (2.5% of cash group and 2.8% of comparison). Fewer women (78.1%) reported receiving information about or a referral to other services during postpartum visits; this proportion was similar in the cash for health group (80.6%) and the comparison group (74.9%) (p=0.145). Women were not asked questions related to referrals during the qualitative interviews.

Figure 6: Referral Services Received Prior to Assistance



MENTAL HEALTH

Participants were asked to report how frequently they felt depressed or hopeless in the prior two weeks (on a 4-point scale from not at all to nearly every day) as well as whether they felt emotionally supported by people in their lives. At baseline, 17.9% of cash for health recipients and 8.5% of comparison group PLW&A reported feeling hopeless either more than half the time or nearly every day (Table 3).

The proportion of women reporting frequent depression decreased in both groups after the intervention to 7.0% in the Cash for Maternal Health group and 4.2% in the comparison group. The magnitude of depression reduction was similar among cash recipients (10.9%) as compared to among women in the comparison group (4.3%) (p=0.653). The only mention of mental health during the qualitative interviews was "stress" associated with accessing and paying for transport to claim cash assistance.

At baseline, 97.7% of both cash recipients and comparison group PLW&A agreed they could get emotional support from people in their lives. This reported support increased to 100% for cash recipients and for the comparison group at end line (Table 3). Changes in emotional support from baseline to end line were not significantly different between groups (p=0.630).

Table 3: Women's Mental Health

	Overall (N=646)			Comparison Group (n=316)		Cash Recipients (n=330)		p-value
	N	Point	(95% CI)	Point	(95% CI)	Point	(95% CI)	
Prior to Receipt of Assistance								
Feelings of depression or hopelessness in last 2 weeks								
Not at all	248	38.4%	(34.7-42.2%)	38.0%	(32.6-43.4%)	38.9%	(33.6-44.2%)	0.001
Several days	311	48.2%	(44.4-52.1%)	53.5%	(48.0-59.0%)	43.2%	(37.8-48.5%)	
More than half the days	36	5.6%	(3.8-7.4%)	2.5%	(0.8-4.3%)	8.5%	(5.5-11.5%)	
Nearly every day	50	7.8%	(5.7-9.8%)	6.0%	(3.4-8.6%)	9.4%	(6.2-12.6%)	
Can get emotional support from people in life								
Strongly agree	596	92.4%	(90.4-94.5%)	93.7%	(90.9-96.4%)	91.2%	(88.1-94.3%)	0.078
Somewhat agree	34	5.3%	(3.5-7.0%)	3.2%	(1.2-5.1%)	7.3%	(4.5-10.1%)	
Somewhat disagree	9	1.4%	(0.5-2.3%)	1.6%	(0.2-3.0%)	1.2%	(0.0-2.4%)	
Strongly disagree	5	0.8%	(0.1-1.5%)	1.3%	(0.0-2.5%)	0.3%	(-0.3-0.9%)	
After Receipt of Assistance								
Feelings of depression or hopelessness in last 2 weeks								
Not at all	411	64.7%	(61.0-68.5%)	67.7%	(62.5-73.0%)	61.8%	(56.5-67.2%)	0.065
Several days	188	29.6%	(26.0-33.2%)	28.1%	(23.0-33.1%)	31.1%	(26.0-36.1%)	
More than half the days	24	3.8%	(2.3-5.3%)	1.9%	(0.4-3.5%)	5.5%	(3.0-8.0%)	
Nearly every day	12	1.9%	(0.8-3.0%)	2.3%	(0.6-3.9%)	1.5%	(0.2-2.9%)	
Can get emotional support from people in life								
Strongly agree	633	98.9%	(98.1-99.7%)	99.4%	(98.5-100.2%)	98.5%	(97.1-99.8%)	0.276
Somewhat agree	7	1.1%	(0.3-1.9%)	0.6%	(-0.2-1.5%)	1.5%	(0.2-2.9%)	
Somewhat disagree	0	0.0%		0.0%		0.0%		
Strongly disagree	0	0.0%		0.0%		0.0%		
Pre/Post Assistance Change								
Feelings of depression or hopelessness in last 2 weeks								
Not at all		26.3%	(21.0-31.6%)	29.7%	(22.3-37.2%)	22.9%	(15.5-30.4%)	0.653
Several days		-18.6%	(-23.9- -13.4%)	-25.4%	(-32.9- -18.0%)	-12.1%	(-19.4- -4.7%)	
More than half the days		-1.8%	(-4.1-0.5%)	-0.6%	(-2.9-1.7%)	-3.0%	(-6.9-0.9%)	
Nearly every day		-5.9%	(-8.2- -3.5%)	-3.7%	(-6.9- -0.7%)	-7.9%	(-11.3- -4.5%)	
Can get emotional support from people in life								
Strongly agree		6.5%	(4.3-8.7%)	5.7%	(2.9-8.5%)	7.3%	(3.9-10.6%)	0.630
Somewhat agree		-4.2%	(-6.1- -2.3%)	-2.6%	(-4.7- -0.4%)	-5.8%	(-8.8- -2.6%)	
Somewhat disagree		-1.4%	(-2.3- -0.5%)	-1.6%	(-3.0- -0.2%)	-1.2%	(-2.4-0.0%)	
Strongly disagree		-0.8%	(-1.5- -0.1%)	-1.3%	(-2.5- 0.0%)	-0.3%	(-0.9-0.3%)	

Questions related to mental health and emotional support were not directly asked to women participating in the qualitative interviews. However, the majority of the interviewed women provided examples of the support they had from their husband or other family members (e.g., mother, mother-in-law, and/or sister) by reporting their accompaniment to the facility for ANC visits and/or the delivery.

SAFETY

Participants were asked about their overall feelings of safety and any changes in household relationships between baseline and endline. Nearly all women reported feeling safe in their households with only one woman, in the cash recipient group, reporting feeling 'not very safe' in her household at baseline. A total of four women (three cash recipients and one in the comparison group) reported feeling 'not very safe' or 'not at all safe' at end line. Given the limited number of women in either group feeling unsafe at baseline and end line, the impact of receiving cash on feelings of safety in the household cannot be reliably determined.

Slightly over one-quarter cash recipients (27.5%) reported better household relationships after the intervention and fewer comparison group PLW&A (11.5%) reported better relationships at the endline (Figure 7) ($p<0.001$). It was uncommon for participants to report worsening household relationships after the intervention compared to before (<1% of participants) and the changes were not specifically attributable to the intervention. Safety and changes in relationships within the household were not questions asked in the qualitative interviews.

The overwhelming majority (99.4%, CI: 98.5-100%) of cash recipients reported feeling safe receiving cash, and only one recipient reported tensions with neighbors. Few recipients (15.9%) reported that there were no challenges in receiving their cash transfer. The main challenges reported were travel time/distance (67.8%), transportation cost (47.2%), and schedule for cash collection at the remittance counter (19.2%). **As one woman explained during her interview,** *"The remittance center was far from our home address so we experienced some challenges regarding long distance and high cost of transportation. But still it was a fast and safe transaction to receive the cash."*

Another woman provided details on the main challenges obtaining the cash. The woman received her cash through the remittance center (a pawnshop) and was accompanied by her husband and her mother. She reported challenges in claiming her assistance because her name was wrong on the list, causing her to have to wait the whole morning for it to be corrected. She noted that the remittance center was very far away and that she needed to travel on public transport to get to it, noting that the health facility did not provide them with transportation fare. **Even so, she explained that even with these challenges she was** *"thankful because the cash assistance was really a big help."*

HOUSEHOLD FINANCIAL DECISION MAKING

In the post-delivery survey, cash recipients were asked to report their level of control over household spending decisions (on a five-point scale from no control to full control) and any anticipated consequences if household members disagreed with their spending decisions. More than three-quarters (76.4%) of cash recipients reported a fair amount or full control over household spending, while 10.1% reported no control (Figure 8).

Nearly half of cash recipients (46.3%) reported they were the singular decision makers on the use of their cash assistance, while 27.9% reported joint decision

Figure 7: Change in Household Relationships After Intervention

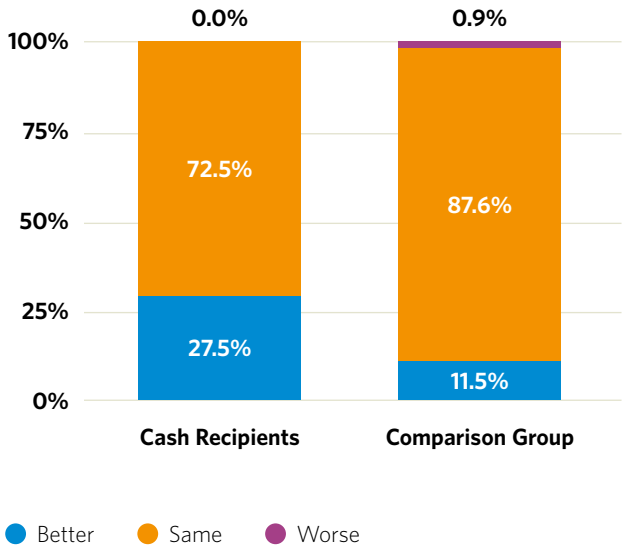
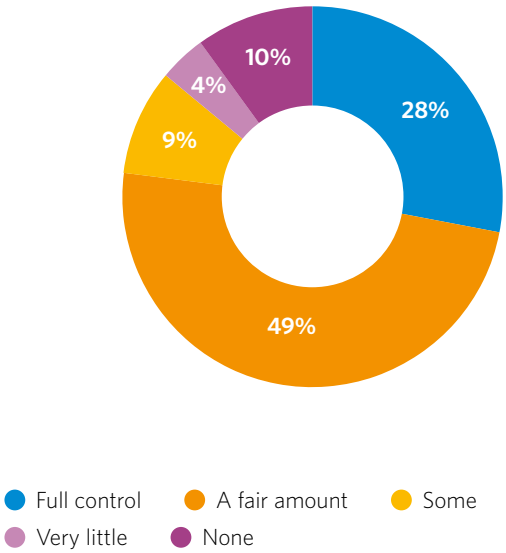


Figure 8: Change in Household Relationships After Intervention

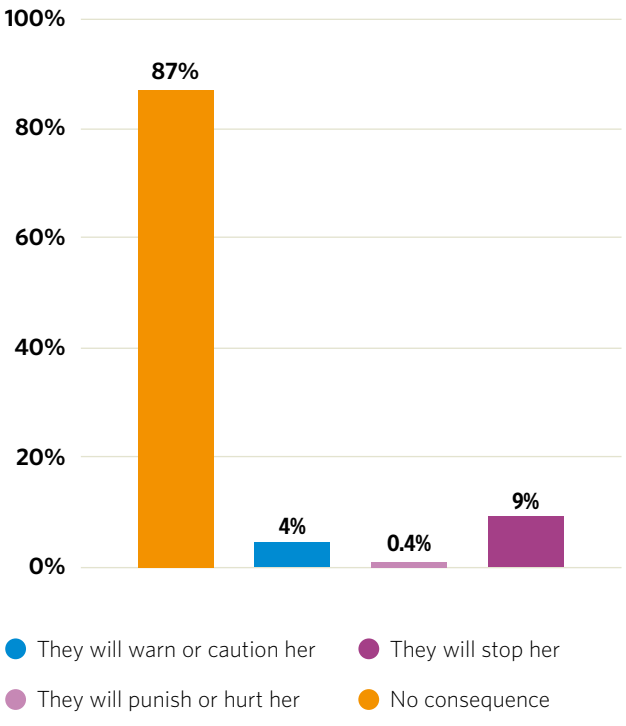


making. Only 25.5% of women reported they were not engaged as a primary decision maker on the use of the cash assistance.

The women interviewed reinforced that they either made decisions on how to spend the cash with their husband or made the decision on their own. **One woman said,** *"There was no conflct or disagreement on how to spend the money because me and my husband both agreed and have mutual understanding."* **Another woman added,** *"It is really important to have mutual understanding in every decision a household makes."* **Only one woman interviewed stated that her husband made the decision on how to spend the cash alone and added** *"I trust my husband in that way."*

When asked about consequences if household members disagreed with spending decisions, the majority of the Cash for Maternal Health recipients (86.8%) reported that there would be no consequence (Figure 9). The next most common response was that family members would stop her, which was reported by 8.5% of Cash for Health recipients. A minority of women reported that their household members would warn or caution them (4.3%) or would punish or hurt them (0.4%). None of the women who participated in the interviews discussed disagreements or negative consequences with a husband or family member related to decisions on how to use the cash assistance.

Figure 9: Post-Intervention Spending Decision Consequences for Cash Recipients



CASH RECEIPT AND USE

Most Cash for Maternal Health recipients (99.1%) reported receiving the cash assistance as cash in hand at a remittance agency counter (Table 4). The majority of the 20 recipients interviewed, in the qualitative interviews, noted that they learned about the cash assistance from the midwife at the health facility. The cash was provided as an incentive for PLW&A to deliver their babies at medical facility level. The amount provided by UNFPA aimed to cover the costs of transportation to services, some of the indirect costs of the medical visits as well as a few items for the mother

Table 4: Cash Transfer Use and Decision Making

Mode of Transfer	Point	(95% CI)
Cash in hand	99.1%	(98.0-100%)
Other	0.9%	(-0.1-2.0%)
Challenges in Collecting Transfer[1]		
No problems faced	15.9%	(11.9-19.8%)
Travel time / distance	67.8%	(62.4-73.3%)
Transport costs	47.2%	(41.4-53.0%)
Schedule	19.2%	(14.6-23.8%)
Cash Transfer Use		
Largest Expenditure[2]		
Food	78.0%	(73.5-82.6%)
Non-food items	12.5%	(8.9-16.1%)
Livelihoods	6.4%	(3.7-9.1%)
Second Largest Expenditure[3]		
Non-food items	50.9%	(45.5-56.4%)
Food	17.7%	(13.5-21.8%)
Hygiene	13.1%	(9.4-16.8%)
Livelihoods	7.3%	(4.5-10.2%)
Other	5.2%	(2.8-7.6%)
Decision Making on Spending		
Recipient	46.3%	(40.9-51.8%)
Husband/male HH member	25.5%	(20.7-30.2%)
Both	27.9%	(23.0-32.8%)
Other	0.3%	(-0.3-0.9%)
Husband aware of transfer	**95.4%**	**(93.1-97.7%)**
Husband's reaction positive	**95.5%**	**(93.1-97.8%)**

1 < 7% reported needing male accompaniment, identification, safety difficulties, cash unavailability, or other challenges

2 < 5% reported their largest cash expenditures being health, hygiene, debt repayment, and shelter

3 < 5% reported their second largest cash expenditures being health, transportation, and shelter

and baby. Once the PLW&A received the cash assistance they were free to use it according to their own individual priorities. Overall, at least 63% of cash recipients spent part of their cash on food, including 78.0% (CI: 73.5-82.6%) that reported food as the largest expenditure and 17.7% (CI: 13.5-21.8%) that reported food as the second largest expenditure. NFIs were the second most frequent use of cash, with 12.5% (CI: 8.9-16.1%) and 50.9% (CI: 45.5-56.4%) of households reporting NFIs as the first or second highest expenditure type (63.4% total). Sharing of cash with other households was reported by 36.4% (CI: 31.2-41.7) of households; the mean amount shared was US$5.70 (CI: 5.0-6.3; median 4.3).

Consistent with the survey findings, the majority of the 20 women interviewed across the 6 municipalities reported using a portion of the cash assistance to purchase food, primarily for their babies when they had stopped nursing, with a few women also using some of the cash to purchase rice to feed their family. Further, women described the purchase of non-food items for the baby, specifically diapers and clothes. **One woman summarized the use of cash for food and non-food items by saying,** *"We used the money to buy milk, diapers, and new clothes, while we added the remaining budget for the food in celebration of Eid."*

Two of the women interviewed discussed using some of the cash assistance for capital to invest in an income generating activity and then using the profits from that activity to purchase the daily needs of the baby and family. Another woman mentioned that some of the cash assistance went to her mother for her help during the pregnancy and another woman stated that she used a portion of the cash to cover childcare costs for when she went to the remittance center to obtain the cash. Another reported that the cash helped her to secure the things needed by her newborn, including supplies for when he was unwell. With this, other women mentioned that the cash assistance helped their families to cover travel expenses and buy food whenever they visited the rural health unit facility.

Most participants (95.4%) reported that their husband was aware of the cash assistance and that his reaction was positive (95.5%, CI: 93.1-97.8%). The qualitative interviews reinforced that husbands and other family members were aware of the cash assistance. **One woman stated,** *"I did not have any problems spending the cash assistance because my husband supported me."*

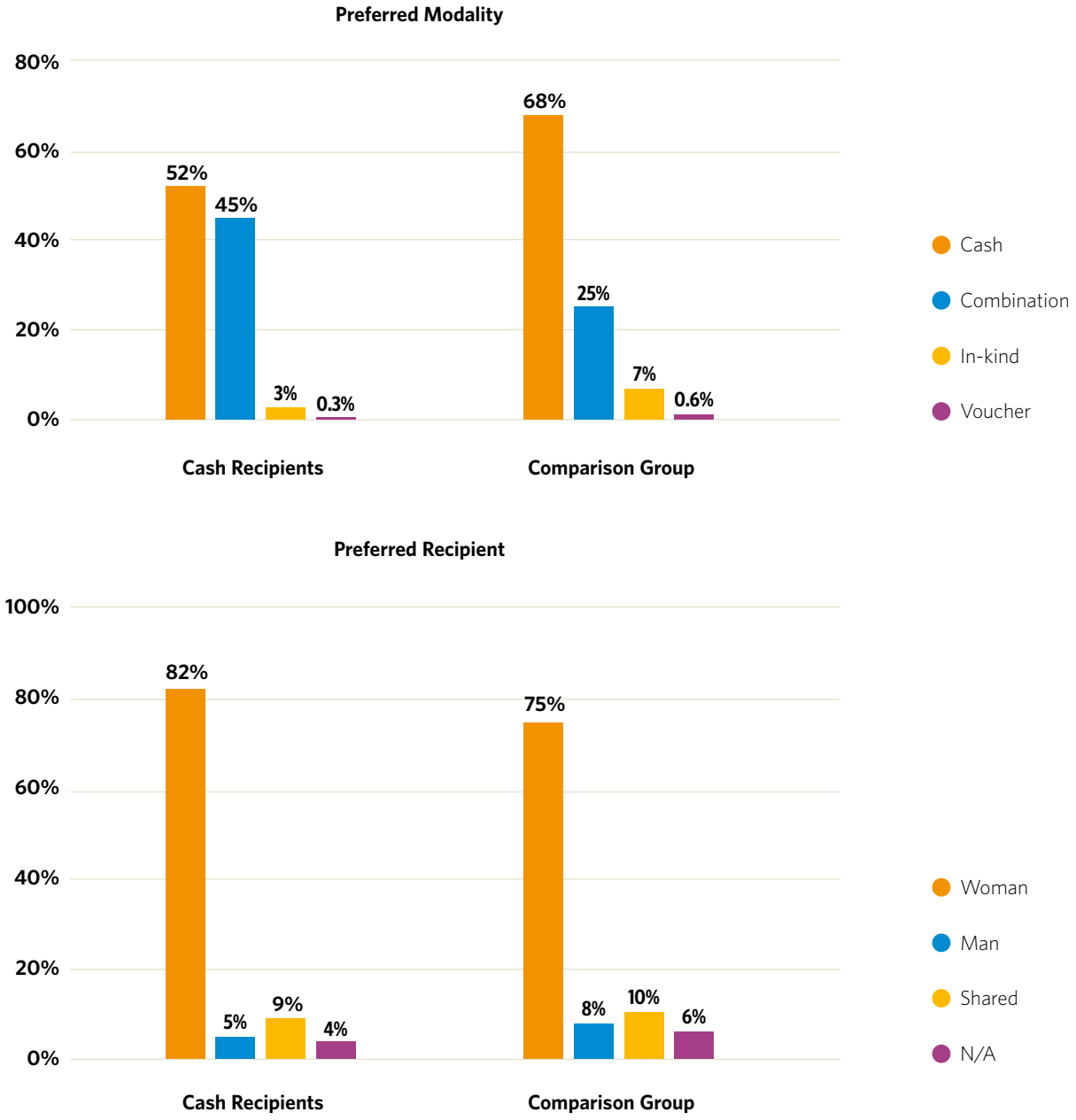
Additionally, most women interviewed said that the husband was not only aware of the cash assistance but was "happy" to be in the program as the cash arrived at the time it was needed by the family. **One woman said,** *"My husband and I became happier. We have never quarreled [about the cash assistance] and we are content with what we received."*

MODALITY OF ASSISTANCE PREFERENCES

For future assistance, 59.5% (CI: 55.7-63.3%) of both the Cash for Maternal Health and comparison groups preferred that future assistance be given in cash rather than as vouchers or in-kind assistance. Another 35.1% (CI: 31.3-38.8%) reported a preference for a combination of assistance types for future cash. Only three participants reported a preference for vouchers. Comparison group PLW&A were significantly more likely to prefer cash transfers (67.5% vs. 51.7% of cash recipients), while cash recipients were more likely to prefer a combination of assistance types (44.9% vs. 24.8% of comparison PLW&A) ($p<0.001$) (Figure 11). This may be linked to the time spent in collecting the cash transfer by cash recipients. Among cash recipients, 82.2% (CI: 78.0-86.3%) would prefer a woman to be the recipient of the assistance, compared to 75.3% (CI: 70.5-80.1%) of comparison group PLW&A ($p=0.272$) (Figure 10).

One woman suggested providing the cash directly to the woman during a home visit to avoid travel and transport costs, saying *"I think it is better to give the financial assistance through the house-to-house visits so that we will not spend a lot in transportation and so our children will not be left at our house with no one to take care of them."*

Figure 10: Future Assistance Preferences After Intervention



SUMMARY OF FINDINGS

This study examined the experiences of 330 women in six municipalities in a humanitarian context in the Philippines who received cash after facility-based registration and delivery of a baby. The programme was part of an overall emergency maternal health response of UNFPA Philippines in these municipalities supporting medical facilities and assisting 850 pregnant and lactating women and adolescents. Questionnaire-based interviews were conducted pre- and post-delivery with the 330 women in the cash assistance program and 316 women in a comparison group. A sub-sample of 20 women among the 330 who received the cash assistance as an incentive for registering and delivering at a health facility also participated in qualitative interviews that were intended to deepen the understanding of women's experiences with cash assistance, facility-based delivery, and support.

Among the cash recipients, ANC care visit attendance was relatively high overall, with 92.6% of all women reporting in the post-delivery surveys that they had attended antenatal care visits at the facility where they were registered. Attendance was higher in the cash group (99.1%) than in the comparison group (84.1%). The number of women attending four or more ANC visits at the facility was also higher among cash recipients (69.6%) than in the comparison group (41.2%), showing the benefits of close monitoring of pregnancies and safe information sharing by medical personnel.

Likewise, more women in the cash group (76.2%) reported attending postpartum care than women in the comparison group (62.3%). Women attending postpartum visits reported an average of 2.6 visits at the facility; this was higher in the cash group (2.9) than in the comparison group (2.3).

Women in the cash group (86.4%) were significantly more likely than those in the comparison group (58.7%) to deliver at the health facility ($p<0.001$). Women who delivered at the health facility most frequently reported doing so because it is safer for the mother and baby (85.7%). Women in the cash group were also significantly more likely to deliver at the health facility because their provider encouraged it (25.2% vs 7.4% of comparison PLW&A) or because the provider was respectful (15.1% vs. 5.0%). If a woman did not deliver at the facility, the primary reason provided was that her prior deliveries were at home (31.4%).

Women in both groups were satisfied with their care at the facilities; however, women in the cash group were significantly more satisfied with the overall care they received compared to women in the comparison group (98.1% vs. 83.9%, $p<0.001$). Further, significantly more women in the cash group (95.8%) planned to deliver in a health facility in the future compared to women in the comparison group (64.0%; $p<0.001$). Most women (96.9%) also said they would recommend facility delivery to their pregnant friends and/or family members, including 98.8% in the cash group and 94.3% in the comparison group.

The most prominent unmet need in both the cash assistance and comparison groups at baseline was food, reported by 96.0% of households. Other top priorities in unmet needs differed by groups and were related to NFIs (65.3%) and livelihoods (47.7%). Food was the top ranked unmet need that was similar between both groups ($p=0.276$). Between the pre- and post-delivery surveys, the proportion of cash recipients that reported food needs decreased by 12.3%, while this proportion decreased by 11.5% in the comparison group. Importantly, the vast majority of women in both groups advocated for cash assistance or a combination of cash assistance and in-kind and preferred that the cash be given directly to women.

UNFPA's cash assistance aimed to cover transportation costs, indirect costs of accessing medical care, and other priority items for the mother and the baby as an incentive to register and give birth in a medical facility. It was to be used flexibly by each woman or adolescent according to her own individual needs. The majority (63%) of cash recipients spent part of their cash on food, including 78.0% that reported food was the largest expenditure and 17.7% reporting food as the second largest expenditure. Additionally, women described using the cash for NFIs–with 63.4% reporting NFIs among their top two expenditures; in particular, women described the purchase of food and NFIs to meet the baby's needs.

Most participants (95.4%) reported that their husband was aware of the cash assistance and 95.5% of these women reported that their husband's reaction to the cash was positive. The overwhelming majority (99.4%) of cash recipients reported feeling safe receiving the cash; however, many recipients (83.9%) reported that there were challenges in receiving their cash. The main challenges reported were travel time/distance to the remittance center (67.8%), transportation costs (47.2%), and scheduling to pick up the cash assistance (19.2%). Because of this, some women recommended continuing to provide cash assistance to pregnant women by providing it to them directly at their homes during home health visits.

The majority of women receiving cash (74.2%) reported they were either the singular decision makers or made the decision on use of the cash jointly with their husband. One-quarter (25.5%) of women reported they were not engaged as a primary decision maker on use of the cash. Almost all of the women in both the cash and comparison groups reported feeling safe in their homes. Further, no women in the cash group reported their relationship worsened from the baseline to end line surveys.

The cash incentive encouraged cash recipients' registration to the rural health facilities, allowing for the health facility to more closely monitor the pregnancy as well as timely sharing of crucial information on how to ensure a safer pregnancy. This seems to have positively encouraged cash recipients to attend ANC visits, as well as postpartum care visits after the delivery. The cash assistance seems to have contributed to the creation of a habit of regular visits in the cash recipient group.

While the study findings indicates that pregnant women in both the cash and comparison groups support and

benefit from facility-based care and delivery, the addition of cash assistance to facility-based care registration was associated with significantly greater satisfaction with care, delivery in the facility, and plans for future pregnancies to be facility-based deliveries for women who received the cash assistance compared to women in the comparison group. Further, there were extremely limited safety and relationship problems reported by women in the cash group. Importantly, women in both groups would recommend facility-based delivery to friends and family, but cash recipients were significantly more likely to recommend facility-based delivery than the comparison group.

Recommendations

Given the current findings and the global context in which humanitarian needs far exceed available resources, with cash assistance providing an efficient and impactful option in humanitarian assistance, UNFPA and their implementing partners should endeavor to expand cash assistance within their maternal health programs. UNFPA Philippines should continue to provide its cash assistance to incentivize access to maternal health services as part of a whole package of services through which UNFPA also supports the availability and quality of services and bolsters provider knowledge to ensure a holistic approach and maximize impact. UNFPA Philippines should also ensure closer coordination with other actors when possible, to more reliably meet complementary sectoral needs – such as food, as highlighted by this evaluation's findings – of the individuals and households assisted.

In its next program iterations, UNFPA Philippines should ensure the availability of CVA delivery mechanisms that allow for closer cash collection by recipients with less travel distance. This should be done on a contextual basis, bearing in mind that in certain areas of operation in the country the coverage and capacity of FSPs is more limited. As there are typically various options available for the delivery of CVA (both technology-based and not), UNFPA should conduct thorough consultations with pregnant women and adolescents at the planning stage for future programmes to select the most appropriate cash delivery methods as well as aim to cover costs of access and opportunity for recipients, if any, within the cash transfer amount itself.

In addition to CVA for maternal health, additional maternal and neonatal health interventions should be considered as part of an expanded package, with a particular emphasis on reaching women who deliver outside facilities. UNFPA Philippines should commit to ensuring the provision of additional promotion of breastfeeding messaging together with the ANC/postpartum care visits and the delivery of cash assistance and the implementation of the Essential Newborn Care protocol, which includes early initiation of breastfeeding immediately after birth. UNFPA should seek to conduct a more thorough exploration of the knowledge, skill, and attitude factors linked to breastfeeding, working with partners to build further evidence on these topics.

Recognizing the limitations of this evaluation, UNFPA should continue to conduct thorough monitoring, evaluations, and research studies on its CVA programme components in the Philippines and globally in order to further build evidence and inform CVA programme design.

Acknowledgements

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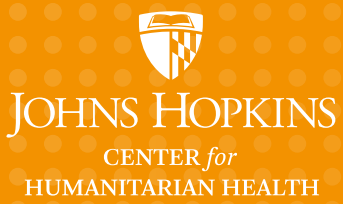

Delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled

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