Health-seeking Behaviors of Beneficiaries and Non-beneficiaries of Pantawid Pamilyang Pilipino Program (4Ps)

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ABSTRACT

Background: The Pantawid Pamilyang Pilipino Program (4Ps) helps beneficiaries become self- sufficient, comply with health services like routine preventive check-ups and vaccination, and helps in poverty alleviation by providing cash grants to extremely poor households to improve their health, nutrition, and education. Determining the beneficiaries' health-seeking behavior is crucial in assessing the effectiveness of the 4Ps program. Low levels of health-related myths, a favorable view of the healthcare system, and good surveillance of health-seeking behaviors are the expected results if the implementation of the 4Ps health program is effective and adequate.

Objective: To determine the difference between the level of health-seeking behaviors of beneficiaries and non-beneficiaries of 4Ps in Barangay Rafael Rueda, Nueva Ecija

Methods: This cross sectional study utilized a 15-item survey questionnaire answerable by a 4- point Likert scale to measure the health-seeking behaviors of 4Ps beneficiaries compared with non-beneficiaries. The questions formulated were based on the concepts and factors influencing health-seeking behaviors (Chronbach's alpha=0.74). Average scores were compared using independent samples t test.

Results: A total of 64 residents of the said barangay were gathered to participate in the study. There were 19 beneficiaries of 4Ps and 45 non-beneficiaries. Independent samples t test analysis of the overall health-seeking behavior of the two groups showed no significant difference (p-value=0.92, 2-tails, 95% CI) and health center visits showed no significant difference as well (p-value=0.98, 2-tails, 95% CI). The 3 variables' influence on health-seeking behavior were also analyzed and yielded p-value=0.51 for cost of healthcare, p-value=0.48 for perception towards the healthcare system, and p-value=0.25 for misconceptions about health.

Conclusion: The lack of significant difference between the health seeking behaviors of 4Ps beneficiaries and non-beneficiaries as influenced by visits to health center, cost of healthcare, perception towards the healthcare system, and misconceptions about health may be explained by the fact that both groups, apart from receiving the benefits of the 4Ps, belong in the same socioeconomic class, are exposed to similar living conditions and interventions from the government and health sector, and pass down the same belief systems. Comparable results between groups reflect the sad reality that the health interventions offered by the program do not facilitate global health-seeking behavior improvement, rather, only incentivized health activities that are monitored by the program that do not have a spill-over effect to other aspects of health.

Key words: Health-seeking behavior, Pantawid Pamilyang Pilipino Programs (4Ps), cost of healthcare, misconceptions about health, perceptions towards the healthcare system

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The Pantawid Pamilyang Pilipino Program (4Ps) provides grants to extremely poor households to improve their health, nutrition and education. It consistently helps beneficiaries become self-sufficient, comply with health services such as regular preventive check-ups, vaccination and other DOH protocols and eventually be delisted from the poverty alleviation program. With healthcare as one of the key assistance provided by 4P's program, determining the health-seeking behavior of the beneficiaries is of great importance as to the effectiveness of the program for an individual's desire to seek medical care varies. As the health seeking behavior affects the population health outcomes, understanding the health seeking behavior of individuals could achieve better health outcomes, reduce the burden of the disease and improve the healthcare programs. There are contradicting results from studies that looked into the program's effects on the overall health of its beneficiaries. The nutritional status and pregnancy health saw a positive impact[1] while on the other hand, stunting[2] was shown to be more prevalent in these beneficiaries. According to Musoke et al. (2014)[3], the community's health-seeking behavior explains health-service utilization and the population's subsequent benefit. However, utilization would also vary in terms of educational levels, economic factors, cultural beliefs, and practices. Other factors include environment, socio-demographics, and knowledge about existing facilities, healthcare systems, and policy.

Adherence to health prevention and intervention are affected by social factors and health care-related factors.[4] In this study, three main factors have been identified that influence low socioeconomic families in their health-seeking behavior: high cost of healthcare, negative perceptions towards the healthcare system, and misconceptions about health. Poor families have high out-of-pocket expenditure due to high cost of hospitalizations, consultations, and medicines, lack of health insurance, and having larger household sizes.[3,5,6] Hence, they end up becoming hesitant in visiting health care facilities[3], turning to folk medicine due to its affordability[7], and utilizing the money for gambling and drinking alcohol instead of using it for children's education, daily needs, and health.[8] Low income communities also have negative perceptions towards the healthcare system due to culture, religion,[9,10] and low social trust in healthcare workers[11] which influences reluctance in health-seeking behavior.[12] Disease cognition is negatively influenced by self-reported severity[13] and low income families only tend to health concerns when they become severe.[14] Most poor families are uneducated[8], less informed and lacking in health awareness which makes them less likely to consult[13], prefer folk healers[11], and more likely to self-medicate.[15,16]

This study aimed to determine the difference between the level of health-seeking behaviors of beneficiaries and non-beneficiaries of 4Ps in Barangay Rafael Rueda, Nueva Ecija, specifically, in terms of visits to the City/Municipal health center/rural health units/barangay health station and as influenced by cost of healthcare, perceptions towards the healthcare system, and misconceptions about health.

MATERIALS AND METHODS

This is a cross sectional study that aimed to determine the factors that affect the health- seeking behaviors of the beneficiaries and non-beneficiaries of 4Ps in Barangay Rafael Rueda Sr., San Jose City, Nueva Ecija. All households that are beneficiaries of the Pantawid Pamilyang Pilipino Program who are currently residing in Barangay Rafael Rueda Sr., San Jose City, Nueva Ecija were included. The respondents were either parent of the enrolled household or a guardian, 18 years or older, of the enrolled children. Excluded were 4Ps beneficiaries currently residing in Barangay Rueda Sr., San Jose City, Nueva Ecija who receive other conditional cash transfers (CCT). 4Ps non-beneficiaries should have an income of less than the poverty threshold of Php12,030 per month[17], currently residing in Barangay Rafael Rueda Sr., San Jose City, Nueva Ecija. Participants excluded from this study were households residing in Barangay Rueda Sr., San Jose City, Nueva Ecija who receive other conditional cash transfers (CCT) and participants with more than three children in their family unit.

The researchers constructed a 15-item survey questionnaire answerable by a 4-point Likert scale (Chronbach's alpha=0.74). The questions formulated were based on the concepts and factors influencing health-seeking behaviors from the studies of Huang et al. (2019),[13] Lau et al. (2020)[12], and Musoke et al. (2014).[13]

Purposive sampling, a non-probability sampling design was employed. A sample of 4Ps beneficiaries based on the provided list by the barangay and nonbeneficiaries living within a 2 kilometers radius

from the Barangay Rafael Rueda Barangay Hall in San Jose City, Nueva Ecija was selected.

The formula used in sample size calculation was based on the estimation of the population proportion. Where in n = , where z^2 is the reliability estimates, P is the estimate z2PQ d2 of the true proportion, Q is 1 subtracted by P, and d^2 is the maximum allowable error. The sample size for the beneficiaries was 19 since there are 19 members of 4Ps in Barangay Rafael Rueda. Using the formula, the weighted sample size for the non-beneficiaries was 45.

Two research members who live in Nueva Ecija, together with four other researchers from Manila traveled to Brgy. Rafael Rueda Sr., San Jose City, Nueva Ecija, to personally invite respondents to participate in the research. The barangay captain was contacted through the phone beforehand to get permission and acquire the list of 4Ps members of the barangay. The barangay captain only gave the list of the 4Ps members and the researchers were the ones who chose the participant in the list, based on the availability of the household members as well as proximity to the barangay office. The employees of the barangay office assisted the researchers in navigating the households of the 4Ps members and in disseminating the survey questionnaires. Researchers politely greeted the respondents and asked for their permission to be surveyed. The researchers handed out informed consent to the respondent and read the content in Tagalog. Respondents were asked to fill out two informed consent forms, one for themselves and another for the researchers for compilation, as they agreed to participate. However, the survey was terminated for those respondents who did not wish to sign the consent form or did not wish to disclose their answers in the middle of questioning.

Following the acquisition of signed informed consent, the researchers asked if they are enrolled in other conditional cash-transfer programs, if they earn more than Php 12,030 per month, and if the number of children living with them is more than 3. The survey was terminated for those respondents who answered yes to any of the questions mentioned as they were included in the exclusion criteria. A 15-item survey questionnaire, answerable by a 4-point Likert scale, was given to the respondents for them to answer by themselves. Those unable to read or write were assisted by the researchers or alternatively, invited someone who the respondent trusted to assist them. The form was accomplished in 15-20 minutes, during which the researchers stayed with the respondent. After answering the questionnaire, the researchers handed out biscuits and juice as tokens of appreciation and thanked the respondents for taking the time to participate in the survey. Data collected from the answered questionnaire were recorded on a spreadsheet. The responses were summarized in a graph and chart form. This helped determine the frequency of responses and the total percentage.

RESULTS

A total of 64 residents of the said barangay were gathered to participate in the study.

There were 19 beneficiaries of 4Ps, 16 female respondents and 3 male respondents with a mean age of 50 years. Out of 45 non-beneficiaries, 29 were female and only 16 respondents were male with an average age of 44 years old. Among the respondents, the majority (70.3%) of participants were female and nearly one-third (29.7%) were male as shown in table 1.

Table 1. Demographic data of respondents.

Demography	Respondents	
	N = 64	100%
Beneficiaries	**19**	**29.7%**
Age		
19 - 29	0	0%
30-40	6	9.37%
41-51	6	9.37%
52 - 62	3	4.69%
63-73	1	1.56%
74-81	3	4.69%
Total	19	29.7%
Sex		
Female	16	25.01%
Male	3	4.69%
Total	19	29.7%
Non-Beneficiaries	**45**	**70.3%**
Age		
19 - 29	9	14.06%
30-40	11	17.18%
41-51	9	14.06%
52 - 62	11	17.18%
63-73	4	6.25%
74-81	1	1.56%
Total	45	70.3%
Sex		
Female	29	45.30%
Male	16	25%
Total	45	70.3%

The frequency distribution on the health-seeking behavior and perceptions assessment of the beneficiaries and non-beneficiaries shows that in Question 2, among the beneficiaries, 47% said that they always go to health centers for prevention of illness and undernutrition while 16% said that they never do this. Among the nonbeneficiaries, 56% answered that they go to health centers for prevention of illness and undernutrition while 11% answered that they never do this. 26% of beneficiaries who almost never go to hospital for prevention of illnesses and undernutrition is distinctly higher compared to those who frequently do with a percentage of 11%. For question 8, among the beneficiaries, 0% strongly agreed that sick family members should be brought to an alternative healer because it's cheaper while 2% agreed amongst the nonbeneficiaries. Also among the beneficiaries, the percentage of those who agree that their sick family member should be brought to alternative faith healers because it's cheaper is distinctly higher compared to those who disagree. For question 13, among the beneficiaries, 11% strongly agreed and 16% agreed that they don't need to consult a doctor because they already know how to take care of their illnesses. Among the non-beneficiaries, only 2% strongly agreed and 2% agreed that they don't need to consult a doctor because they already know how to take care of their illnesses. The percentage of beneficiaries who agreed that they don't need to consult a doctor because they already know how to take care of their illness is distinctly higher compared to the non-beneficiaries. For question 14, among the beneficiaries, the 26% who agreed that all they need is a strong faith and a prayer rather than see a doctor when they are sick is distinctly higher compared to those 16% who disagreed as shown in table 2.

Table 2. Health-seeking behavior and perceptions assessment.

Question 2: We go to a health center or hospital for prevention of illness and undernutrition.				
	Beneficiaries		***Non-Beneficiaries***	
	Frequency	*Distribution*	*Frequency*	*Distribution*
4 - We always do this	9	47%	25	56%
3 - We frequently do this	2	**11%**	8	18%
2 - We almost never do this	5	**26%**	7	16%
1 - We never do this	3	16%	5	11%
Grand Total	19	100%	45	100%
Question 8: Sick family members should be brought to alternative healers because it is cheaper there.				
	Beneficiaries		***Non-Beneficiaries***	
	Frequency	*Distribution*	*Frequency*	*Distribution*
4 - strongly agree	0	0%	1	2%
3 - agree	3	**16%**	5	11%
2 - disagree	2	**11%**	11	24%
1 - strongly disagree	14	74%	28	62%
Grand Total	19	100%	45	100%
Question 13: We know how to take care of our illness so we do not need to consult a doctor.				
	Beneficiaries		***Non-Beneficiaries***	
	Frequency	*Distribution*	*Frequency*	*Distribution*
4 - strongly agree	2	11%	1	2%
3 - agree	3	**16%**	1	**2%**
2 - disagree	7	37%	15	33%
1 - strongly disagree	7	37%	28	62%
Grand Total	19	100%	45	100%
Question 14: You don't need to see a doctor when you are sick, all you need is strong faith and a prayer.				
	Beneficiaries		***Non-Beneficiaries***	
	Frequency	*Distribution*	*Frequency*	*Distribution*
4 - strongly agree	1	5%	2	4%
3 - agree	5	**26%**	5	11%
2 - disagree	3	**16%**	22	49%
1 - strongly disagree	10	53%	16	36%
Grand Total	19	100%	45	100%

The health-seeking behavior average levels shows that the average level of overall health seeking behaviors of both beneficiaries and non-beneficiaries is 35. The visits to the health center, results show that both beneficiaries and the non-beneficiaries have satisfactory health seeking behavior with an average level of 19. The average level for the perception towards the healthcare system of both beneficiaries and non-beneficiaries is 15 and both of them have neutral perception towards the healthcare system. Both beneficiaries with an average level of 9 and non-beneficiaries with an average level of 10 perceive the cost of healthcare as low. Beneficiaries with an average level of 11 have average misconception about health while non-beneficiaries with an average level of 10 have low misconception about health as shown in table 3.

Independent samples t test analysis of the overall health-seeking behavior of the two groups showed no significant difference (p-value=0.92, 2-tails, 95% CI) and health center visits showed no significant difference as well (p-value=0.98, 2-tails, 95% CI). The 3 variables' influence on health-seeking behavior were also analyzed and yielded p-value=0.51 for cost of healthcare, p- value=0.48 for perception towards the healthcare system, and p-value=0.25 for misconceptions about health.

DISCUSSION

This study revealed no significant difference between the health seeking behaviors of beneficiaries and non-beneficiaries of the Pantawid Pamilyang Pilipino Program (4Ps). This means that despite the expected intervention of the 4Ps to promote (required health check-ups for children and pregnant women, vaccinations, deworming etc.), their health seeking behaviors remain comparable to those not involved in the program.

Although presumptive, the results of this study reflect unfavorable outcomes of the 4Ps despite having been long implemented since 2007. A recent outcome that can easily paint a picture of the desired behavioral modification as a result of this program is their COVID-19 vaccination rate. The national vaccination rate exceeds 100% while the Department of Social Welfare and Development (DSWD) reports that only 59.14% of target 4Ps beneficiaries have completed their primary shots. Meanwhile, in the same 2022 report, health compliance rates are reported to be high, particularly 97.59% for check-up/ immunization for pregnant and children 0-5 years old and 99.63% in deworming for children 6-14 years old. Responses from the questionnaire do not mirror this report's results as only around half of the beneficiaries reported to always go for deworming of children. All of these numbers reflect different outcomes signifying the difference of reality and published reports.

Failure of CCTs have been reported in Honduras[18] and Kenya[19] as well, owing to poor implementation and poor quality of the healthcare system respectively. Similarly, 4Ps seems to be unable to deliver the expected improvement in health- seeking behavior due to the combination of the aforementioned reasons. As an example, compliance rates reaching almost a hundred percent do not reflect the reality that these households do not undergo rigorous compliance monitoring. In addition, the declining healthcare system of the country cannot support the improvement expected from these households even if said expected improvement were to occur. As such, the comparable health-seeking behavior levels among both groups in the same low socioeconomic level is understandable, mostly explained by the infectivity of the CCT program.

Another plausible explanation for the similarity of both groups' health-seeking behavior is the COVID-19 pandemic which forced the government to raise all citizens' awareness about acute illnesses. This means that both groups received similar health education and encouragement to improve their health-seeking behavior. Furthermore, with the laxing of

Table 3. Health-seeking behavior average levels

	Overall	Visits to health center	Perception towards healthcare system	Cost of healthcare	Misconception about health
Beneficiaries	35	19	15	9	11
Non-Beneficiaries	35	19	15	10	10
Grand Total	35	19	15	9	10

regulations in this community where digital health is not as developed as in Mega Manila, face-to-face consultations became the more preferred mode of consultation as it is accessible for most members of the community.[20] The resumption of actual patient interaction and formerly encouraged health-seeking paved the way for increased translation of the built-up health- consciousness over the course of the height of the pandemic into behavior.

The assumption of low health-seeking behavior pre-pandemic would support this assumption.[21] Contrary to prioritizing 4Ps beneficiaries in vaccination efforts and giving incentives to encourage vaccination, reciprocal social protection policies better encourage initiative among constituents as further stigmatization of indigents was avoided.[22]

As such, all members of the community experienced similar treatment, even in terms of financial assistance as the government also gave "ayuda" regardless of 4Ps membership. Visits to the City/Municipal health center The result showed no statistically significant difference in terms of visits to the city/municipal health center in both beneficiaries and non-beneficiaries. In this study, 47% answered that they always go to a health center or hospital for prevention of illness and undernutrition among 4Ps beneficiaries. However, 26% of beneficiaries also answered that they almost never go to city/municipal health centers. The reluctance to seek medical healthcare is usually due to the reason that common individuals perceive it as unnecessary because their symptoms eventually improve over time. The lack of information and support, poverty, low education, and poor access to health care could also result in poor health seeking behavior.

In a study conducted by Lee et al. (2019)[23], they found out that health-seeking behaviors are driven by one's perceived health status. The study stated that 55% of the respondents did not seek professional medical care because they thought that their illness was not serious. It was indicated that unless there is pain and the condition is severe, the migrants do not seek medical care. Another study conducted by Thuzar et al. (2019)[15], stated that self-medication is one option to remedy certain health conditions. It was noted that buying over-the-counter drugs was one of the most common health-seeking behaviors for minor illnesses. In cases of major illness, it is the only time they opted to visit a health center, especially if the health conditions were not cured. In relation to this study, there are more beneficiaries who agreed that they know how to take care of their illness so they do not need to consult a doctor compared to those not enrolled in the 4Ps program.

Attitude toward health seeking in general and healthcare in particular influences actual health-seeking behavior. For instance, the study of Afolabi et al. (2019)[24] identified that the attitude toward health care can be examined in various domains such as the availability of health care services, accessibility, and quality of care. It could also be measured in terms of health care facility preference, whether to seek professional medical care, to self-medicate, or to access traditional health remedies or care.

Cost of Healthcare

In terms of the cost of health care, the population of lower socioeconomic status has been more hesitant to seek medical attention due to the high cost of hospitalizations and consultations, believing that the mild symptoms they experience are not worth the price they will have to pay to get a consultation. In a study conducted by Musinguzi et al. (2018)[25] on the factors of health seeking behaviors of hypertensive patients, they found that health seeking behavior is dependent on the socioeconomic status and the easy accessibility to over the counter antihypertensive drugs. This gives the notion that further medical consultation is not needed due to the ease of getting medication. However, the results of this study shows that both the beneficiaries and non- beneficiaries of the 4PS would still choose to consult a doctor when a family member is sick even when they do not have enough money for it. It is possible that Filipinos still value life, especially that of another family member, more than actual financial costs. Concurrently, 16% of the respondents who are beneficiaries of 4Ps would rather bring sick family members to alternative healers, despite respondents mentioning that doctors will charge them a lower price. This coincides with the study of Cerio (2018)[11] wherein it states that folk healers are usually preferred because they cost less and it is the more common practice in the area.

Low socioeconomic status is also associated with lower levels of education. In a study conducted by Amin et al. (2010)[26], it was found that seeking of prenatal care had significant differences by level of schooling of either parent. Wealthier families that have more years of education and have higher use of newborn health checkup and child delivery care. The low socioeconomic status is associated with

poorer decision making leading to poorer allocation of money but this is not the only reason for the poor decision making. There is a shift of focus of the basic essentials. The allocation of money is then more focused on food, water, and shelter as these are scarce resources that are more needed for survival. Nonetheless, this study showed that the respondents, both beneficiaries and non-beneficiaries, would rather be diagnosed and are willing to change their lifestyles to address health issues.

Perceptions Towards the Healthcare System

Existing studies suggest that Filipinos generally have negative perceptions toward the healthcare system, which can be categorized into two (2); mainly cultural and religious. Culturally, Filipinos are prevented from seeking formal help by leaning heavily on their sense of resilience and self-reliance (tiyaga) and humor (tawanan ang problema) (Martinez et al., 2020). Religion is emphasized in older Filipino adults who tend to cope with illness through faith in God regarding a complete cure or even the slightest improvement to the concept of miracles (Stanford Medicine, 2019). In addition to these, poor education on when to seek care, poverty, and other perceived characteristics were highlighted as barriers to using health facilities. Some other factors include perceived high cost of services; perceived lack of necessary services, such as medications and basic laboratory testing; perceived shortage of healthcare professionals; perceived low quality of care; and perceived proximity to the health facility.[21]

In contrast, the average level for the perception towards the healthcare system of both beneficiaries and non-beneficiaries in this study showed indifferent perception towards the healthcare system bordering positive perception. This is likely explained by trust of the community in healthcare workers which appears as one of the major drivers of health-seeking activities. Additionally, it has been found that when support providers aid people, by offering health information, encouragement, or physical assistance, and when people feel more supported, they are better able to cultivate positive attitudes about their own health and well-being.[12] The study of Pambid et al., (2017)[28] on health-seeking habits of 4Ps beneficiaries showed excellent responses to acquiring complete vaccination and deworming from the health center or hospital, ongoing to health check-ups for disease prevention or health monitoring, and on visiting the health center or hospital for proper treatment. This in turn reflects a positive perception of the beneficiaries towards the healthcare providers and the healthcare system.

Misconceptions About Health

The results revealed that 4Ps beneficiaries have average misconception about health while non-beneficiaries have low misconception. This result reflects a higher level of misconception among 4Ps beneficiaries ergo, a lower level of knowledge. Ideally, however, those enrolled in the 4Ps Program should have improved knowledge about health since beneficiaries are required to attend family development sessions (FDS) and to visit health centers. The prior assumption is supported by several studies. 4Ps in different cities and regions in the country show higher knowledge on immunization, deworming, pregnancy nutrition, child nutrition, supplement intake, responsible parenthood and family planning as the monthly FDS provides them additional knowledge.[29,30,31] The disparity between the study's findings and theirs may be explained by the different parameters used to measure the level of knowledge or misconception about health.

The studies focused on the level of knowledge of 4Ps beneficiaries on child health and nutrition, maternal health and nutrition, and family development which are included in the social development objective of the 4Ps program. Meanwhile, the study included other aspects of health and measured the level of misconception regarding disease cognition regarding symptoms, severity, and emergency, self-medication, and adherence to folk medicine.

The younger members of the low socioeconomic class are more likely to follow suggestions from health experts in health centers and hospitals compared to the older members.[31] Age affects health seeking behavior.[14] 4Ps respondents are older, with an average age of 50 and the youngest within the range of 30-40 years old. Meanwhile, non-4Ps are younger, with an average age of 44 and the youngest being 19 years old. Households of lower incomes may likely to incur less expenditure on self-medication[16] which may apply to both 4Ps and non-4Ps, hence, the difference not being significant as both groups have the tendency to adhere to suchhabits of self-medication as both respondent groups belong to the same socioeconomic class.

Beneficiaries of 4Ps, in particular, rarely see a doctor or visit a health clinic unless sickness becomes

severe[5] which also explains the 4Ps' higher level of misconception about health due to passive symptom cognition of severity. However, families of low socioeconomic class, in general, regardless of CCT status, respond to health concerns when they already perceive these concerns to be serious[14], hence the comparability of health seeking behaviors between 4Ps and non-4Ps respondents.

CONCLUSION

The lack of significant difference between the health seeking behaviors of 4Ps beneficiaries and non-beneficiaries as influenced by visits to health center, cost of healthcare, perception towards the healthcare system, and misconceptions about health may be explained by the fact that both groups, apart from receiving the benefits of the 4Ps, belong in the same socioeconomic class, are exposed to similar living conditions and interventions from the government and health sector, and pass down the same belief systems. These factors play a bigger role in influencing their health- seeking behavior than the 4Ps program which only tackles a few aspects of health and provides financial aid barely elevating their beneficiaries' status. In addition, having the same socio- economic status would mean that both groups also receive the same treatment from doctors, in the sense that discounts and financial aid are offered to both.

Furthermore, this study tried to explore the programs' impact in health-seeking behaviors wider than those specifically covered by the program. Comparable results between groups reflect the sad reality that the health interventions offered by the program do not facilitate global health- seeking behavior improvement, rather, only incentivized health activities that are monitored by the program that do not have a spill-over effect to other aspects of health.

The researchers recommend utilizing other parameters which influence health-seeking behavior in comparing between 4Ps beneficiaries and non-beneficiaries. Future studies may further investigate sociodemographic factors such as age, educational attainment, and occupation as constructs which may better predict health-seeking behaviors. The researchers also recommend including a bigger sample size to picture a more significant difference between the two groups. Therefore, exploring other factors that may influence health-seeking behavior and including more communities of different area development status may better assess the influence of 4Ps and other CCT Programs on health-seeking behaviors of households of low socioeconomic class.

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