Evaluation of DSWD Residential Care Facilities

Final Report

Policy Development and Planning Bureau

Research & Evaluation Division

Contents

EXECUTIVE SUMMARY

Since 1950's, the Department of Social Welfare and Development (DSWD) has been providing 24-hour nurturing environment to various vulnerable sectors through its residential care facilities. These centers serve as home and provide rehabilitation programs/services for children in need of special protection, youth with special needs, women in especially difficult circumstances, older persons, persons with disability and individuals in crisis. Relative to the implementation of residential care services, accreditation of services of centers are performed by the Department through the Standards Bureau (SB) to help the facilities comply with/maintain the standards in providing optimal services to its clients.

This study attempts to investigate how well programs/services are being implemented by centers with different levels of accreditation and how accreditation is associated with delivery of services and outcomes of the residential care services. Outcomes were also evaluated to gauge the responsiveness/effectiveness of rehabilitation programs and services of level 1, 2, and 3 accredited centers.

Mixed-method approach, comprising of quantitative and qualitative approaches, was employed to ensure reliability and credibility of results. For the quantitative portion of the study, the evaluation team reviewed quantitative reports and collected information from beneficiaries through survey interviews. On the other hand, qualitative methods such as Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) were employed to delve deeper into the beneficiaries' and implementers' perspective and insights on the implementation and management of residential care centers. Clients coming from all sectors served by the selected 30 centers starting from 2015 (to present) and those clients with more than or equal to the average length of stay (ALOS) at the center were covered by the study.

The following details the summary of findings of the report:

Relevance

1. Overall, DSWD residential care facilities are highly relevant due to high magnitude of vulnerable Filipinos in need of social welfare and development programs and services through residential care services. However, it was noted that modification of services based on the nature of clients' cases (e.g. establishing facilities solely for trafficked victims) and coverage of residential cares services (e.g. coverage of abused elders) seemed to be lacking.
2. Findings from the study have disclosed how clients' issues are rooted from poverty and dysfunctional/broken families, because these had affected various dimensions of residents' lives.

3. Both (1) residential care programs and services and (2) accreditation activities were strategically contributing to the strategic priorities of the Department, i.e. to the attainment of the Organizational Outcomes 2 and 4 and to the 2019 Thrusts and Priorities of DSWD.
4. Findings revealed accreditation was highly relevant in improving the quality of services of non-accredited facilities. Moreover, it was found that non-accredited facilities are less effective than accredited facilities. However, findings also revealed that having lower levels of accreditation would not necessarily undermine the centers' overall effectiveness and quality of services. Thus, effectiveness and quality of services of accredited facilities are not strongly linked to their status or level, contrary to the theory.
5. The current accreditation standards lacked indicators that focus on person-centered or client-level outcomes, i.e. effectiveness of service delivery and ultimate effects of residential care facilities (e.g. rehabilitation, recovery and reintegration).

Efficiency

1. Financial resources for the DSWD Residential Care Facilities are highly sufficient and have increased significantly in 2018 because of the additional PhP 2.3 Billion additional funds from the Centers and Residential Care Facilities (CRCF) Infrastructure Project. CRCF project provided adequate funding support to address the administrative and human resource needs of the centers.
2. Human resource gap was generally addressed, but sustainability and competency issues remain.
3. Current facilities, vehicles and equipment are inadequate to completely respond to the needs of the residents.
4. Moderate spending has been sustained over the years. Overall spending of residential care facilities from 2015-2018 has been at a moderate of 82-86%.
5. Evidence gathered indicate that resource generation mechanisms in the centers are in-place. Funding support from LGUs and resource generated through donations and coordination with partners helped the centers deliver the needs of the clients.
6. Actual cost of care estimates showed that clients in 50 DSWD residential care facilities received either *adequate or highly abundant* programs and services.
7. Based on the findings, RSCC-CAR, Home for Girls FO III and X, Haven for Women-FO NCR, Haven for Women and Girls -FO CAR, RRCY-FO VIII, and Haven for the Elderly-FO IV-A have the most cost-effective programs and services in terms of rehabilitation outcomes.
8. Issues on slow procurement, financial and approval process continue to weigh down the operational efficiency of the centers.

9. Support and assistance by Standards Bureau, Protective Services Bureau and the DSWD Management were generally viewed positively by the informants. However, more active role from them are being sought by the study participants, especially in meeting the accreditation indicators.

Effectiveness

1. Despite the existence of challenges along resources and processes, these did not compromise the effectiveness of the services and interventions of the centers.
2. Overall, quality of service delivery was exhibited by the DSWD Residential Care facilities, except that some services were not delivered in a timely manner.
3. Findings revealed that the facilities were generally successful in improving the quality of life among the residents.
4. Based on the results, the strongest points of the centers are provision of opportunities (e.g. education) and conduct of socio-cultural activities, support structures, and staff's skills. On the other hand, most of the issues frequently mentioned were about management, policies and processes.
5. Discrepancy between the provisions laid out in the operations manuals and the reality in practice have been observed.
6. Findings showed that gender can affect someone's admission to residential care facilities. Varying approach to addressing gender/sexuality needs and issues of clients could be due to lack of clear policies and guidelines on how to deal with sexual expression and sexuality in residential care centers.
7. All clients coming from different religious, culture and ethnicity are respected. Findings also showed that religion is considered in the delivery of services. However, it was found that religious groups visiting the centers tend to recruit members and take this opportunity to change the religions of some clients.

Impacts

Clients affirmed that their behavior, outlook in life, self-esteem and health have significantly improved because of the support provided by the centers. Moreover, they were most grateful about the knowledge and skills they gained from the centers, because these will be helpful and useful as they deal with the outside world after their discharge.

Sustainability

Sustainability of rehabilitation and reintegration efforts of the facilities have been found to be challenging because DSWD relies on other actors (e.g LGUs) to continue to support the residents upon discharge.

In view of the findings presented, the following are recommended by the study team:

To Program Management Bureau

1. The residential care facilities should be well-budgeted, have adequate physical resources and sufficient human resources in terms of competency and quantity.
2. Guidelines for setting cost of care per client (including dependents) need to be updated/revised.
3. Provide more specialized trainings especially for Houseparents to meet the competencies required in handling different types of clients.
4. Revisit and update the operations manuals of residential care facilities at the central level which would then be the bases of the facilities in developing their own manuals.
5. Ensure inclusiveness of residential care programs and services to address concerns on gender/sexuality, disability and religion.
6. Ensure that critical services such as medical services are delivered in a timely manner.
7. Clear policies/guidelines in dealing with gender and sexuality should be established to address varying approach of the centers in addressing gender/sexuality needs and issues of clients.
8. Improve the participation of the families/relatives in the rehabilitation and/or recovery process of the clients.
9. Establish more pro-active and stronger monitoring mechanisms for reintegration and after-care services for the discharged clients. Higher-level outcomes – such as reintegration and recovery of clients – should be reflected in the results frameworks of residential care clients and should be monitored to gauge the sustainability and effectiveness of interventions.
10. Revisit the accountability of higher management and Program Management Bureau in improving the accreditation status of the centers given that some of the accreditation indicators are beyond the center heads'/FOs' sphere of control.

To Standards Bureau

1. Together with PMB, establish a more active role in ensuring that all accreditation indicators are met by the residential care facilities.
2. Strong coordination mechanisms between Standards Bureau and Program Management Bureau shall be established to avoid issues such as conflicting recommendations/messages to the centers.
3. Build a manual which would include explanations or interpretation of the accreditation indicators to avoid different interpretation and analysis of indicators and ensure more objective assessment of the centers' accreditation status.
4. Review the accreditation indicators. The accreditation indicators shall clearly distinguish the difference of centers with varying levels of accreditation.
5. Develop accreditation indicators that will focus on results/outcomes.

To Social Technology Bureau:

1. Range of the programs and services of the residential care facilities should be expanded and customized to cover all cases experienced by the vulnerable sectors (e.g. elderly abuse cases, illegally recruited or trafficked minors).
2. Social Technology Bureau could explore the possibility of developing a *family support program/intervention*-which could include parent education and financial assistance components- intended to assist and improve the capacity of families during the process of reintegration of discharged clients.

To Partner LGUs (and SWIDB):

1. LGUs should ensure that after-care services interventions are included in their plans and budget. On the other hand, SWIDB should also assess the LGUs based on their capacity to implement aftercare services.
2. In relation to the previous recommendation, proactive monitoring, provision of social services and livelihood/employment opportunities to the discharged clients, and to the whole household, shall be ensured by the LGUs. The neighborhood or the community where a discharged resident belongs to should also be mobilized to help in the reintegration process.

Evaluation of DSWD Residential Care Facilities

I. INTRODUCTION

Background and Rationale

Since 1950's, the Department of Social Welfare and Development (DSWD) has been providing 24-hour nurturing environment to various vulnerable sectors through its residential care facilities. These centers serve as home and provide rehabilitation programs/services for children in need of special protection, youth with special needs, women in especially difficult circumstances, older persons, persons with disability and individuals in crisis. Relative to the implementation of residential care services, regulatory functions specifically accreditation of services of centers are performed by the Department through the Standards Bureau (SB) to help the facilities comply with/maintain the standards in providing optimal services to its clients.

SWD programs and services implemented by centers are being assessed by SB against the five (5) work areas of standards in accreditation namely *Administration and Organization, Program Management, Case Management, Helping Strategies/Interventions* and *Physical Structures* and Safety. Upon assessment, the SWDAs may be accredited as level 1, 2, or 3 compliance with accreditation valid for three, four, and five years, respectively. Within 60 days prior to expiration of accreditation, the SWDAs shall apply for renewal of accreditation. Failure to do so will subject the SWDAs for suspension and revocation of registration certificate and license to operate.

Cognizant of the importance of accreditation of centers as reflected in the Thrusts and Priorities for CY 2018, the DSWD-Policy Development and Planning Bureau conducted an evaluation study entitled *"Evaluation of Implementation of DSWD Residential Care Programs and Services and its Link with Levels of Accreditation"* to examine how various levels of accreditation are linked with the effectiveness of programs and services delivered by DSWD-run residential care facilities; to investigate the efficiency of accreditation processes; and if these accredited facilities are indeed producing positive change/intended outcomes.

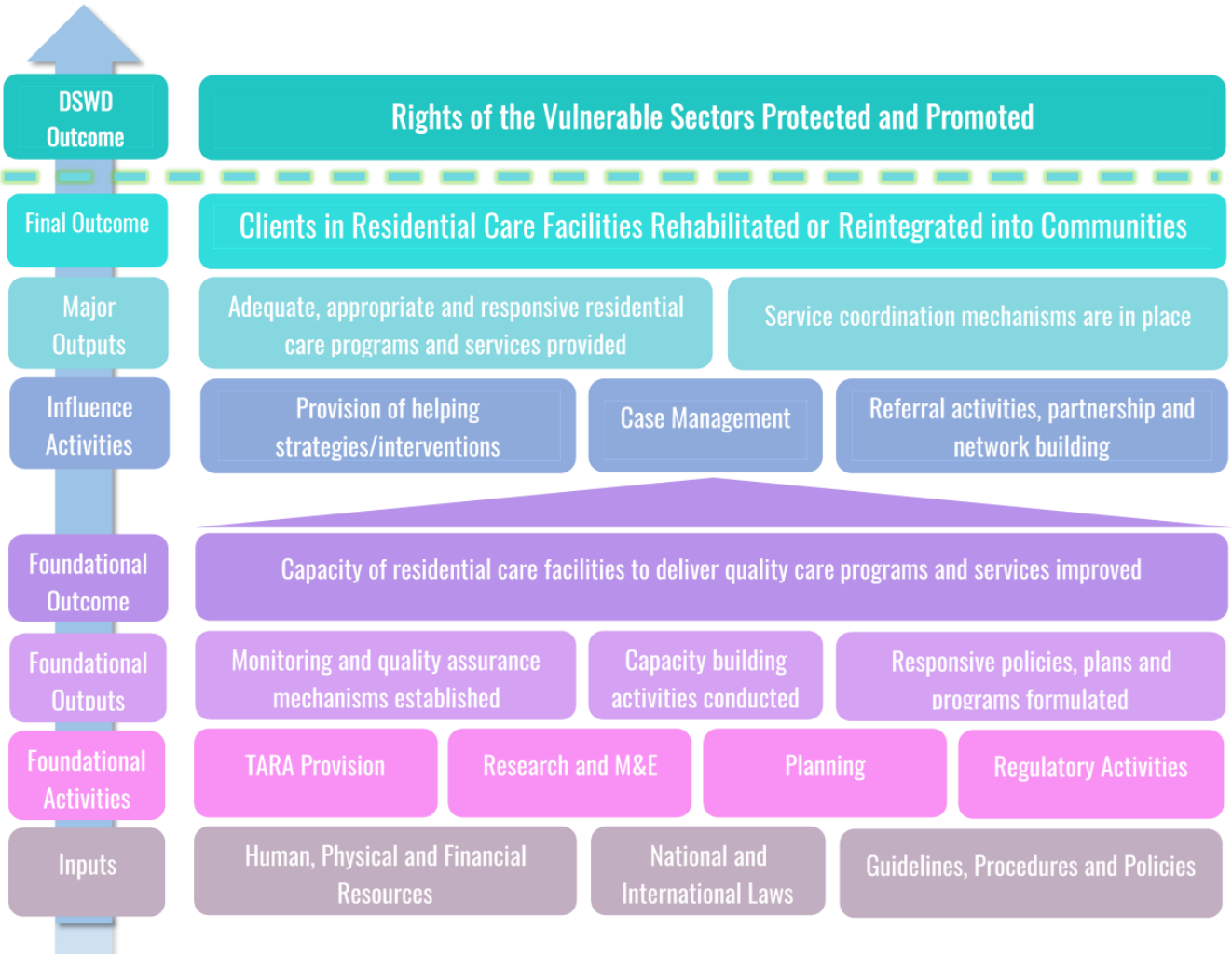
Objectives and questions

The evaluators examined how well programs/services are being implemented by centers with different levels of accreditation and how accreditation is associated with delivery of services and outcomes of the residential care services. Outcomes were also evaluated to gauge the responsiveness/effectiveness of rehabilitation programs and services of level 1, 2, and 3 accredited centers. Specifically, the study aims to:

1. Evaluate the programs and services delivered by centers;
2. Examine the accreditation processes for residential care facilities;
3. Investigate the link between levels of accreditation and responsiveness/ effectiveness of programs and services delivered by centers;
4. Determine the issues/gaps, good practices, and lessons learned in the implementation of rehabilitation programs and management of centers; and
5. Provide specific recommendations to improve accreditation processes for centers and implementation of residential care services.

Evaluation Framework

The study used the following framework as guide to evaluate the residential care programs and services and the accreditation processes for centers. Specifically, this framework was the evaluation team's guide in assessing the programs/services and accreditation processes against the evaluation criteria in section III. To evaluate the efficiency of programs/services/process, the team will analyze the input, activity and output levels which will involve review of resources, existing guidelines and policies, national and international laws, and processes and service/program implementation. Lastly, the output and outcome levels will be assessed to determine the relevance, effectiveness, and sustainability of residential care interventions and accreditation processes. Delivery of interventions/processes and their effects will be the focus of these components.



Approach and Methodology

The data for the evaluation was collected from the Central Office, eight (8) Field Offices. Field Offices with (1) highest number of level 1 and 2 centers combined and (2) highest number of level 3 centers from different island clusters were chosen to be part of the study. This was done to be able to capture Field Offices (FOs) with centers which have relatively lower performance (level 1 and 2) vis-à-vis FOs with high performing centers (level 3). A total of 30 residential care centers were selected. Sample selection is shown in the following table:

Table 1. Selection of Sample

Regions	Level 1 + Level 2	Level 3	Included in the sample?	No. of Centers Selected	Remarks
CAR	3	0	Y	2	Chosen instead of FO II since all of its centers are level 1
NCR	5	0	Y	7[1]	
II	3	0	N	0	
III	4	0	Y	4	
IV-A	1	1	N	0	
IV-B	1	0	N	0	
V	0	3	Y	3	
VI	1	2	Y	3	
VII	3	2	N	0	
VIII	3	0	Y	2	Chosen instead of FO VII since all of its accredited centers are level 1
IX	6	0	Y	5	
X	0	4	Y	4	
XI	4	0	N	0	Not chosen despite high number of level 2 centers since only two FOs are covered for Visayas and Mindanao
XII	3	0	N	0	
CARAGA	1	1	N	0	
Total	22	9		30	

Mixed-method approach, comprising of quantitative and qualitative approaches, was employed to ensure reliability and credibility of results. For the quantitative portion of the study, the evaluation team reviewed quantitative reports and collected information from beneficiaries through survey interviews. On the other hand, qualitative methods such as Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) were employed to delve deeper into the beneficiaries' and implementers' perspective and insights on the implementation and management of residential care centers. Clients coming from all sectors served by the selected 30 centers starting from 2015 (to present) and those clients with more than or equal to the average length of stay (ALOS) at the center were covered by the study.

[1] Includes centers which are not accredited

The evaluation team conducted the following study methods:

A. Review of Documents

All existing guidelines on the implementation of Residential Care Centers were reviewed and served as reference in developing the evaluation design and questions for the study. Further, other program-related documents such as but not limited to the following were also studied:

• Program Organization/Structure
• Periodic Physical Accomplishment and Financial Reports
• Other Relevant Program Documents

B. Key Informant Interviews

Semi-structured interview guides were developed to generate necessary information from approximately 80 key stakeholders who are particularly knowledgeable about the program implementation and institutional arrangements. Interviews of the following key officials/personnel were conducted for the study:

- PSB Director
- Standards Bureau (SB) Director
- DSWD Residential Care Centers Focal Staff (CO and FO Level) – staff who are in-charge in monitoring the implementation of the program both in terms of physical and financial accomplishments
- Protective Services Division Heads
- Standards Unit Heads
- DSWD Residential Care Centers Head/Staff
- Members of academe, Heads of NGOs and other subject matter experts

C. Focused Group Discussions

Focused group discussions (FGDs) with 5 to 7 clients in each residential care facilities (or a total of 210 participants) were conducted to gauge how well the center programs are being implemented at the perspective of the beneficiaries. This was also done to gauge beneficiaries' satisfaction on the services provided to them.

D. Client Survey

A total of 185 potential survey respondents from the 30 centers formed part of the sample for the study. These beneficiaries may or may have been part of the FGDs. The survey interview aims to collect information on the efficiency and effectiveness of residential care interventions based on the perspective of the beneficiaries. Centers were selected through purposive sampling to ensure representation of all sectors and nature of cases. Within the centers, selection of respondents was randomized to ensure internal validity. The following table shows the number of respondents per sector.

Table 2. Number and Percentage of Respondents by Sector

Sector	Center	Frequency	%
Children	Haven for Children	5	3%
	Home for Girls	9	5%
	Balay Dangpanan sa Kabataan	5	3%
	Haven for Girls	3	2%
	Nayon ng Kabataan	5	3%
	Reception and Study Center for Children	9	5%
Children Sector Sub-total		***36***	***19%***
Youth	Regional Rehabiliation Center for Youth	36	19%
Youth Sector Sub-total		***36***	***19%***
Women	Haven for Women	27	15%
	Regional Center for Women	6	3%
	Regional Haven for Women and Girls	5	3%
	Tarlac Home for Women	3	2%
Women Sector Sub-total		***41***	***22%***
Older Persons	GRACES	15	8%
	Home for Elderly	15	8%
OP Sector Sub-total		***30***	***16%***
Persons with Disability	Amor Village	10	5%
	Elsie Gaches Village	15	8%
Persons with Disability Sector Sub-total		***25***	***14%***
Individual and Family in Crisis Situation (IFCS)	Jose Fabella Center	13	7%
	Processing Center for Displaced Persons	4	2%
IFCS Sector Sub-total		***17***	***9%***
TOTAL		185	100%

Overview of DSWD Residential Care Facilities

The DSWD has a total of 64 residential care facilities which are distributed in 16 regional offices. Description and nature of clients catered in the facilities are provided by Table.

SECTOR	RESIDENTIAL	LOCATION	Nature/Description
Children	Reception & Study Center for Children	NCR, CAR, II, III, V, VII, VIII,IX, X, XI, XII	Child-caring institution that provide services to abandoned, neglected and/or surrendered children 0-6 years of age.
	Haven for Children	NCR , I	A residential institution that provides rehabilitation facilities for boys aged 7-13 who are recovering from substance abuse.
	Lingap Center	III	A transitional home for street children ages 7-17 who are abandoned or whose parents cannot at the time provide for their needs adequately
	Nayon ng Kabataan	NCR	A residential institution for abused, orphaned, abandoned, neglected and exploited children ages 7-17 years old.
	Marillac Hills	NCR	A rehabilitation center for young women which caters to abused, exploited or are in conflict with the law.
	Home for Girls	I, III(2), IV-A, VI,VII,VIII,IX,X,XII, Caraga	A residential institution that provides protection, care, treatment and rehabilitation to abused and exploited girls below 18 years old.
Youth	National Training School for Boys (NTSB)	IV-A	A residential facility that provides care and rehabilitation to juvenile in conflict with the law who are 9-17 years old.
	Regional Rehabilitation Center for Youth (RRCY)	I,II, III,V, VI,VII,VIII,IX,X,XI, XII, Caraga, CAR	A residential facility that provides care and rehabilitation to juvenile in conflict with the law who are 9-17 years old.
	MIMAROPA Youth Center	IV-B	a regional rehabilitation center for Children In-Conflict with the Law (CICL)
Women	Haven for Women	I, III,IV-A,VI, VII, VIII,IX,X, NCR	Provides temporary shelter and protective custody to women ages 18-59 years old who are victims of involuntary or forced prostitution, illegal recruitment, battered/abused women, victims of sexual abuse, women in detention, women victims of armed conflicts and others.
	Sanctuary Center	NCR	A residential institution that serves as halfway home to female 18 years old and above who are improving from psychosis and other mental illness.
YNSP and Women	Haven for Women and Girls	CAR, II, V, XI	Provides temporary shelter and protective custody to women who are victims of involuntary or forced prostitution, illegal recruitment, battered/abused women, victims of sexual abuse,women in detention, women victims of armed conflict, and others.
Older Person	Golden Acres: Haven for Elderly	IV-A	Provides care to senior citizens aged 60 and above, both male and female who are abandoned, neglected and needy.
	GRACES (Golden Reception and Center for Elderly and other special needs)	NCR	A 24-hour, 7-day-a-week assessment/diagnostic and processing center for senior citizens and Spinal Cord Injured (SCI) clients referred by Philippine Orthopedic Center-Department of Rehabilitation Medicine (POC-DRM).

SECTOR	RESIDENTIAL	LOCATION	Nature/Description
	Home for the Elderly/ Aged	IX,XI	Provides care to senior citizens aged 60 and above, both male and female who are abandoned, neglected and needy.
Person with Disability	Elsie Gaches Village	NCR	A residential institution that provides care and rehabilitation services to abandoned and neglected children with special needs such as cerebral palsy, epilepsy, visual and hearing impairment, mental retardation, autism and others.
	Amor Village	III	A home for children ages 1 month to 16 years old with special needs that were abandoned, abused and neglected by their respective families. It is a world-class facility wherein the children will have access to different services for recovery, rehabilitation and development for purposes of mainstreaming them in the community later on.
Individual and Family in Crisis Situation	Jose Fabella Center	NCR	Provides temporary shelter for strandees, vagrants and mendicants.
	Processing Center for Displaced Person	IX	Provides temporary residential care, homelife services and psychosocial intervention to deportees and displaced persons in coordination with other agencies with the end view of reintegrating them to their families and communities as well as to prepare them to become socially functioning individuals.

Source: Program Management Bureau

Description of Major Services and Interventions

Services and interventions of residential care facilities can be categorized into the following:

Social Services – These are interventions that seek to restore/develop the social functioning of the residents from admission to discharge and preparation for family reunification and community reintegration. Case management is undertaken by a multidisciplinary team utilizing social work interventions which include but not limited to counseling, casework, groupwork and family/group/individual therapy.

Homelife Services - This refers to the provision of basic needs of each client such as food, clothing and shelter and the development of values and appropriate social skills. The clients are provided with well-balanced and organized activities approximating a wholesome family experience appropriate to meet their physical, emotional, mental and social needs. The residents' age, sex, interest and needs are taken into consideration in their assignment to a group or cottage.

Health Services - These refer to the provision of medical and dental examination and treatment, psychological/psychiatric assessment and evaluation as well as special dietary care. The health program is under the supervision or in coordination with an appropriate medical professional.

Educational Services - These are opportunities for formal, non-formal and special education.

Skills Training/Vocational Counseling- These are activities to guide the residents towards the choice of a vocation suitable to their activities or toward training for such vacation.

Recreational and Cultural Activities – These activities that provide opportunities for play amusement or relaxation.

Spiritual Enhancement – All residents are provided with opportunities for spiritual growth considering their own faith and convictions.

Community Participation - This allows the residents to experience community life by participating in selected community resources and services like schools, health centers and hospitals, market, churches, and other offices. (Administrative Order 141, Series of 2002: Standards in the Implementation of Residential Care Service)

II. MAJOR FINDINGS

Assessment Ratings

The evaluation team used the following Likert scale ratings to rate the level or extent of achievement of each evaluation criterion. The ratings provided by the evaluation team were based on their assessment which was informed and supported by the quantitative and qualitative findings generated.

Rating/Category	Description
To a very great extent	The criterion was highly satisfied; performance was very satisfactory.
To a great extent	The criterion was generally satisfied/accomplished; performance was satisfactory.
To a moderate extent	The criterion was partly satisfied/accomplished; performance was neutral.
To a small extent	The criterion was somewhat satisfied/accomplished; performance was weak.
Not at all	The criterion was not satisfied at all; performance was poor.

Relevance	
Questions/Criteria	**Relevance Rating**
1.1 To what extent have DSWD residential care facilities been relevant to the needs of sectors/clients	To a very great extent
1.2 To what extent have residential care programs and services to the contributed to Department's Organizational Outcome (OO) 2 – Rights of the vulnerable sectors promoted and protected?	To a very great extent
1.3 To what extent have accreditation services contributed to the Department's Organizational Outcome (OO) 4 – Continuing compliance of social welfare and development agencies (SWDAs) to standards in the delivery of social welfare services ensured sectors promoted and protected	To a very great extent
1.4 To what extent have accreditation process been relevant in improving the effectiveness and quality SWD services of residential care facilities	To a very great extent – for non-accredited facilities To a moderate extent – for level 1,2, and 3 facilities

1.1 To what extent have the interventions of DSWD residential care facilities been relevant to the needs of sectors/clients?

There is a continued need for residential care facilities due to high magnitude of vulnerable individuals who need protective and SWD services from these facilities. Residential care facilities are highly relevant because they provide services such as temporary home, protection, food, education, livelihood, psychosocial and counselling services, and reintegration services among others. As implied by the interviews, these had been vital to meet the rehabilitation needs of the clients and improve their quality of life. Despite this, it was noted that customization of services (e.g. establishing facilities solely for trafficked victims) and coverage of residential cares services (e.g. coverage of abused elders) seems to be lacking. The succeeding discussions on the current situation of vulnerable sectors reinforce the relevance of these residential care facilities.

Children and Youth

Significant increase in the total number of Children in Conflict with the Law in the Philippines has been observed in 2018. *Refer to Table 1.* The total number of crimes committed by CICLs increased in 2018 as shown in the following table. Data also show that physical injury was the most committed crime for 2017 and 2018, followed by theft. Attention should also be given to cases of malicious mischief as it tremendously increased in 2018. Meanwhile, drug-related cases and theft went up by more than 70%.

Table 1. Crimes Committed by Minors in the Philippines, 2017-2018

Crime	2017	2018	% Change
Physical Injury	2,086	2,256	8%
Theft	877	1,517	73%
Malicious mischief	180	1,324	636%
Drug-related cases	481	857	78%
Rape	772	887	15%
Other cases	5,992	4,387	-27%
TOTAL	10,388	11,228	8%

Source: The Manila Times

Evidence from the collected data appear to confirm this pattern. Most of the offenses committed by the CICLs served by DSWD are rape, theft/robbery, drug use and murder.

Evidence emerged from the FGDs indicate that the CICLs catered by RRCYs have generally experienced socio-economic difficulties prior to their admission in the centers. Several residents were out-of-school youth/school dropouts who had to engage in child labor (table below would reinforce this finding). Poverty can also be seen as one of the factors why these CICLs enter into labor and job markets. In fact, it was identified by the respondents as one of the root causes of their offenses.On the other hand, some interviewed clients come from broken/dysfunctional family relationships. There were clients who moved away from their families; some tried to live on their own or with their friends where they experienced abuse/ exploitation while others learned to use drugs and vices.

The following table shows that number of child abuse cases served by DSWD. As illustrated by the data, there is a clear indication of high demand for residential care programs and services for abused children. Most prevalent forms of abuse are sexual abuse and neglect.

Table 2. Number of child abuse cases served by DSWD, 2016-2018

Number of Cases Served by DSWD	Girls			Boys			Total		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Total	2,645	2,381	2,685	1,212	1,078	1,402	3,857	3,459	4,087
Sexually Abused	1,013	970	804	32	15	5	1,045	985	809
Neglected	672	450	369	630	498	395	1,302	948	764
Physically Abused/Maltreated	131	101	82	99	84	66	230	185	148
Abandoned	348	317	242	392	320	265	740	637	507
Victims of Child Labor	16	42	68	5	24	17	21	66	85
Sexually exploited	124	99	141	25	5	5	149	104	146

Number of Cases Served by DSWD	Girls			Boys			Total		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Others[2]	341	402	979	29	132	649	370	534	1,628

It also worth noting that 357 cases or nearly 50% of the sexual abuse cases in 2018 are incest and are mostly girls. Highest number of incest cases can be found in Region IX.

Evidence available from FGDs and KIIs support the quantitative results. Several interviewed residents at the Home for Girls were victims of sexual abuse, wherein family members/relatives (e.g. step-father, cousin, grandfather) were either the perpetrator or pimp/*bugaw* (e.g. aunt). They came from "broken families" and mostly live with their stepfathers and grandparents after being abandoned by their parents due to death, separation or work abroad. Poverty was also commonly mentioned as one of the residents' issues.

Women

Table below shows the percentage of women in the Philippines age 15-49 who have ever experienced different forms of violence in 2013 and 2017. While incidence of violence against women decreased in 2017, a considerably high proportion of women still experience violence (18.5%).

Table 3. Percentage of Women in the Philippines Age 15-49 who have ever experienced different forms of violence, 2013 and 2017

Age	2013		2017	
	N	%	N	%
15-17	1437	16.7	2,184	13.8
18-19	777	21.6	1270	16.2
20-24	1888	22.1	3048	19.4
25-29	1473	22.7	2708	18.9
30-39	2864	22.9	4770	19.4
40-49	2524	22.5	3989	19.5
Total	10963	21.7	17969	18.5

Source: National Demographic Health Survey, 2013 and 2017

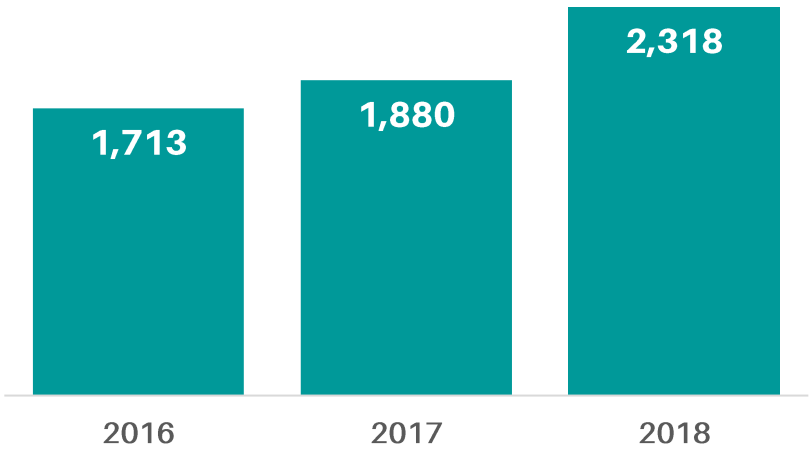
Women in especially difficult circumstances, together with their dependents, can be catered by DSWD's Home for Women (and Girls). Victims of abuse, illegal recruitment, human trafficking and

[2] Includes victims of trafficking, illegal recruitment, in armed conflict and sexually abused and exploited children, and other cases not specified.

those needing temporary shelter (e.g. abandoned women) are some of the most common cases served by the facility. During the field visits conducted, it was observed that HFW facilities also provide protective services to victims rescued near national border exits such as airports and seaports. For instance, HFW-NCR also serve minor victims of illegal recruitment rescued from Ninoy Aquino International Airports. On the other hand, HFW-IX provides residential care to undocumented Filipino women deported from Sabah, Malaysia, who were initially served at PCDP. These victims/residents, based on the FGDs, wanted to go to the city and/or overseas hoping to have a better job and generate more income support for their families.

In the past years, the number of trafficked victims served by the Department has been significantly increasing. In 2018, DSWD served 2,318 victim-survivors, of which 70-80% are women. Despite the high number of cases, facilities exclusively for victim-survivors of trafficking are lacking. As mentioned by the United States Department of State in its 2018 Trafficking in Persons Report, currently, there are no facilities solely designed for trafficked victims.

Figure 1. Number of trafficked victims served by DSWD, 2016-2018



Older Persons

As defined by the World Health Organization (WHO), elder abuse is "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect."

Elder abuse among older people (age 60 and above) is still prevalent around the globe. According to WHO, prevalence of elder abuse in the community setting is estimated at 15.7%. With a total of 7,548,769[3] senior citizens in the Philippines, the estimated number of senior citizens in the country who suffered from any form of abuse could be as high as 1,185,157, applying WHO's estimates.

Table 4. Prevalence of Elder Abuse, 2018

Type of Abuse	Prevalence (%)
Overall Prevalence	15.7
Psychological abuse	11.6
Physical abuse	2.6
Financial abuse	6.8
Neglect	4.2
Sexual abuse	0.9

Source: World Health Organization

The DSWD through its facilities for the elderlies (GRACES, Home for the Elderly/Aged) provides 24-hour alternative form of family care to neglected, unattached, homeless senior citizens age 60 years old and above. However, given the target clientele of GRACES and Home for the Elderly/Aged, other senior citizens experiencing other types of abuse such as psychological, physical, financial and sexual abuse are currently not covered by the said residential care facilities. Nonetheless, under the proposed "Anti-Elder Abuse Act" or House Bill 7030, the DSWD will be mandated to provide protective services such as temporary shelter, counseling, rehabilitation services and livelihood assistance to elderlies who suffered from any form of abuse.

Persons with Disability

Of the 92.1 million household population in the country, 1,443,000 persons or 1.57% had disability, based on the 2010 Census of Population and Housing. Of the total persons with disabilities in 2010, males accounted for 50.9% while females comprised 49.1%. For every five persons with disabilities, one (18.9%) was aged 0 to 14 years, three (59%) were in the working age group (aged 15 to 64 years), and one (22.1%) was aged 65 years and over.

Abandoned and neglected children with disabilities are provided with residential cares services by DSWD through Elsie Gaches Village and AMOR Village.

[3] 2015 Census of Population

Other Families/Adults in Need

Other families/adults in need are also provided with protective services through the DSWD residential care services. Jose Fabella Center, operating in NCR, provides temporary shelter catering to strandees, vagrants and mendicants. On the other hand, Processing Center for Displaced Persons in FO IX, providing temporary shelter and social services to deportees/repatriates from Malaysia, victims of trafficking and illegal recruitment. High number of deportees from Malaysia is expected since according to the 2015 report of Philippine Embassy in Kuala Lumpur, an estimate of 298,450 are undocumented overseas Filipinos are in Malaysia who are at risk of being deported/repatriated.

Based on 2018 Factsheet of Philippine Statistics Authority, a total of 160,036 individuals sought DSWD's protective services in 2018. Out of these number, 1663 were catered through residential care facilities (JFC and PCDP).

1.2 To what extent have the residential cares facilities contribute to the Department's Organizational Outcome (OO) 2 – Rights of the vulnerable sectors promoted and protected?

The fact that Organizational Outcome 2 refers to the "results of the Department's protective programs and services provided to vulnerable and disadvantaged sectors in residential and non-residential facilities and community-based settings" guarantees the contribution and relevance of DSWD residential care facilities to the said outcome. Apart from that, strong alignment of residential care services to national and international guidelines/ instruments relating to protection of rights of the vulnerable sectors was demonstrated through the guidelines and operations manuals of centers.

The informants further affirmed that the residential care services contribute much to the attainment of this outcome. They added that, without the residential care facilities, protection of rights and SWD needs of the vulnerable sectors will not be addressed.

1.3 To what extent have the accreditation of residential care services contribute to Organizational Outcome (OO) 4 – Continuing compliance of social welfare and development agencies (SWDAs) to standards in the delivery of social welfare services ensured?

On the other hand, accreditation of residential care services was found to be largely contributing to the Organizational Outcome 4. According to the informants, it has been helpful in ensuring that the centers are complying to the accreditation standards set by the Standards Bureau. Another element of contribution of accreditation services is its relevance to the strategic priorities of DSWD. Specifically, improving the centers' accreditation status to level 3 is one of the priorities indicated in the DSWD Thrusts and Priorities for 2019.

Standards Bureau and Standards Units generally perceive that they had much contribution to the achievement of OO 4. Standards Bureau is mandated to comply with the OO4 requirements, in close collaboration with the FOs, hence annual targets on OO4 must be accomplished, if not exceeded.

SB has also demonstrated stronger efforts towards achieving accreditation targets. The Bureau challenged their FO counterparts to mentor at least some SWDAs that can level up their accreditation level and influenced the Department of Interior Local Government to include in the seal of good local governance the indicator of "at least one LGU residential facility must be accredited."

1.4 How relevant are the accreditation process in improving the effectiveness and quality of SWD services of residential care facilities?

To answer this evaluation question, link between the effectiveness and quality of SWD services of facilities and their level of accreditation was examined through analysis of client satisfaction and cost-effectiveness of centers.

Effectiveness and quality of services at the point of view of the clients were analyzed by measuring their satisfaction rate on a specific set of criteria. Satisfaction ratings of residents catered in Residential Care Facilities that are **not accredited** are shown in Table 5. On the other hand, satisfaction ratings of residents catered in **Level 1, 2 and 3 centers** are exhibited in Table 6.

The data suggest that overall, accredited facilities are indeed more effective than non-accredited residential care facilities. Specifically, satisfaction ratings of residents in accredited facilities are higher than those facilities without accreditation.

However, when accredited centers were compared to each other, it appears that their effectiveness and quality of service do not vary too much. In fact, the small coefficient of variation (0-5%) would tell us that there is low variability among accredited centers with different accreditation status. That is, satisfaction ratings of centers coming from different accreditation levels are statistically the same. This contradicts the expectation that centers with higher accreditation status are more effective than centers with lower accreditation level.

Table 5. Satisfaction of residents catered in Residential Care Facilities that are not accredited

Criteria	Satisfaction Rate (%)
Timeliness of services	78
Adequacy of services	74

Table 5. Satisfaction of residents catered in Residential Care Facilities that are not accredited	
Criteria	Satisfaction Rate (%)
Responsiveness of interventions to the needs of residents	70
Addressing the residents' problems and issues	70
Appropriateness of services/interventions	80
Living Environment	69
Social Environment	80
Overall services received	79

Table 6. Satisfaction of residents catered in Residential Care Facilities with Level 1, 2 and 3 accreditation status				
Criteria	Satisfaction Rate (%)			Coefficient of Variation
	Level 1	Level 2	Level 3	
Timeliness of services	88	81	89	5%
Adequacy of services	94	96	92	2%
Responsiveness of interventions to the needs of residents	91	88	84	4%
Addressing the residents' problems and issues	91	88	84	4%
Appropriateness of services/interventions	94	100	92	5%
Living Environment	86	82	87	3%
Social Environment	86	86	86	0%
Overall services received	97	92	95	3%

Moreover, upon examination of the cost-effectiveness ratios of residential care facilities[4], it was found that the most cost-effective centers come from different levels of accreditation. In addition, most of them are only at Level 1. Hence, it is not always true that Level 3 centers provide the most cost-effective interventions. *Refer to table 7.*

[4] This will be further discussed under the Efficiency Section

Table 7. Most Cost-effective Centers, 2018

Field Office	Cost (Utilization)	Benefit (Rehabilitated Clients)	Cost Effectiveness Ratio	Accreditation Status
Reception & Study Center for Children				
CAR	6,696,108.34	54	340	Level 1
Home for Girls				
III-N. Ecija	11,533,902.42	57	554	Level 2
Haven for Women				
NCR	18,739,002.12	130	395	Not Accredited
Haven for Women and Girls				
CAR	6,342,320.88	43	404	Level 1
Regional Rehabilitation Center for Youth/NTSB				
VIII	4,255,370.67	45	259	Level 1
Haven for the Elderly/Home for the Aged				
IV-A	24,324,751.39	101	660	Level 3

The findings above suggest that having lower levels of accreditation would not necessarily undermine the overall effectiveness and quality of services of centers. In other words, effectiveness and quality of services of accredited facilities are not strongly linked to the status or level, contrary to the theory.

One of the reasons behind this finding is that the accreditation tool lacks success indicators that will measure person-centered/client-level objectives---effectiveness of service delivery and ultimate effects of residential care facilities (e.g. rehabilitation, recovery and reintegration). This could have biased the approach of determining the accreditation status towards focusing more on the institutional aspects than on client aspects. The accreditation indicators tend to focus on organization-level objectives----inputs, institutional capacity, management, physical structure and processes rather than the outputs and outcomes of the services and interventions, i.e. quality/effectiveness of the services and positive effects of interventions to the clients. But, based on

the best international practice[5], person-centered standards (e.g. outcomes, quality of life) shall also be set apart from institutional capacity-centered standards.

The findings above were further supported by the results of the KIIs. While all the informants valued the accreditation standards and processes, some of them said that the accreditation level does not perfectly reflect the performance of the centers.

> "Level of quality of service is not reflected by accreditation level because the center ensures provision of quality service whatever its accreditation status is." – Center staff

Efficiency	
Questions/Criteria	Efficiency Rating
2.1 How sufficient are the resources in the implementation of interventions and in management of the centers?	
2.1.1 Financial Resources	To a very great extent
2.1.2 Human Resources	To a moderate extent
2.1.3 Physical Resources	To a moderate extent
2.2 Are the resources managed efficiently	To a moderate extent
2.3 How established were the structures and processes which support the operations of residential care facilities?	To a great extent
2.4 What are the facilitating and hindering factors in the implementation of programs and services?	N/A

2.1 How sufficient are the resources in the implementation of interventions and in management of the centers?

Sufficiency of Funds

Table 3 below shows the amount of funds allocated for both residential and non-residential services in 2018. The budget allocation for Centers and Residential Care Facilities in 2018 increased by approximately 150% versus the previous year's budget of Php 1,416,408,000. Clearly, the additional funds amounting to PhP 2.3 billion from the Centers and Residential Care Facilities (CRCF) Infrastructure Project significantly increased the 2018 budget for centers against 2017. In fact, fund allocation in 2018 has increased by 1.5 times versus the previous year[6].

[5] National Standards for Residential Care Centers by Health Information and Quality Authority

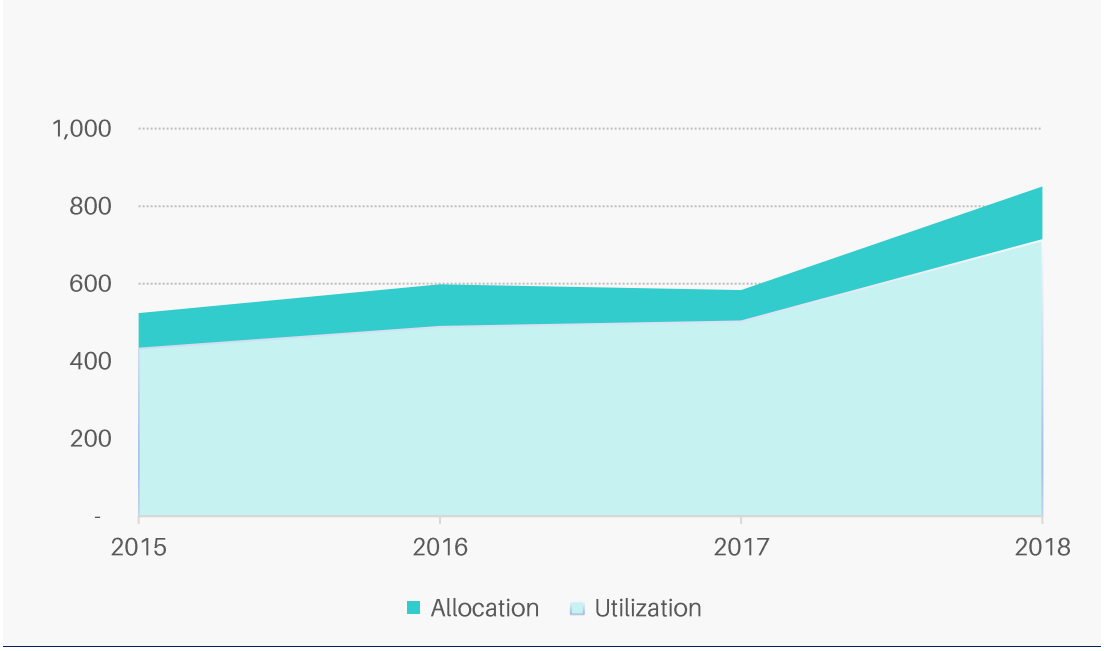
[6] In 2017, PhP 1,416,408,000 was allocated for Center-based services

Table 8. Fund Allocation for Center-based Services

Fund	PS	MOOE	Capital Outlay	Total
Direct Release	431,810,563.00	1,102,514,330.00	-	1,534,324,893.00
Centrally-Managed Fund	-	527,327,261.00	1,800,000,000.00	2,327,327,261.00
Total	431,810,563.00	1,629,841,591.00	1,800,000,000.00	3,861,652,154.00

Examining more closely the direct release funds (MOOE only) for residential care facilities, it could be observed that the said funds also increased significantly in 2018. The allocated budget for the residential centers through direct release fund ranged from around PhP 430-500 Million in the previous years but in 2018, the budget increased to PhP 850 Million. *See Figure 1.* This is approximately 50% higher than the previous year's budget.

Figure 2. Direct release fund allocation and utilization, 2015-2018 (PhP in 000000s)



Overall, the financial data suggest that funds for the residential care facilities in 2018 were highly sufficient. Indeed, key informants generally viewed the budget as sufficient and attested that CRCF had adequate funding support to address the administrative and human resource needs of the centers. Center repairs, purchase of equipment, furniture, appliances and vehicles were also made possible through the additional funds. Necessary workers with Cost of Service and Job Order status were hired because of the said additional budget.

While those interviewed were generally satisfied on the funds allocated in 2018, the presumed sufficiency of budget did not prove to be the case in FO III and NCR. In some centers of FO III, most of the budget were allocated for the salary of the staff. Hence, only a little portion of the budget goes to the programs and services. Meanwhile, due to insufficiency of budget of some centers in FO NCR, other needs were funded through donors, partnerships and sometimes, by staff themselves. In RSCC of FO NCR, expenses for other homelife and medicals needs are sourced from donations and partnerships.

Sufficiency of human resources

Table presents the magnitude of residential care facilities which are within the standard social worker-client and houseparent-client ratios. The data suggest that staffing in the residential care facilities in eight (8) Field Offices is moderately sufficient except for FOs NCR, III and IX. Based on the table, residential care facilities in FOs CAR and V have sufficient number of social workers. Meanwhile, centers in FOs VI, VIII, and X have sufficient number of houseparents.

Table 9. Centers which are within the Standard Worker-Client Ratio, Q3 2018

Field Office	Within the Standard Social Workers to Client Ratio		Within the Standard Houseparent to Client Ratio	
	N	%	N	%
FO CAR	3	100%	2	67%
FO NCR	3	43%	6	86%
FO III	6	86%	3	43%
FO V	3	100%	2	67%
FO VI	2	67%	3	100%
FO VIII	3	75%	4	100%
FO IX	4	57%	2	29%
FO X	3	75%	4	100%

Similar evidence had emerged from the key informant interviews. Majority of the informants are satisfied in terms of the number of staff in the residential care facilities in 2018. As mentioned in previous statements, adequate staff was attributed to the additional CRCF funds. However, although human resource gap was generally resolved through CRCF funds, many cited their concern about the sustainability of the current staffing since CRCF funds will be discontinued in 2019.

DSWD FOs NCR, III and IX on the other hand, had less staff compared to other Field Offices. In FO NCR, GRACES, Elsie Gaches Village, and Haven for Women, had limited number of houseparents. Meanwhile, JFC is in need of additional Occupational Therapist for improved mental patients.

Similarly, informant from FO III also expressed the lack of houseparents in the centers especially in AMOR Village, which caters to clients with disabilities. Lastly, FO IX also had concerns on the number of its social workers and houseparents. Apart from that, FO IX's centers lack drivers, supply officer, administrative assistant, laundress, cook, and physical therapist.

Competency of Staff

Although it may seem that the number of staff is moderately sufficient for the majority of FOs, some informants felt that competencies of some staff are still inadequate. For instance, in Haven for Women of FO CAR, the number of staff is within the standard ratio but is lacking the required competencies for handling CICL clients with drug-related cases. An informant in FO III mentioned that competencies of houseparents handling persons with disability differ from those of houseparents handling clients without disability. This finding emphasizes that the level and type of competencies required from the staff depends on the nature of cases of clients being served.

Capacity Building for Staff

In most of Field Offices, competency and capacity of staff are established or improved through capacity building activities. Staff undergo various trainings such as handling clients, gender sensitivity, stress management, and positive disciplining which are initiated by DSWD and partners. In fact, all of the houseparents received at least one training, except for the interviewed houseparent who did not receive any training since 2003.

There were also social workers and houseparents who underwent a specialized training program implemented by DSWD together with A Child's Trust is Ours to Nurture (ACTION), with support from Japan International Cooperation Agency (JICA). This project, which was first implemented in FO III and was expanded to NCR, aims to equip the staff with the necessary knowledge, skills, and attitude in the proper parenting of children. Indeed, in the KIIs, this project was considered helpful in improving the capacity of staff in residential care facilities.

However, consistent to the findings above, specialized trainings or trainings customized based on their nature of work still appeared to be inadequate.

Sufficiency of Physical Resources

Key informants were also asked about how they perceive the sufficiency of physical resources. In several cases, informants perceived that the centers' current facilities are still not enough to fully respond to the needs of clients. Based on the results of the KII, there is still a need to construct separate facilities for different types of clients. For instance, there were requests for

control/quarantine room for clients with contagious diseases (e.g. tuberculosis), persons with disability-friendly facilities, and quarters for clients who are ready to be discharged, separate room for clients with dependents, and villas dedicated for drug-related cases. Moreover, additional facilities such as therapy rooms, activity centers, and garage are needed. Lastly, lack of vehicles was persistently raised during the interviews.

2.2 Are the resources managed efficiently?

Fund utilization

Moderate spending has been sustained over the years. Spending of residential care facilities from 2015-2018 has been within the range of 82-86%[7]. In 2018, fund utilization rate registered at 84% or a utilization of P712 Million out of the P850 Million budget. Meanwhile, the following table shows the distribution of facilities according to level of fund utilization. As shown by the data, majority of the residential care facilities have moderate to high utilization rate.

Table 10. Distribution of Facilities According to Level of Fund Utilization, 2018

Level of Utilization	Frequency	%
Low Utilization Fund utilization is less than 60%	9	14.1
Moderate Utilization Fund utilization is between 60%-90%	26	40.6
High Utilization Fund utilization is greater than 90%	29	45.3
TOTAL	64	100.0

Resource Mobilization

Evidence gathered indicate that resource generation mechanisms in the centers are in-place. As indicated by the previously mentioned finding, these resource generation strategies were a key factor in effectively addressing financial resource concerns of the centers. Funding support from LGUs and resource generated through donations and coordination with partners helped the centers deliver the needs of the clients. Some partners and organizations offer free medical services, trainings, lectures and course offerings while donations are mostly in kind such as medicines, food and clothes.

[7] Financial data (MOOE) of Residential Care Centers provided by Program Management Bureau

Synergy amongst residential care facilities was also apparent and promoted resource efficiency. For example, in the case of FO CAR, its three (3) centers share their resources among each other. If the supplies of one center become depleted because of sudden increase in the number of clients, another one shares their supplies.

Cost of Care

Through DSWD Administrative Order 22, Series of 2005 and Memorandum Circular 11, Series of 2005 or Recommended Cost of Care and Maintenance of Service Users in Residential Care Facilities, standard cost of care[8] per client and cost parameters were set to ensure that financial resources are being optimized without compromising the quality of residential care programs and services. Cost of care is comprised of direct and indirect costs.

Direct costs pertain to good and services directly consumed by the clients (e.g. food, clothing, personal supplies, health and educational expenses) while indirect costs refer to goods and services which are not directly provided to the clients but benefit him/her (e.g. electricity, water, office supplies, and similar items).

Using the guidelines, the evaluators analyzed the adequacy of spending of the residential care facilities for each client by comparing the actual cost of care[9] with the standard cost[10] of care. Cost of care can also reflect whether the residential care facilities are producing the expected outputs using the available resources.

However, note that due to limited information gathered from the financial data, the evaluators were not able to disaggregate the estimated cost of care into direct and indirect costs, i.e. only the whole cost of care was estimated.

Table 11 shows the estimated standard cost of care for different sectors, adjusted to inflation.

[8] Cost of care is comprised of direct and indirect costs. Direct costs pertain to good and services directly consumed by the clients (e.g. food, clothing, personal supplies, health and educational expenses) while indirect costs refer to goods and services which are not directly provided to the clients but benefit him/her (e.g. electricity, water, office supplies, and similar items)

[9] Calculated using the amount of utilized MOOE divided by the number of served clients

[10] The standard cost of care was adjusted to inflation through https://www.worlddata.info/asia/philippines/inflation-rates.php

Table 11. Standard Cost of Care Per Capita Per Day, by Sector

Sector	Standard Cost of Care Per Capita Per Day	
	Minimum	Maximum
Younger Children	146	220
Older Children	150	220
Youth	114	163
Women	155	228
Older Persons	138	213
Person with Disabilities	155	228
Family	135	203

The cost of care per capita per day of each DSWD residential care facilities was calculated and compared with the standard cost of care. Consequently, the cost of care of each facility was classified by the evaluators as low, acceptable, and high cost of care.

Based on the estimates, it was revealed that cost of care of clients in 38% of the residential care facilities fall within the acceptable range. On the other hand, 41% have high cost of care while 22% have been operating on a low cost. Likewise, the data suggest that clients in 50[11] DSWD residential care facilities received either adequate or more than adequate programs and services, in monetary terms. Whereas clients in 14 facilities of DSWD received less than what is expected.

Table 12. Distribution of Facilities According to Level of Cost of Care, 2018

Classification	Frequency	%
Low Cost of Care Cost of care is less than the standard cost of care	14	21.9
Acceptable Cost of Care Cost of care is within and not 30% higher than the standard cost of care	24	37.5
High Cost of Care Cost of care is at least 30% higher than the standard cost of care	26	40.6
TOTAL	64	100.0

[11] Number of facilities with acceptable cost of care plus number of facilities with high cost of care.

Cost-effectiveness

Cost-effectiveness analysis, as defined by BetterEvaluation, is a technique which compares the relative costs to the outcomes (effects) of two or more courses of action. It measures costs in a common monetary value and the effectiveness of an option in terms of physical units. (https://www.betterevaluation.org)

Cost effectiveness ratio is calculated as follows:

$$CER = \frac{Cost\ of\ Option\ x}{Effectiveness\ of\ Option\ x}$$

Cost-effectiveness analysis was employed to determine which among the residential care facilities[12] is most effective in rehabilitating clients given the available financial resources. Cost-effectiveness ratios of facilities of the same type were compared to determine which among them is the most cost-effective in rehabilitating clients. Based on the findings, RSCC-CAR, Home for Girls FO III and X, Haven for Women-FO NCR, Haven for Women and Girls -FO CAR, RRCY-FO VIII, and Haven for the Elderly-FO IV-A have the most cost-effective programs and services when compared with DSWD facilities of the same type.

Table 13. Cost Effectiveness Ratio of Residential Care Facilities

Field Office	Cost (Utilization)	Benefit (Rehabilitated Clients)	Cost Effectiveness Ratio
Reception & Study Center for Children			
CAR	**6,696,108.34**	**54**	**340**
III	12,087,546.84	35	946
XI	7,227,078.49	40	495
Home for Girls			
III-N. Ecija	**11,533,902.42**	**57**	**554**
III-Pampanga	7,935,134.76	28	776
IV-A	4,628,158.43	16	792
VIII	5,209,102.78	22	649

[12] Only those residential care facilities who are operating within the acceptable cost of care were compared.

X	**7,683,027.88**	**38**	**554**
XII	2,348,660.48	11	585
Haven for Women			
NCR	**18,739,002.12**	**130**	**395**
I	5,488,449.07	25	601
VIII	15,900,587.89	92	474
IX	6,961,611.35	27	706
Haven for Women and Girls			
CAR	**6,342,320.88**	**43**	**404**
IVA	4,717,040.10	13	994
Regional Rehabilitation Center for Youth/NTSB			
IV-A (NTSB)	24,588,911.90	81	832
VIII	**4,255,370.67**	**45**	**259**
X	6,604,504.70	57	317
Haven for the Elderly/Home for the Aged			
IV-A	**24,324,751.39**	**101**	**660**
XI	4,425,463.12	9	1,347

2.4 What are the facilitating and hindering factors in the implementation of programs and services?

Facilitating and hindering factors in the implementation of residential care services are detailed in the following table. Based on the results of the interview, the strongest points of the center on support structures and staff's skills and values. On the other hand, most of the challenges identified are frequently about management, policies and processes.

Theme	Facilitating Factors	Hindering Factors
Staff-Skills and Values	▪ Commitment of staff ▪ Partnership skills ▪ Friendly and approachable staff ▪ Right treatment of clients ▪ Some staff have caregiving background and a college degree ▪ Trainings provided to the staff	▪ There are staff who go on leave for two (2) weeks ▪ Ineffective case handling ▪ Difficulty keeping up with the children's demands/likes and dislikes
Resources	▪ Availability of funds ▪ Complete supplies	▪ Budget for food affected by inflation - procured goods are lesser ▪ Delayed salaries of staff ▪ Job security of project-based staff. ▪ Some social workers are given additional tasks as SDOs ▪ Lack of vehicles

Theme	Facilitating Factors	Hindering Factors
Support Structures and Enabling Environment	▪ Support from center and higher management ▪ Strong coordination with LGU ▪ Close coordination with judges ▪ Support from the Field Office (technical and financial) ▪ Establishment of partnership / linkages with other organizations and individuals ▪ Technical assistance	▪ Weak coordination between PSB and SB ▪ Slow court hearings ▪ Uncooperative LGUs ▪ Lack of aftercare services in the communities
Management, Policies and Processes	▪ Regular consultation with all staff on issues and concerns and actions to be undertaken to resolve the issues. ▪ Multidisciplinary team meetings	▪ Delayed delivery of supplies ▪ Cash advance is not allowed, thus purchase of supplies has to undergo the procurement process ▪ Slow disbursement process ▪ Slow processing of documents (due to strict procurement and accounting rules) ▪ Rising prices affected bidding and procurement process in general ▪ Slow and bureaucratic approval process ▪ Some DSWD officials assert to accept clients that the Center staff has already referred to other institutions (Center cannot cater to the client's needs); ▪ Procurement delays ▪ Disapproval of proposals, thus huge funds are unutilized ▪ Too stringent rating system (e.g. IPC rating of 100% is only equivalent to 4) ▪ Referrals with mental cases are admitted even it is not the center's mandate (e.g. clients with mental conditions are referred to the center just because the client is 60 years old)

2.3 How established were the structures and processes which support the operations of residential care facilities?

Assistance and Support from DSWD Offices and Management

A. Standards Unit and Standards Bureau

The types of support received by the centers from Standards Bureau and Standard Units are facilitation of accreditation requirements, (pre-) accreditation assessments and monitoring visits, among others. Technical assistance to the centers such as organizing case folders and manual development are also being provided.

Evidence gathered from the interviews suggest that there was some variation on the extent to which the assistance/support from SB and SU had been effective. There were informants who appreciated the

> "Na-appreciate kasi na-aaffirm yung tamang ginagawa at ano pa yung kailangan i-improve"

Bureau/Unit for validating the centers' performance and providing recommendations to improve the centers.

Despite this, other informants noted some limitations on the support received. Based on the interviews, the assessment results provided by SB/SU tend to vary due to different persons assessing the centers. In addition to that, lack of regular visits/monitoring from SU was also cited by one informant. According to the informant, last visit of SU was 2 years ago.

Moreover, some informants felt that assistance, particularly in terms of helping the centers comply with the assessment results, is lacking.

> "After the Standards presented us with the findings and recommendations, we are still the ones who work to comply with those recommendations."

> "They provide us with findings with corresponding recommendations but no support (budget) was given because majority of the recommendations are on the physical structure, it was just recently that they address these concerns of DSWD facilities."

More than sharing of findings and recommendations, follow-through actions and direct assistance on complying with the indicators, such as facilitation of budgetary support, are being sought from the SU and SB. Ultimately, the informants felt that SB and SU, together with PSB and PSD, could play a stronger role to ensure that all accreditation indicators are met.

B. Protective Services Division and Protective Services Bureau

Similar to SU and SB, PSD and PSB also conduct monitoring visits, capacity building activities and technical assistance to the residential care facilities. Structures such as the National Inspectorate Committee and Regional Center Coordinators are also in place to monitor the centers.

PSB and PSD's support was described positively by several informants. Informants frequently cited the active support and monitoring of Director Alice Bonoan of PSB to the centers. They mentioned that the Director herself conduct monitoring visits. Apart from that, National Inspectorate Committee's assistance was also considered as helpful.

However, extent of assistance appeared to vary based on the interviews. In several cases, it was mentioned that engagement with the centers of the Protective Services Division can be further improved. One interviewee said that PSD provide strong support on provision of emergency needs of clients (e.g. medical assistance) but tend to have weaker support on other aspects. Another respondent, on the other hand, felt that PSB is more hands-on while PSD focuses more on review of documents. Conflicting recommendations from SB and PSB were also observed. For instance, an

informant mentioned that on case management, SB advised that there should be a monthly progress report (formal format accepted in courts). On the contrary, PSB advised that progress notes of clients (informal format) will do.

A concern also emerged in FO NCR, specifically the lack of support received by centers on the salary of MOA and JO staff of centers. The salary of staff was funded only until September 2018. This forced the centers to look for additional budget for October-December 2018.

C. DSWD management

Generally, management support was viewed satisfactorily by the informants. They felt that the centers are being supported and prioritized in terms of conduct of trainings, provision of physical resources, allocation of budget, and approval of activity proposals. In some instances, Executive Committee members also visit the centers. Regional Directors, most especially, were very supportive to the centers concerns.

Some difficulties, however, were experienced such as abrupt management decisions and slow approval process. The approval process was hampered because of the sudden change in organizational structure, according to an informant. *"Medyo magulo sa FO nung nagbago ng structure."*

Operations Manuals

All centers have manual of operations but are still for finalization/enhancement. These manuals serve as the center staff's reference and overall guide in delivery of services. However, there are some instances that the staff deviate from the manuals, based on the KII results. *The discrepancies can be further illustrated under the Effectiveness Section*.

As to the development of manuals, it was noted that center staff formulate their own manuals, that is, the current manuals that are being used were not developed centrally at the Central Office level. Thus, standardization of operations amongst the centers is not ensured.

Grievance Mechanisms

While in general, the centers have their own grievance mechanism, it appears that these are mixed in terms of processes, formality and structure. Some centers resolve grievances during meetings through their grievance committee or during regular discussions called "Talakayan." While others are resolved through less structured ways or informal channels, e.g. talking with social workers/house parents, writing in their notebooks, leaving complaints in suggestion boxes.

Effectiveness

Questions/Criteria	Effectiveness Rating
3.1 To what extent were the outputs and outcomes of rehabilitation programs and services been achieved?	To a great extent
3.2 How well are the services being provided to the clients?	To a great extent
3.3 To what extent did the centers integrate gender, religion and ethnicity, and disability in the delivery of programs/services?	To a moderate extent

3.1-3.2 To what extent were the outputs and outcomes of rehabilitation programs and services been achieved? How well are the services being provided to the clients?

Magnitude of Clients Receiving Residential Care Programs and Services

In 2018, the DSWD served a total of 9,276 clients through its residential care programs and services. This is 17% less than the target of 11,149. With the exception of RRCY, Marillac Hills and AMOR Village, centers' targets were generally under-accomplished. As shown by DSWD Assessment Report 2018, huge increase in the number of clients in RRCY could be brought by the increase[13] in the total number of children in the Philippines committing crimes.

Table 14. Number of Clients Served in Residential Care Facilities, 2018

Center	Targets	Accomplishments	Variance[14]
TOTAL	11,149	9,276	-17%
RSCC	850	795	-6%
RRCY	1134	1542	36%
NTSB	438	386	-12%
MYC	45	40	-11%
Haven for Children	226	156	-31%
Lingap Center	84	57	-32%
Home for Girls	979	854	-13%
Nayon ng Kabataan	461	263	-43%
Haven for Women and Girls	397	368	-7%
Haven for Women	1263	1007	-20%
Marillac Hills	324	325	0%
Elsie Gaches Village	640	634	-1%
AMOR Village	117	122	4%
Sanctuary Center	259	244	-6%
Jose Fabella Center	3108	1663	-46%
HE/A/GRACES	824	820	0%

[13] From 10,388 in 2017 to 11,228 in 2018

[14] Variance of 2018 Target from 2018 Accomplishment

Effectiveness: Quality of Service Delivery (Activities to Outputs)

The following tables present the responses/satisfaction levels of the interviewed clients on a series of statements relative to the following services and interventions of centers: Homelife Services, Healthcare Programs, Spiritual Enhancement and Values Formation, Skills Development, and Socio-Cultural Recreation. The respondents were asked to provide their rating on the statement using the following Likert Scale: 1-Highly Dissatisfied, 2-Moderately Dissatisfied, 3-Neutral, 4-Moderately Satisfied, 5-Highly Satisfied, and N/A-Not Applicable. Summary statistics such as median, mode, minimum, and maximum are also shown in the tables.

A. Homelife Services

Results of focused group discussions and surveys suggest that homelife services vary in terms of effectiveness. In general, moderate to high satisfaction levels were generated from the data.

Table 15. Client Satisfaction on Homelife Services

Criteria	Satisfaction Level (%)	Median	Mode	Min	Max
Discipline methods/approaches	90.8	5	5	1	5
Responsiveness to personal needs (e.g. clothes and toiletries)	88.1	5	5	1	5
Character building interventions	84.9	5	5	1	5
Adequacy of personal items provided	83.8	5	5	1	5
Room size	83.2	5	5	1	5
Quality of food	81.5	5	5	1	5
Assistance with daily living tasks such as bathing, eating, and changing clothes	81.0	5	N/A	1	5
Adequacy of food	78.9	5	5	1	5

Discipline methods/approaches were perceived positively by the respondents and even generated the highest satisfaction rate of 90.8%. Although at times the clients are being scolded, they completely understand that the staff are only doing this to discipline them, as mentioned in the FGDs. Meanwhile, **character building interventions** which seek to enhance the residents' values were also generally viewed positively (84.9%).

Satisfaction was second highest on the **responsiveness of centers to personal needs** (88.1%). This finding was consistent to the results of FGD, where it was frequently mentioned that items such as

> "Kaya nga parang hindi pa namin gusto umuwi kasi libre lang kasi dito "- Respondent, Haven for Women

clothing, toiletries, and other personal items being requested are immediately provided. Centers also provide milk, soap and diapers to dependents of residents. These free goods were highly appreciated by the clients and made them want to stay longer in the center.

On the other hand, in terms **adequacy of personal items provided,** satisfaction was recorded at 83.8%. While it is true that personal items are immediately provided, there were clients who felt that they were not receiving adequate supplies.

In terms of facilities and amenities, respondents expressed satisfaction in general. Based on the FGDs,

> "Minsan konti lang binibigay nila eh. Konti yung mga pagkain, mga gamit, mga shampoo, sabon. " - Respondent

residents are provided with big, clean, and comfortable rooms to sleep in. Gardening areas, productivity spaces, are also present.

Overall, the residents valued their bedrooms which have electric fans, televisions, cabinets and cozy beds. Clients in Home for Girls in FO III and IX are delighted because they could use facilities that they do not have before (soft bed, clean rooms, TV, air conditioner, sofa, etc.). The perception can also be reinforced with reference to the survey data, wherein 83.2% said they were satisfied on their **room size**.

In a small number of cases, inadequacy of facilities in terms of quantity and quality, were mentioned. Limited number of electric fans have caused poor ventilation particularly in FO VI and FO X. Similarly, Haven for Women-FO NCR expressed limited access to electric fans (as well as televisions) because schedule of use is bounded by center's regulations.

On the other hand, clients in Haven for Children-FO NCR felt that the comfort rooms are barely sufficient. Some residents could not use the comfort rooms as soon as they needed them. Meanwhile, one comfort room is still under construction. To compromise, some of them have to take a bath together, while others would really have just to wait for their turn.

The clients are provided with breakfast, lunch, dinner as well as morning and afternoon snacks. In FGDs, food in the centers are often perceived as balanced, sufficient and in fact, very abundant. Satisfaction was often expressed during the FGDs as most of the residents did not frequently had abundant and delicious food outside the center. Huge difference, compared to their previous

> "Our sufferings in the Malaysian detention centers/jails were offset by the good treatment here in PCDP. During our stay in the detention centers, we receive few servings of food which tastes terrible. We are also sometimes forced to eat grass. Whereas in PCDP, all our food needs are completely provided. " - Respondent, PCDP-FO IX

situation, was immediately felt by the residents because of the quantity and quality of food served. Also, residents mentioned that they gained weight after staying in the centers.

However, there was some variation among the respondents in terms of the satisfaction level on the **adequacy (78.9%) and quality (81.5%) of food**. While many expressed satisfaction, it was noted that residents in some centers were not highly satisfied. Lower ratings were found mostly in GRACES, JFC and Haven for Women.

Commonly cited reason for the perceived inadequacy of food was the lack of budget to support huge number of clients. One of the FGD participants in Haven for Women-NCR mentioned that the center's budget for food was stretched due to higher number of clients. Consequently, snacks were not distributed anymore, according to the respondent. This directly affected not only the women residents, but also their children.

> "Kasi po noong kakaunti lang po kami dito meron po kaming meryenda sa umaga, may meryenda rin po sa hapon. Pagkatapos po namin ng almusal, mga 9 or 10 ng umaga po may meryendang darating, ngayon wala na po. Hindi po tulad dating na lagi po kaming may hawak hawak na pagkain para sa mga anak namin. Noon, ang dami pong meryenda; halos araw-araw po meron. Sa ngayon ano na lang po budget budget na lang po. Syempre naawa rin po kami sa mga bata." – Resident, Haven for Women

Similarly, residents in JFC and GRACES directly felt this shortage, particularly on the supply of beverages. FGD participants in JFC and GRACES mentioned that they do not receive coffee, and not even milk. In addition, one FGD participant in JFC commented that rice was inadequate. FGD participant in RRCY, on the other hand, said that the serving size is small.

Interestingly, it was observed that residents are very much aware of the budget concerns of the centers and that willingness to adjust to these constraints was consistently expressed during the FGDs.

Some FGD participants, on the other hand, felt some limitation on the quality of food/viands served. Lack of variety of meals was perceived ---there are some cases where meals are not served based on a menu-rotation. The clients mentioned during the FGDs that they experienced receiving repeated meals in the past.

> "Noong mga nagdaang buwan, isang buwan po yata kaming nag-ulam ng ano, ng nilaga, tapos nilagang egg. Tapos po nung nakaraang taon, mga 2016 po, pamatay po ng ipin Lucky Me. Lagi-lagi pong Lucky Me. "– Resident

Assistance on daily living tasks such as bathing, changing of clothes, and eating are provided especially to the persons with disability, younger children, and elderly residents. Survey results suggest moderate satisfaction on the assistance provided (81.0%). This finding is in harmony with the discussions of respondents on how they are being taken cared for, especially by the houseparents.

It is also worth noting that other elderlies tend to exhibit independence and empowerment to perform daily tasks. These elderlies expressed that they do not need assistance from the staff on their personal dwellings because they are still functional.

> "The staff take care of us very well, help us with bathing. They also feed the elderly. The houseparents are like mothers and fathers here, while the elderlies are their children. " - Respondent, Home for the Aged

B. Healthcare Services

Survey data revealed that the clients are generally satisfied with the healthcare services. Statements related to health services had satisfaction levels close to 80%. This finding is congruent with the FGD results which suggest that good healthcare practices are in place and that medical personnel in the facilities are often present. On the other hand, around 20% of them were not satisfied or have neutral responses.

Table 16. Client Satisfaction on Healthcare Services

Criteria	Satisfaction Level (%)	Median	Mode	Min	Max
Medical check-up/physical examination	83.0%	5	5	1	5
Dental Services	77.8%	5	5	1	5
Adequacy of health services	80.3%	5	5	1	5

In general, clients undergo regular medical and dental check-ups, receive medicines, vitamins and vaccines. In some cases (e.g. Haven for Children), testing for human immunodeficiency virus (HIV) is practiced. Medical services are also offered by center clinics particularly for minor health issues. Whereas, more serious health problems are referred to hospitals. Apart from that, during FGDs, it was mentioned that education sessions related to health, hygiene, sex and gender are conducted.

Despite this, serious health issues particularly spread of contagious diseases were still encountered, based on the interviews. Such diseases include skin diseases and sexually transmitted infections. One informant also shared that there was an incident in the center (RRCY) wherein sexually transmitted

disease was spread to several residents. This shows that there is an apparent weakness in terms of establishing measures to prevent and control contagious diseases. Nonetheless, the need for control measures (e.g. construction of control/quarantine rooms) was already acknowledged by the informants, as cited previously in this report.

Moreover, in some cases, vaccination is not provided as scheduled.

> "Tulad po nung anak po nya dapat po nabakunahan na po nung October kaso wala pa rin po. Eh ako nga po September nakabalik na po ako kaso wala pa rin po eh anong buwan na po ngayon (November); Dapat nga po nung 9 months 'to, dapat i-measles vaccine na siya. Pero wala, kasi busy daw po. Kaya di po nasasakto sa buwan yung pagbabakuna" –Resident, Haven for Women

In terms of presence of health personnel, data gathered also revealed that there are doctors, dentist, nurse and psychologists at the facilities. Moreover, it was noted that presence of a nurse was more frequently mentioned in the FGDs, thus hinting that nurses are more common than any other medical staff. However, nurses in centers for the elderly tend to be limited and sometimes perform multiple tasks. As echoed by a resident in Home for the Elderly, they only have one (1) nurse who also functions as a houseparent.

> "Yung nars namin, takbo magisa. Payat pa. Nag bisikleta. Punta sa isa, punta pa sa isa, pabalik-balik. Naawa kami sa mga nars namin. Isa lang ang nurse namin. Meron kaming nars dito pero hindi sila duty. Ang nars namin dito, nag ha-house parent din." - Kung sino hindi maka punta sa banyo, kakargahin niya" – Resident, Home for the Elderly

Because of age and increased vulnerability, elderlies often require greater assistance and medical support. As such, ensuring adequate health personnel in terms of number and competency is imperative in light of the seniors' needs. While importance of these health personnel is recognized, it was noted that the presence of health personnel is not explicitly reflected in the standards for accreditation of centers.

C. Educational Services

Generally, residents are provided with opportunities to access formal, non-formal (Alternative Learning System) and special education. Dependents of clients in Haven for Women are also allowed to attend day care centers inside the facilities.

Survey data indicate high satisfaction level amongst the residents on their **schooling** (92.4%). Most of the respondents were also satisfied on their **school lessons** (89.7%). It would also appear that **school supplies and other needs** (85.4%) are often provided by the center. Meanwhile, clients in RRCY, though generally satisfied with the services, expressed some disappointment over "broken promises" – particularly their inability to enroll in formal school despite having no violations at the center.

Table 17. Client Satisfaction on Healthcare Services

Statements	Satisfaction Level (%)	Median	Mode	Min	Max
Schooling in general	92.0%	5	N/A	2	5
School supplies	85.4%	5	N/A	1	5
Class lessons	89.7%	5	N/A	1	5

In the case of RRCY, as mentioned during FGDs, not all residents can choose to undergo formal schooling. According to the interviews, clients will be assessed in terms of their behavior to determine if they will be allowed to go to formal school. Equally, whether or not a resident in RRCY could continue his formal schooling would depend on his behavior. For instance, it was mentioned in an interview that once a resident commits a violation or shows misconduct, his formal schooling will automatically be discontinued.

This somehow hints at a contradiction between the operations manual and the actual procedures done in determining who will be allowed to go to formal schooling. In the operations manual of RRCY, it was indicated that selection of residents who would undergo formal schooling will be done by "identifying the eligible residents who show keen interest and enthusiasm to go to school." Thus, based on the actual implementation, it appears that access of RRCY residents to formal schooling is largely dependent on their behavior rather than their interest and enthusiasm.

D. Spiritual Enhancement

Opportunities to participate in religious activities are being provided by the center. Residents mentioned that they are able practice their own religion and that all religions are being respected. Overall, they are satisfied with the bible studies, mass, and other spiritual activities conducted in the facilities.

Table 18. Client Satisfaction on Spiritual Enhancement Services

Criteria	Satisfaction Level (%)	Median	Mode	Min	Max
Bible studies, mass, and spiritual activities	85.8	5	5	2	5

E. Social Services

Social services through case management, counselling and interviews are conducted to improve social functioning of residents and prepare them for family and community reintegration (if applicable). Although relatively high satisfaction rating (84.8%) on counselling services was observed, conduct of regular counselling activities is not always ensured because of limited social workers, as implied in the FGDs.

Table 19. Client Satisfaction on Social Services

Criteria	Satisfaction Level (%)	Median	Mode	Min	Max
Counselling Services	84.8	5	5	1	5

A participant in the FGDs said they seldom receive counselling services from the social workers. They are only 'counselled' when there are conflicts among the residents. She added that the lack of counselling activities could be caused by the limited number of social workers in the center.

> "Minsan pag may gulo sa cottage, sunod sunod na yung gulo, saka na sila magka-counsel, pero pag bihira hindi naman sila magcounsel or ano. Siguro dahil sa kaunti lang yung social worker dito. Ano lang kasi social worker dito, apat. Eh sa dami namin dito." – Resident, Haven for Women

F. Skills Training and Livelihood Services

Skills trainings and livelihood interventions are provided to interested clients. Residents may undergo productivity trainings such as those offered by TESDA. They are also offered with livelihood projects such as baking, and candle-, flower-, rug- and wallet-making which can be sold to generate income. Elderlies and persons with disability may also participate in these livelihood activities.

The residents seem to be happiest with the skills training and livelihood services among the services provided by the centers as shown by the 92.4% satisfaction rate.

Table 20. Client Satisfaction on Skills Training and Livelihood Services

Criteria	Satisfaction Level (%)	Median	Mode	Min	Max
Skills training and other livelihood interventions	92.4	5	5	1	5

G. Socio-cultural, Sports and Recreational Activities

The centers also conduct socio-cultural activities and provide opportunities for sports and recreational activities. The centers organize social events and parties for the residents such as celebration of birthdays, center anniversary, Nutrition Month which promote interaction with other residents and the community. The residents can also play different sports inside the centers. Outreach activities are also conducted. Majority (88%) of the respondents are satisfied with the socio-cultural, sports and recreational opportunities in the centers.

Table 21. Client Satisfaction on Skills Training and Livelihood Services

Statements	Satisfaction Level (%)	Median	Mode	Min	Max
Sports and recreational activities	88.0	5	5	1	5
Socio-cultural events and celebrations	88.4	5	5	1	5

H. Overall Quality of Service Delivery

Table 14 suggests that overall services of DSWD residential care facilities are highly effective except for timeliness and addressing residents' difficulties and issues.

Table 22. Client Satisfaction on Overall Services

Statements	Satisfaction Level (%)	Median	Mode	Min	Max
Responsiveness of interventions to the needs of residents	81.2	5	5	1	5
Adequacy of services	82.7	5	5	1	5
Timeliness of services	79.4	4	5	1	5
Appropriateness of services/interventions	85.1	5	5	1	5
Addressing the residents' problems and issues	78.8	4.5	5	1	5
Overall services received	84.2	5	5	1	5

Effectiveness: Quality of Life (Outputs to Outcomes)

The effectiveness of services in terms of how the quality of life of the residents have improved was also measured by assessing two (2) dimensions: living environment and social environment. Agreement level of survey respondents on several statements pertaining to their quality of life in the center is exhibited in Table 15.

Table 23. Agreement level on Factors Affecting Quality of Life of the Residents

Statements	Agreement Level (%)	Median	Mode	Min	Max
Living Environment					
The toilets and rooms are clean.	75.8	4	4	1	5
My privacy is being respected.	69.8	4	5	1	5
I feel safe in the center.	87.2	5	5	1	5
Social Environment					
The Social workers treat me well.	91.1	5	5	1	5
The Houseparents treat me well.	89.6	5	5	1	5
I have a good relationship with my co-residents.	75.8	4	5	1	5
I am satisfied with how often my family visits me.	68.9	5	5	1	5
I am satisfied with the support my family gives.	81.1	5	5	1	5
I feel cared for.	89.0	5	5	1	5
I feel loved.	85.6	5	5	1	5

A. On living environment

Majority of the clients **feel safe and protected** in the centers based on the high agreement rating of 87.2%.

Cleanliness is generally maintained because the clients are tasked to clean the facilities especially the bedrooms and comfort rooms. However, there were some issues negatively affecting the cleanliness and could explain the **lower agreement on cleanliness of toilets and rooms** (75.8%). Residents in RRCY-FO CAR shared that challenges in accessing water consequently affected the cleanliness of their facilities and rooms. Meanwhile, respondents in Haven for Women-FO NCR said that their bathrooms are not in a good condition due to defective sewer lines. Similarly, respondents in Haven for Women-FO X mentioned that some of their toilets are clogged. Also, RRCY and Haven for Women in FO V need improvements especially in terms of cleanliness and orderliness of environment considering that they all have Level 3 accreditation status.

Rating on **privacy was the lowest** at 69.8%. This is due to the fact that residents are in a group-living arrangement and occupy shared rooms. Beds in some centers are also arranged close together, which minimizes clients' personal spaces. Also, based on the FGDs, there were clients who felt that their privacy is not highly respected by their co-residents (e.g. some of them tend to be noisy).

A related factor for the low satisfaction was the lack of privacy in doing personal activities such as taking a bath. For instance, because of limited supply of water in Haven for Women-FO X, the female residents would still have to get water outside the facility just to take a bath. They take a bath with their clothes on because the water supply is situated in a public space, suggesting that their privacy is being compromised.

B. On social environment

Interaction of clients with staff were also analyzed through the survey and FGDs. Survey results revealed that overall, **houseparents and social workers treat the clients well** with ratings of 89.6% and 91.1%, respectively. During the FGDs, the clients appreciated how most of the staff have treated them like their family. They are approachable and helpful when the clients have problems (e.g. when they miss their family). The FGD respondents appreciated the houseparents the most, as they are the ones who act as their primary caregiver and who interact with them the most.

> "Ang pinakamadalas na tumutulong sa mga residente, mga house parent. Kasi sila ang tiga salo ng problema eh, sila ang nakakaalam ano yung pangalan, kasi lagi namin silang kasama eh. Maganda naman ang pakikitungo.". -Resident, GRACES-FO NCR

Moreover, consistently during the FGDs, clients expressed the they **felt loved and cared for**. This finding is also reflected by the survey results above. They provide guidance and when there are things that bother the residents; they console the residents and provide emotional support. They can approach the staff and HPs when they have problems. They also acknowledge the efforts of the center staff to teach them and lead them to the right path. In addition, the staff are always there to resolve conflict among the residents.

> "House parents, nakakasundo ko minsan. Nagkakatuwaan po kami, nagjoke joke ganun. Mas maganda yung ano, yung samahan namin dito. Hindi kami tinatrato na iba…parang ano, parang pamilya talaga."-Resident, FO VIII

Still, occurrence of conflicts between staff and clients were found to be inevitable. During the FGDs, clients mentioned that they have experienced negative incidents with the staff. According to a respondent, some of the houseparents are kind while some are short-tempered.

> "Yung iba naman mabait, yung iba masungit. Pag di kami kumikilos, sinisigawan kami."– Resident

Some clients also had similar unpleasant experience. They affirmed that not all houseparents treat them nicely. One of the clients shared that she was scolded by a houseparent because of some misunderstanding. She was also coarsely reminded of the things that the government provides them.

> "Sinusumbatan nya ako. Kinwenta yung mga *respondent cried* kinakain namin dito, kung ano ang mga binigay ng gobyerno para sa amin. Imbis na turuan ka, bubulyawan ka. Sinabi ko sa sarili ko na magtitiis nalang ako kasi, nanghihingi ako tulong ng gobyerno eh. -Resident

Influencing positive relationship among the residents also signify that centers foster an enabling social atmosphere for effective rehabilitation of clients. Recreational activities, sports and group tasks offered by the centers provided opportunities for clients to socialize. Throughout the FGDs, the clients mentioned that they appreciated the friendships built with their co-residents. Residents even mentioned that they are like one big family in the center. They eat their meals together, share their food, and help each other.

Despite this, conflicts among the residents is not uncommon. This is reinforced by the survey results which revealed a **relatively lower rating on relationship with co-residents** (75.8%). Clients sometimes fight over miniscule matters (asaran/pikunan), particularly in facilities catering children and youth. Some just argue with each other, but in worse cases, some children use deadly weapons when engaging in fights. Instances of bullying is also present, but the center staff are always ready to meddle in order to maintain harmonious relationship among clients. Generally, conflicts are immediately resolved. Clients involved in conflicts, however, would face disciplinary actions such as exclusion from outreach activities.

Clients in the center have different personalities and behavior. Dealing with them requires a lot of patience, especially for clients who have mental illness. One client reported difficulties on dealing with her mentally ill roommate who was assigned by the center staff under her care.

> "Ako binibigyan ng mga tita ng mga ganyan (mentally-challenged clients). Lagi sa kwarto ko napupunta kaya sabi ni tita ang bait bait ko daw, sobrang kabaitan kaya binigyan ako ng mga ganyan na kasama. Kahit habaan nang habaan yung pasensya lalo na may kasama ako sa kwarto ganun dalawa pa oy, kahit po ang haba haba ng pasensya ko, minsan nakakakarindi na" -Resident

Another important factor affecting effective rehabilitation of clients is the extent of support they receive from their families. Unfortunately, high proportion of residents expressed **dissatisfaction on the frequency of visits** (31%) **and support received** (19%) from their families. One of the primary factors which hinders frequency of visits is the location of the centers, given that the residents come from different provinces and sometimes from different regions. One of the FGD participants felt sad because his family cannot visit him due to the lack of budget for transporting to the centers.

Findings from the FGDs also highlighted the importance of contact and communication of clients with their families. Extent to which the clients are visited and contacted by their loved ones seemed to affect their emotional state and behavior. For instance, some attempted to commit suicide while others escaped from the center because of limited communication with families. One of the interviewees felt that some social workers are not helpful in connecting the clients with their families. *"Hawak ng social worker (SW) ang cellphones. Hindi papasukin ng guard ang clients sa admin building kasi sinasabi ng SW na busy sila."* Moreover, some of the disciplinary measures appeared to be inappropriate. According to the interviewee, *"Pati yung pagpapanood ng television pinagbabawal pag may ginawang misbehavior. Bawal din dalawin kapag nagmisbehave ang clients, akala tuloy ng kliyente binabartolina sila."* Another client expressed dissatisfaction because sometimes, he cannot contact his family during emergencies since the social worker is not always present.

Strengths and Weaknesses of DSWD Residential Care Facilities

When asked about the strengths and weaknesses of the centers, the study participants commonly answered the following:

Strengths

1. Based on the findings, one of strengths of the DSWD residential care facilities is the **responsiveness of its services to the basic needs of the residents**. Study participants were asked what they liked the most about the centers. Their responses implied that responsiveness of the centers to the basic needs such as food, toiletries and personal items is one of the greatest strengths of the centers.
2. The clients were also most grateful on the **opportunities and activities** offered by the centers. Opportunities to learn and be equipped with new skills through access to education and skills trainings (e.g. livelihood trainings) were viewed positively. Social and daily activities also helped the clients manage/overcome their sadness and boredom.

3. Social environment components such as **love, support and care from the center staff, and sense of belongingness** were also emphasized by the study participants.

Weaknesses/Issues

1. The centers still need to improve their medical services. As cited in the findings, **in some cases, medical needs are not prioritized or provided in a timely manner**. In the case of some facilities for the elderly, psychological needs are prioritized over basic medical needs. On the other hand, some clients in Haven for Women experienced delayed vaccination of their children.
2. **Mixing mentally ill clients with normal residents** was also cited as a major issue.
3. **Conflicts and misunderstanding between center staff and the residents** are also some of the most common issues encountered.

2.3 To what extent did the centers integrate gender and sexuality, religion and ethnicity, and disability in the delivery of programs/services?

Gender and Sexuality

In general, gender is considered in the delivery of services. Moreover, gender sensitivity trainings are attended by the staff which they apply in the provision and planning of interventions. In turn, staff educate clients on gender and development.

Separation of clients' rooms according to sex are practiced by the facilities. In other cases, gay clients (e.g clients in RRCY) are prone to abuse by their co-residents, so they sleep separately from the rest of the residents. On the other hand, children's rooms in RSCC are not separated by sex. According to an informant, gender would not be a major issue because the children are too young.

While the centers respect some forms of sexual expression (e.g. cross dressing), it was noted that, overall, centers differ in terms of managing sexuality issues of the clients. For instance, some centers allow same sex-relationship, while some do not. Moreover, while some centers allow same-sex relationships, they discourage these residents to display their affection and romantic gestures towards other clients. It was also consistent during the interviews that the centers prevent development of romantic relationships and intimacy among the residents by doing close monitoring. Varying approach to addressing sexuality needs and issues of clients could be due to lack of clear policies and guidelines on how to deal with sexual expression and sexuality in residential care centers.

It was also found that homosexuality can affect someone's admission to residential care facilities. In one of the interviews, one of the informants from RRCY said that admission of gay youth is avoided due to a previous experience wherein STDs became rampant at the center. The informant also attributed the disease to the gay clients. After that incident, the center rejected gays and transferred them instead to other centers (e.g. Bahay Pag-asa).

Religion and Ethnicity

All clients coming from different religious, culture and ethnicity are respected. Findings also showed that religion is considered in the delivery of services. Religion, and ethnicity are captured by the centers upon admission to provide their needs appropriately. For instance, religious dietary restrictions on food is observed and respected---Muslim clients, are served with food different from the rest of the clients. Also, in other cases, assignment of rooms is based on the residents' religion. In Haven for Women-FO NCR, Muslims stay in a different cottage.

The residents are given freedom and opportunities to practice their own religion. In some centers, there are separate prayer rooms for different religions. Also, in one of the interviews, an informant said that the center brings Muslim children to a specific place for their rituals/prayer activities. Most importantly, clients are not forced to attend masses, bible studies or other religious activities.

Various religious groups also visit the centers, but some informants felt that these groups use this opportunity to recruit members or change the religions of some clients. In Nayon ng Kabataan, not all requests from religious groups are accommodated because some are very persistent in "recruiting" members. This case is also similar with Haven for Women. As a result, some residents tend to convert to other religions by attending spiritual activities conducted by different religious groups visiting the centers. It also emerged during the interviews that some religious groups lure non-Catholic residents to participate in activities intended for Catholics by offering free food just to meet the target number of participants.

> "Na-coconfuse ang mga clients sa dami ng religious organizations na pumupunta dito. May ibang religious groups na pinipilit na sumama sa session na pang-Catholic kahit na Muslim sya (para lang maka-quota sa attendance), especially that may food (reward). Yung iba nagpapalit ng religion from Catholic to Seventh Day Adventist."

Beliefs, traditions, and practices of the residents are also respected but are balanced with the implementation of rules and the law. As an example, Haven for Women and Girls in FO CAR handled a client from Kalinga who was raped and had a baby. The father of the client did not want her daughter to breastfeed the baby because they have a belief that the body of someone who was raped

becomes dirty. The social workers from the LGU and center worked together to explain to the family that the hospital where the client gave birth had to implement the breastfeeding law and the client has to breastfeed her baby. The father eventually agreed after their discussion.

On the other hand, some Badjao adults in JFC are not accustomed to bathing every day as they lived in or near the seas before. Because of this, the center staff do not force them to comply with the bathing schedule. They only encourage them to bathe their children to observe proper hygiene. The Badjao clients have also expressed that they do not know how to sweep the floor because in their previous homes, they just let the sea tide wash away their litter: *"pinapaanod lang namin yan sa amin."* The house parents recognize their ways of living but also encourages them to still do the chores like cleaning and washing their clothes.

Disability

The DSWD provides residential care services to abandoned, neglected and abused children with special needs in Amor Village and Elsie Gaches Village. Apart from these two (2) centers, there are no other DSWD residential care facilities catering to persons with disability. Moreover, acceptance of persons with disability in centers other than Amor Village and Elsie Gaches Village is not explicitly stipulated in the operations manuals. In fact, as indicated in the operations manuals, only those individuals who are free from psychosis or any type of mental illness (except for senile and Alzheimer's cases for elderly facilities) should be admitted in the centers. It was also emphasized in the manuals that individuals with mental illness shall be referred or transferred to appropriate institutions for proper treatment.

However, based on the data gathered, residents who have mental illnesses such as psychosis, bipolar disorder, and schizophrenia are still being admitted in some centers such as Haven for Women and GRACES. As mentioned during the interviews, clients with mental disorders tend to be violent and could harm others. These findings suggest that mentally ill residents present risks to safety and protection of both residents and center staff.

Impact

Questions/Criteria	Impact Rating
4.1 To what extent were direct and indirect consequences (positive and negative) of the interventions/processes felt by the clients?	To a very great extent

Changes in the situation of the clients

Impacts in terms of the changes on the clients' condition, capacity, perspective, outlook or behavior brought about by the centers were also gauged through measuring their agreement level on the

statements in the following table. Likert scale similar to the effectiveness section was employed to measure the impacts or changes.

Table 24. Agreement level on the Impacts of Residential Care Services to the Residents

Statements	Agreement Level (%)
I am ready to go back to my family and community.	75.0
I have become more optimistic.	89.7
I am happier now.	84.4
My physical and mental health have improved.	87.2
My character improved.	87.1
I have stronger and better relationship with my family and relatives	80.2
I have gained more self-confidence.	87.4
I gained new knowledge and skills.	90.5

The clients mostly agree that they **gained more knowledge and skills** because through the centers. This was also consistently mentioned during the FGDs. Apart from livelihood trainings, they have also learned practical life skills by doing household chores. Clients also mentioned that they have become empowered thru the capability building activities and thus learn how they would adapt and survive in the community. Some used their learning from the productivity training to look for job/ employment once discharged from the Centers.

The data also suggest that the centers have changed the clients outlook; 89.7% of the surveyed clients **have become more positive** in life. In relation to that, many clients (84%) **have become happier** after their stay in the centers. Suicidal thoughts and depressive episodes have also been managed through the residential care interventions. A client in Haven for Women mentioned she had suicidal tendencies. Realizing that she is loved, her perspective in life has positively changed.

> "Akala ko wala nang nagmamahal sakin. Pero nandito pa rin po yung mga social worker, house parent, mga kasamahan ko po na tinuturing na rin po akong kapatid. Sa kanila ko rin po naranasan na may nagmamahal pa pala sakin. Kasi po nagtry na rin po akong magpakamatay. Akala ko magwawakas na ko, parang gusto kong sirain lagi yung buhay ko. Pero di pa po pala tapos ang lahat. Maganda yung pakikitungo po nila sakin, kaya po sa kanila ko lang din po ginagaya or natutularan ko rin po sila kung ano po yung kabaitan na binigay po nila sakin. Sinusuklian ko rin po ng kabaitan." –Resident, Haven for Women FO-NCR

High proportion of the respondents (87%) also observed that their **character/attitude and self-confidence have improved**. During the FGDs with clients, it was consistently mentioned that they were able to change their behavior and learned to show respect. At first some tend to be rebellious because they do not want to stay in the Center, but as time flies, they have enjoyed and valued their stay at the Center. They were able to quit their vices, learned to respect others and behave appropriately. Clients' temper has become more manageable since they have learned self-control. Positive disciplining, well-trained houseparents, spiritual activities and effectiveness in handling clients were also mentioned as factors which contributed to change in clients' behavior. In terms of confidence, the center staff observed that the residents have become more participative in activities while other clients were able to develop and showcase their talents--- indicating improved self-confidence.

Data also revealed that **physical and mental conditions of most clients (87%) have improved or become more manageable**. The most common change in terms of physical aspects as mentioned during the interviews was weight gain. On the other hand, elderly clients shared that they are able to manage their health concerns because of the medicines provided at the center. Also, similar to the findings above, depression of clients has become more manageable. However, some negative effects were also mentioned such as acquiring infections and diseases inside the center.

On the other hand, some clients (19.8%) **do not feel that their relationships with their families and relatives had improved** after their stay in the center. Consistent to the findings in the previous section, only few residents (60%) are frequently visited by their families.

Relatively high proportion of the clients (25%) are not prepared to leave the centers and to be reintegrated with their families and communities. One most common reason behind the apparent unreadiness is that the clients want to learn more from the centers. During the FGDs, those who said that they are not yet ready to leave the center mentioned that they still want to better themselves and learn more skills so that they can take care of themselves once they go back to the community. Moreover, the readiness for reintegration depends on when their social workers or families have already found employment for (employable) residents. Other clients, on the other hand, want to finish their schooling before they leave. In other cases, some residents are homeless and do not have families, thus would still require finding a home outside the center where they will be safe.

On the other hand, clients who are ready to be reintegrated said that they have personally noticed the positive change in their behavior and their improved capacity to survive in the "real world."

Moreover, they think that they have already stayed long in the Centers and are already missing their families.

Sustainability	
Questions/Criteria	Sustainability Rating
5.1 To what extent have the positive effects of the interventions been sustained after the clients' stay in rehabilitation centers?	To a moderate extent
5.2 To what extent have the centers maintained or established networks/partnerships to sustain the benefits of centers' services and programs?	To a moderate extent
5.3 To what extent were the centers capacitated to be able to sustain or improve their level of accreditation?	To a moderate extent
5.4 How can the accreditation processes be more sustainable?	N/A

5.1-5.2 To what extent have the positive effects of the interventions been sustained after the clients' stay in rehabilitation centers? To what extent have the centers maintained or established networks/partnerships to sustain the benefits of centers' services and programs?

Mechanisms on discharging residents and referral to LGUs are in place. Prior to reintegration, parents' and/or relatives' capacity are assessed by the City/Municipal Social Welfare Officer of the Local Government Units to check their readiness to accept and take care of the clients. If the findings of the assessment provide enough basis for reintegration of clients to the communities, the social worker conducts preparation of documents for discharge of clients and referral to concerned LGUs for provision of after-care services.

The LGUs are then tasked to submit monthly progress report on the reintegration status of the clients 3-6 months after discharge from the centers. That is, the LGUs are given the responsibility to monitor the clients once returned to their families and communities. The center staff on the other hand, monitors if the terminal report agreements (for family of the client and LGU) are being satisfied. However, according to the KIIs, some LGUs do not cooperate and comply with the reintegration plans and agreements. Hence, the center staff conduct informal monitoring through visits to the family since the LGUs fail to monitor the discharged clients.

While procedures on discharging clients have been established, it was observed that mechanisms to ensure that the LGUs are doing their responsibilities towards reintegration of clients are still weak. Systems and procedures on monitoring LGUs and conducting follow through activities for reintegration are not strongly established. Some center heads admitted that they are weak on the part of monitoring the reintegration of clients, which is mainly because of lack of staff. Thus, center staff rely on monitoring of LGUs but as mentioned above, in general, monitoring is rarely conducted

by the LGUs. For those who returned to their families, monitoring is conducted through the MWSDO status reports which should be submitted quarterly for one year. But it is very rare that they would provide after care reports. If policies on reintegration of clients are imposed and strengthened, compliance of LGUs may improve.

> "Ang monitoring namin ng clients ay informal---through facebook. Wala na kasing written feedback galing sa LGU kaya through informal channels, sa kwentuhan na lang o sa text (kapag nakasama sa event ang LGU social worker) ang feedback"–DSWD Center Staff

Challenges on sustaining the rehabilitation and reintegration efforts of residential care facilities

Detailed below are the major challenges on sustaining the rehabilitation and reintegration of the residents identified by the informants:

- ✓ Cooperation and capacity of families and communities
  - Some cases of clients who belong to a tribe are resolved through intervention of elders. The client and the accused perpetrator must obey whatever the decision of their elders. These cases are a challenge because there is chance that the abuse will just be repeated.
  - Family/relatives are not prepared to take care of the rehabilitated residents because they do not have enough capacity (e.g. due to financial limitations) to provide the needs of the residents and sustain the rehabilitation efforts. In some cases, there are no families who will take care of the discharged clients, especially for those who are abandoned and unattached.
  - Some families are biased towards perpetrators, particularly on incest cases.
- ✓ Support from partners and LGUs
  - Lack or weak interventions (after-care services) provided by the Local Government Units to the families and discharged clients.
  - Some LGUs are not responsive on documentary needs for effective reintegration of the residents, e.g. issuance of Parent Capability Assessment Report and timely feedback on the situation of the discharged clients.
- ✓ Other external factors
  - Lack of opportunities (employment and free education) present in the communities.
  - Slow and delayed court hearings hinder the timeliness of reintegration.
  - Limited foster families and custodians, especially for those clients with special needs.

5.3 To what extent were the centers capacitated to be able to sustain or improve their level of accreditation?

As mentioned in other parts of the report, the Standards Bureau and Standards Units under the Field Offices are providing regular technical assistance to the residential care centers to help them meet the accreditation standards. Field monitoring and follow-through activities are also conducted in relation to accreditation. However, some SU staff admitted that they do not frequently visit the centers due to lack of staff.

5.4 How can the accreditation processes be more sustainable?

According to the informants, accreditation processes would be more sustainable if there are enough staff, strong management support and more capability building programs for the assessors. The informants were also asked on their thoughts about decentralizing accreditation processes. Based on the interviews, their views on the decentralization were mixed. Some informants said that decentralization would facilitate timeliness of accreditation. Meanwhile, others disagree with the decentralization because it would require more staff. Another informant also said that check and balance would not be ensured if accreditation would be done directly by the Field Offices since there would be biases towards giving higher accreditation status to the residential care facilities under their management.

III. CONCLUSIONS

Relevance

1. Overall, DSWD residential care facilities are highly relevant due to high magnitude of vulnerable Filipinos in need of social welfare and development programs and services through residential care services. The facilities have also been relevant in providing social services such as temporary home, protection, food, education, livelihood, psychosocial and counselling services, and reintegration services among others that are deemed vital to meet the recovery and rehabilitation needs of the clients and/or improve their quality of life. Despite this, it was noted that modification of services based on the nature of clients' cases (e.g. establishing facilities solely for trafficked victims) and coverage of residential cares services (e.g. coverage of abused elders) seemed to be lacking. Furthermore, continued increase of trafficking, incest and juvenile offending cases would be needing more targeted interventions in the foreseeable future.
2. Findings from the study have disclosed how clients' issues are rooted from poverty and dysfunctional/broken families, because these had affected various dimensions of residents' lives.

3. Both (1) residential care programs and services and (2) accreditation activities were strategically contributing to the strategic priorities of the Department, i.e. to the attainment of the Organizational Outcomes 2 and 4 and to the 2019 Thrusts and Priorities of DSWD.
4. Accreditation was found to be relevant in ensuring that the DSWD residential care facilities are providing the minimum standards in delivery of services. Findings revealed accreditation was highly relevant in improving the quality of services of **non-accredited facilities**. Moreover, it was found that non-accredited facilities are less effective than accredited facilities.

   However, accreditation level/status of accredited facilities does not necessarily reflect their level of effectiveness because effectiveness scores of Levels 1, 2 and 3 were statistically the same. The findings further revealed that having lower levels of accreditation would not necessarily undermine the centers' overall effectiveness and quality of services. Thus, effectiveness and quality of services of accredited facilities are not strongly linked to their status or level, contrary to the theory.
5. The current accreditation standards lacked indicators that focus on person-centered or client-level outcomes, i.e. effectiveness of service delivery and ultimate effects of residential care facilities (e.g. rehabilitation, recovery and reintegration). This could have biased the approach of determining the accreditation status towards focusing more on the institutional aspects rather than on the client aspects. The accreditation indicators tended to focus on organization-level objectives----inputs, institutional capacity, management, physical structure and processes rather than the outputs and outcomes of the services and interventions of residential care facilities.

Efficiency

1. Financial resources for the DSWD Residential Care Facilities are highly sufficient and have increased significantly in 2018 because of the additional PhP 2.3 Billion additional funds from the Centers and Residential Care Facilities (CRCF) Infrastructure Project. CRCF project provided adequate funding support to address the administrative and human resource needs of the centers.
2. Human resource gap was generally addressed, but sustainability and competency issues remain. In connection to the previous finding, human resource gap was generally resolved through CRCF project funds, albeit some exception in some Field Offices (NCR, III, IX). However, sustainability of staff was not ensured since CRCF fund was discontinued in 2019. Although it may seem that the number of staff is moderately sufficient for the majority of FOs, findings revealed that competencies of some staff are still inadequate. Specialized capability building activities for handling different types of clients are still needed.

3. Current facilities and equipment are inadequate to completely respond to the needs of the residents. The centers' current facilities are still not enough to fully respond to the needs of clients. Based on the results of the study, there is still a need to construct separate and customized facilities for different types of clients. Lack of vehicles was also persistently raised during the interviews. Nonetheless, addition physical structures are being constructed to respond to physical resource needs of the centers.
4. Moderate spending has been sustained over the years. Overall spending of residential care facilities from 2015-2018 has been at a moderate of 82-86%.
5. Evidence gathered indicate that resource generation mechanisms in the centers are in-place. Funding support from LGUs and resource generated through donations and coordination with partners helped the centers deliver the needs of the clients.
6. Actual cost of care estimates showed that clients in 50 DSWD residential care facilities received either *adequate or highly abundant* programs and services. Specifically, 24 or 38% of the facilities fall within the acceptable range of cost of care, while 26 or 41% of them have high cost of care.
7. Based on the findings, RSCC-CAR, Home for Girls FO III and X, Haven for Women-FO NCR, Haven for Women and Girls -FO CAR, RRCY-FO VIII, and Haven for the Elderly-FO IV-A have the most cost-effective programs and services in terms of rehabilitation outcomes.
8. Issues on slow procurement, financial and approval process continue to weigh down the operational efficiency of the centers.
9. Support and assistance by Standards Bureau, Protective Services Bureau and the DSWD Management were generally viewed positively by the informants. However, more active role from them are being sought by the study participants, especially in meeting the accreditation indicators.

Effectiveness

1. Despite the existence of challenges along resources and processes, these did not compromise the effectiveness of the services and interventions of the centers. Based on the available evidence, the services were implemented in a broadly effective fashion in majority of centers. However, consistent to the findings in the relevance section, accredited facilities appeared to be more effective than non-accredited facilities.
2. Overall, quality of service delivery was exhibited by the DSWD Residential Care facilities, except that some services were not delivered in a timely manner. Moreover, effectiveness of interventions on solving residents' issues appears to be weak in some centers.
3. Findings revealed that the facilities were generally successful in improving the quality of life among the residents. High ratings were recorded on safety, treatment of staff, and quality of care.

However, high proportion of residents expressed dissatisfaction on the frequency of visits and support received from their families. One of the primary factors which made family visits difficult is the location of the centers, given that the residents come from different provinces and sometimes from different regions. Similarly, lack of budget for transporting to the centers hindered the families to visit the residents.

4. Based on the results, the strongest points of the centers are provision of opportunities (e.g. education) and conduct of socio-cultural activities, support structures, and staff's skills. On the other hand, most of the issues frequently mentioned were about management, policies and processes.
5. Discrepancy between the provisions laid out in the operations manuals and the reality in practice have been observed. For instance, the manuals indicate that mentally ill individuals shall be transferred to more appropriate facilities, but in the current practice they are still being accepted in the centers. Also, minor victims are being admitted in Haven for Women.
6. Findings showed that gender can affect someone's admission to residential care facilities. It was found that in some instances, gays are not admitted in fear of risks of STD transmission among the residents. On the other hand, in terms of sexuality, it was noted that overall, centers differ in terms of managing sexuality issues of the clients. Varying approach to addressing gender/sexuality needs and issues of clients could be due to lack of clear policies and guidelines on how to deal with sexual expression and sexuality in residential care centers.
7. All clients coming from different religious, culture and ethnicity are respected. Findings also showed that religion is considered in the delivery of services. However, it was found that religious groups visiting the centers tend to recruit members and take this opportunity to change the religions of some clients.

Impacts

Considerable evidence showed that in majority of cases, positive effects from the services and interventions of DSWD Residential Care Facilities were felt by the clients. Residents affirmed that their behavior, outlook in life, self-esteem and health have significantly improved because of the support provided by the centers. Moreover, clients were most grateful about the knowledge and skills they gained from the centers, because these will be helpful and useful as they deal with the outside world after their discharge.

Sustainability

Sustainability of rehabilitation and reintegration efforts of the facilities have been found to be challenging because DSWD relies on other actors to continue to support the residents upon discharge. Specifically, sustaining the social services and provision of the discharged residents are largely dependent on the capacity and support of the Local Government Units and residents' families/relatives or foster families.

IV. RECOMMENDATIONS

In view of the findings presented, the following are recommended by the study team:

To Program Management Bureau

1. With the support of General Administration and Support Services Group, ensure that all institutional requirements of centers in order to operate efficiently are in place. The residential care facilities should be well-budgeted, have adequate physical resources and sufficient human resources in terms of competency and quantity.
2. Review the allocation of program cost against administrative cost and ensure that the clients are provided with sufficient services/interventions in monetary terms. In line with this, guidelines for setting cost of care per client (including dependents) need to be updated/revised.
3. Provide more specialized trainings especially for Houseparents to meet the competencies required in handling different types of clients.
4. The Program Management Bureau should develop, revisit and update the operations manuals of residential care facilities at the central level which would then be the bases of the facilities in developing their own manuals. This would standardize the implementation of programs and services under the residential care facilities.
5. Ensure inclusiveness of residential care programs and services to address concerns on gender/sexuality, disability and religion.
6. Ensure that critical services such as medical services are delivered in a timely manner. Services from health centers and other medical entities may also be maximized to support the medical needs of the clients.
7. Clear policies/guidelines in dealing with gender and sexuality should be established to address varying approach of the centers in addressing gender/sexuality needs and issues of clients.
8. Improve the participation of the families/relatives in the rehabilitation and/or recovery process of the clients. PMB/residential care facilities may provide transportation assistance to

families/relatives to encourage visits and participation of families and relatives in the centers' activities.

9. Establish more pro-active and stronger monitoring mechanisms for reintegration and after-care services for the discharged clients. Higher-level outcomes – such as reintegration and recovery of clients – should be reflected in the results frameworks of residential care clients and should be monitored to gauge the sustainability and effectiveness of interventions.
10. Revisit the accountability of higher management and Program Management Bureau in improving the accreditation status of the centers given that some of the accreditation indicators are beyond the center heads'/FOs' sphere of control. Office Performance Contracts of Program Management Bureau and Operations Program Group should reflect indicators on accreditation level of the centers.

To Standards Bureau

1. Together with PMB, establish a more active role in ensuring that all accreditation indicators are met by the residential care facilities. The residential care facilities should not be left on their own in complying with the standards. Follow through actions on the identified needs of the centers shall be facilitated, coordinated and relayed to the Program Management Bureau and Higher Management. More proactive and specific technical assistance in weak areas of the centers should be provided.
2. Strong coordination mechanisms between Standards Bureau and Program Management Bureau shall be established to avoid issues such as conflicting recommendations/messages to the centers.
3. Build a manual which would include explanations or interpretation of the accreditation indicators to avoid different interpretation and analysis of indicators and ensure more objective assessment of the centers' accreditation status.
4. Review the accreditation indicators. The accreditation indicators shall clearly distinguish the difference of centers with varying levels of accreditation.
5. Develop accreditation indicators that will focus on results/outcomes. Apart from institutional aspects, the accreditation tool shall include success indicators which would measure person-centered/client-level objectives---effectiveness of service delivery and ultimate effects of residential care facilities (e.g. rehabilitation, recovery and reintegration). Moreover, higher weights on outcomes and impacts rather than inputs, activities and outputs shall be established.

To Social Technology Bureau:

1. Range of the programs and services of the residential care facilities should be expanded to cover all cases experienced by the vulnerable sectors (e.g. elderly abuse cases, illegally recruited or trafficked minors). Moreover, interventions should be customized or modified based on the nature of cases to effectively address the dynamic issues and needs of the clients. In relation to this, additional facilities could be constructed to cater different types of residents. These strategies would strengthen the relevance and contribution of DSWD in protecting and promoting the rights of the vulnerable sectors.
2. As revealed by the findings, capacity and support of families/relatives are critical to the success and sustainability of rehabilitation/recovery/reintegration efforts of the centers. However, this assumption is often difficult to satisfy. With this, Social Technology Bureau could explore the possibility of developing a *family support program/intervention* -which could include parent education and financial assistance components- intended to assist and improve the capacity of families during the process of reintegration of discharged clients.

To Partner LGUs (and SWIDB):

1. Achievement of ultimate objectives of residential care programs and services is contingent to the cooperation commitment of Local Government Units in the implementation of after-care services. With this, LGUs should ensure that after-care services interventions are included in their plans and budget. On the other hand, SWIDB should also assess the LGUs based on their capacity to implement aftercare services.
2. In relation to the previous recommendation, proactive monitoring, provision of social services and livelihood/employment opportunities to the discharged clients, and to the whole household, shall be ensured by the LGUs. The neighborhood or the community where a discharged resident belongs to should also be mobilized to help in the reintegration process.

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Administrative Order 35, Series of 2003: Rehabilitation Indicators

Administrative Order 17, Series of 2008: Rules and Regulation on the Registration and Licensing of Social Welfare and Development Agencies and Accreditation of Social Welfare and Development Programs and Services

Administrative Order 09, Series of 2010: Guidelines of the National Inspectorate Committee for DSWD Centers and Residential Care Facilities

Administrative Order 15, Series of 2012: Amended Administrative Order No. 11 Series of 2007 Entitled Revised Standards on Residential Care Service

Program Management Bureau's Physical and Financial Reports on Residential Care Facilities

ANNEX

Residential Care Facilities with Acceptable Cost of Care		
Facility	**Field Offices**	**N**
RSCC	CAR, III, XI	3
Nayon ng Kabataan	NCR	1
Marillac Hills	NCR	1
Home for Girls	I, III (N.Ecija), III (Pampanga), IV-A, VIII, X, XII	7
National Training School for Boys (NTSB)	IV-A	1
Regional Rehabilitation Center for Youth (RRCY)	VIII, X	2
Haven for Women	NCR, I, VIII, IX	4
Haven for Women & Girls	CAR, IVA	2
Sanctuary Center	NCR	1
HE/A/GRACES	VI-A, XI	2
TOTAL		24

EVALUATION TEAM COMPOSITION AND RESPONSIBILITIES[15]

The Evaluation Team comprised the following:

Name of Group	Roles and Responsibilities	Actual Name of Responsible Person
Evaluation Team Leader	▪ Oversee the overall implementation of the evaluation study; ▪ Review the final evaluation report; ▪ Present the final report to DSWD management and stakeholders; and ▪ Seek management responses to the recommendations.	Assistant Secretary Joseline P. Niwane Director Rhodora G. Alday
Evaluation Task Manager	▪ Lead the implementation of the evaluation study; ▪ Review the evaluation report prepared by the Evaluation Specialist; ▪ Provide overall guidance in analysis of data; ▪ Lead the collection of the key documents and data; and ▪ Lead the dissemination of the report and follow-up activities after finalization of the report.	Ms. Cynthia B. Lagasca Mr. Aljo Quintans
Evaluation Specialist and Lead Writer	▪ Develop the evaluation design, questions and tools in consultation with key stakeholders; ▪ Prepare the report and ensure quality and reliability of the evaluation findings; ▪ Supervise (and conduct) data gathering activities ▪ Manage the recruitment of the evaluation support team members; and ▪ Lead in the coordination with the Data Gathering Team, Fieldwork Coordinating Team, and Evaluation Support Team.	Ms. Raquel O. Celeste
Technical Writers	▪ Provide support to the Lead Writer in processing the findings and writing the report.	Ms. Marianathe Kay Misa Ms. Angela Nartea Ms. Kristine Joy Loneza Ms. Zoe Dominique Cunanan
Data Gathering Team	▪ Provide support to the Evaluation Specialist in pre-testing of tools and actual conduct of data gathering activities. Activities will involve key informant interviews, focus group discussions, administration of survey, and on-site observations; ▪ Assist the Evaluation Specialist in refining the tools; ▪ Coordinate with the Fieldwork Coordinating Team and Facilitators on the logistics and administrative requirements for the data gathering activities; and ▪ Provide feedback report on the activities conducted.	Director Rhodora G. Alday Mr. Aljo Quintans Ms. Raquel O. Celeste Ms. Marianathe Kay Misa Mr. Louie Destacamento Ms. Angela Nartea Mr. Paul Paler
Fieldwork Coordinating Team	▪ Provide administrative and substantive technical support relative to the evaluation activities and work closely with the Evaluation Specialist and	DSWD Field Office M&E Focals Mr. Karlo Lim Ms. April Rocamora

[15] Terms of Reference: Final Project Evaluation for Ending SRGBV project in Malawi

Name of Group	Roles and Responsibilities	Actual Name of Responsible Person
	Data Gathering Team throughout the data gathering (e.g. venue, transportation, board and lodging and food requirements); and ▪ Identify key informants, FGD and survey participants, and site visit locations, and develop agreed schedule for visits and interviews; and ▪ Shall also collect data together with the data gathering team.	Ms. Marifil Jugal Ms. Liezyl Astodillo Mr. Dexter Samidan Ms. Mary Airezelle Carpio Mr. Paul Jessie Cruz Ms. Donna Osial Mr. John Piermont Montilla Ms. Lizbelle Marian Gonzaga Ms. Gloria Carmencita Sinoy Gimoto Ms. Girl Ley Arroyo Mr. Alfie Escalante Ms. Roselle Almayda Mr. Alnafe Tiblani Mr. Hasan Alfad Ms. Evita Jungao Ms. Imee Louise Canios Ms. Lois Marie Murillo
Evaluation Communications Specialist/s	Implement strategies to effectively communicate the evaluation findings to the DSWD management and stakeholders and to engage them to utilize the evaluation report (e.g. Evaluation study synthesis products, development of infographic materials, conduct of brownbag sessions, and other types of communication strategies)	Mr. Louie Destacamento and Mr. Paul Paler