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Private Sector Solutions to Public Health Needs



Private Sector Mobilization for Family Health (PRISM) Project
Completion Report

November 2009

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Private Sector Solutions to Public Health Needs

Private Sector Mobilization for Family Health (PRISM) Completion Report

Contract No. 492-C-00-04-0036-00

COVER PHOTO: Employees of the Chiquita Unifrutti Philippines/MADC Pineapple Plantation in Valencia City, Bukidnon, share a light moment during work. These employees work under the pineapple washing, weighing, and packaging sections of the facility. Chiquita Unifrutti is one of 500 companies that received assistance from USAID's private sector health project in improving availability and accessibility of family planning and maternal and child health information and service delivery.

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
AIPH	AARM-wide Investment Plan for Health
ANC	Antenatal care
ARMM	Autonomous Region in Muslim Mindanao
BANGON	Bohol Alliance of Non-Government Organizations
BCC	Behavior change communication
BCCI	Bulacan Chamber of Commerce and Industry
BEST	Business Enhancement Support and Training
BPO	Business process outsourcing
CLIN	Contract line item number
CPR	Contraceptive prevalence rate
CSR	Contraceptive self-reliance
CTU	Contraceptive technology updates
CYP	Couple-years of protection
DOH	Philippine Department of Health
DOLE	Philippine Department of Labor and Employment
EBM	Evidence-based medicine
EO	Executive Order
FDA	Philippine Food and Drug Administration
FHSIS	Field Health Service Information System
FIES	Family Income and Expenditure Survey
FP	Family planning
FPS	Family Planning Survey
FRCI	Foundation for Reproductive Care Incorporated
GATHER	G=Greet respectfully, A=Ask/Assess needs, T=Tell information, H=Help choose, E=Explain and demonstrate, R=Return and reinforce/refer
HIV	Human immunodeficiency virus
IMAP	Integrated Midwives Association of the Philippines
IMS	Intercontinental Medical Statistics (Health Philippines Inc.)
IMR	Infant mortality rate
IPHO	Integrated provincial health office
IR	Intermediate result
IUD	Intrauterine device
IV	Intravenous
LAPM	Long-acting and permanent methods
LEAD	Local Enhancement and Development for Health Project
LGU	Local government unit
LMM	Local market model
MAT	Moving annual total
M&E	Monitoring and evaluation
MCH	Maternal and child health
MDG	Millennium Development Goal
MMR	Maternal mortality rate

MOU	Memorandum of understanding
MWRA	Married women of reproductive age
NDHS	National Demographic and Health Survey
NGO	Nongovernmental organization
NSO	Philippine National Statistics Office
OC	Oral contraceptive
OTC	Over-the-counter
PBSP	Philippine Business for Social Progress
PCPD	Philippine Center for Population Development
PHD	Private Health Desk
PHIC	Philippine Health Insurance Corporation
PHO	Provincial Health Office
Php	Philippine peso
PNDF	Philippine National Drug Formulary
PPM	Private Practice midwife
PPP	Public-private partnership
PRISM	Private Sector Mobilization for Family Health
RH	Reproductive health
SBA	Skilled birth attendant
SFFAII	Socksargen Fishing Federation and Allied Industries Incorporated
SIA	Strategic intervention area
SMEs	Small and medium enterprises
SO	Strategic Objective
SOCOPA	South Cotabato Purse Seiners Association
STI	Sexually transmitted infection
STAR	Strategic Technical Assistance Resource program
TB	Tuberculosis
TMA	Total market approach
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

EXECUTIVE SUMMARY

In 2004, prior to implementation of the Private Sector Mobilization for Family Health (PRISM) project, approximately 2.5 million married women of reproductive age in the Philippines — around 17 percent of the total — had an unmet need for family planning services, on average bearing one child more than intended (National Demographic and Health Survey-NDHS 2003). The disparity contributed to high infant and maternal mortality rates and exacerbated the economic and social insecurity associated with rapid population growth.

In 2002, USAID began phasing out its contraceptive donations to the Philippines Department of Health (DOH) family planning program. The purpose was to align USAID support with the Philippine government’s contraceptive self-reliance (CSR) strategy, which sought maximum national self-reliance in providing family planning services. To build local capacity to provide contraceptives, USAID launched PRISM in September 2004. It aimed to engage the private sector in providing family planning services and products to segments of the population that could pay; simultaneously filling the gap left by the withdrawal of donor assistance and enabling the public sector to better target and serve the poorest. Three mechanisms were designed to achieve this goal:

- Strengthen initiatives to provide access to family planning (FP) and maternal and child health (MCH) products and services in or through the workplace.
- Develop a viable commercial market for family planning products.
- Build the capacity of private sector health care providers to provide high-quality, affordable FP/MCH products and services.

PRISM Achievements

- *Contraceptive self-reliance.* Between 2003 and 2008, the private sector played an important role in sustaining the contraceptive prevalence rate (CPR) at approximately 34 percent by filling the supply gap resulting from the phaseout of donated FP commodities. In fact, the CPR for modern methods obtained from the private sector showed an increasing trend, almost doubling from 2003 to 2008. For example, according to the NDHS, the use of unsubsidized (private sector) pills increased from 38.6 percent in 2003 to 73.9 percent in 2008, and of unsubsidized injectables from 7.5 percent to 12.8 percent over the same period.

CPR and CYP Defined

In this report, the contraceptive prevalence rate (CPR) is defined as the percentage of married women using any form of contraception.

Couple-years of protection (CYP) is the estimated protection provided by contraceptive methods during a one-year period based on the volume of all contraceptives sold or distributed to clients during that period.

- Provision of high-quality services by the private sector.* Due to the increasing market share of PRISM-supported products, the project team noted a corresponding trend in couple-years of protection (CYP) from the sale of these products. PRISM exceeded its target of 592,992 by almost 32 percent, with the greatest increase between Years 3 and 4. Project impact (FP method use) can best be measured at the level of the ultimate beneficiaries, such as company employees and midwife clients. Modern FP use among a total of 343,948 company employees reached by PRISM showed a 16.8 percent increase between the start and end of the project, while traditional FP methods declined by 28 percent among the same group. PRISM worked to generate increased demand for FP services using a two-pronged approach: widespread dissemination of information on FP services, and improving the capacity of service providers (especially private sector midwives) to provide FP counseling. Workplace programs and clinics were the predominant channels through which PRISM worked to disseminate FP/MCH information.
- Strengthening demand for and supply of private sector MCH services.* MCH services, added in Year 3 of the project, picked up quickly in both volume and caseload per provider. The number of pregnant women with at least four antenatal care (ANC) visits in Year 4 quadrupled to 20,766 from the Year 3 baseline value (4,133), and in Year 5, the number was 15,700 or 75 percent of Year 4 levels, after only two operating quarters. Likewise, the caseload per trained provider increased from around 3 per provider per month during Year 3 to 12 per provider per month by Year 5.
- Sustainability of private sector providers.* PRISM trained a corps of private practice midwives with entrepreneurial skills and linked them to the government insurance corporation, PhilHealth. This led to a large flow of PhilHealth resources to private service providers, a key component of sustainability. Between Year 2 and Year 5, the number of claims filed for reimbursements from PhilHealth for covered FP services jumped from 2,892 to 21,328 in PRISM's strategic intervention areas (SIAs). Most claims were for MCH services. This was to be expected, since the out-of-pocket cost of FP services is much lower than the cost of MCH services, especially birth deliveries.
- Development of local market models for effective public-private partnerships (PPPs) for family health.* Although PRISM's main focus was the private sector, increased private sector activity began to involve local public health systems. Some localities responded vigorously to the commercial opportunities for meeting family health needs. This led to the recognition that some of PRISM's 32 SIAs could become models for local market development. In Year 5, the team embarked on a more focused local market approach in 12 of the 32 strategic intervention areas. Referred to as Local Market Model (LMM) areas, these 12 localities established a former PRISM grantee or partner that had expressed interest as an "LMM driver," leading local market initiatives for family health in that geographic area. Most LMMs were led by private sector or civil society organizations. In some LMM areas, however, public-private FP initiatives were spearheaded by local government or government-created groups. Through the LMMs drivers, PRISM worked to secure private sector presence

in FP policy, commodity procurement, service delivery, and monitoring and evaluation (M&E) in public health systems and programs.

The Way Forward

- *Strengthen the DOH and Department of Labor and Employment (DOLE) role in promoting workplace FP/MCH programs to companies and cooperatives*, with an eye to achieving the right mix between regulation and technical assistance. Government must budget for capacity building. There is also a need to harmonize DOH and DOLE M&E indicators and tools. Relationships with local government units should be strengthened to implement national initiatives locally. Enhanced networking with private sector partners will help sustain successful FP/MCH programs and replicate them in more companies.
- *Develop the enabling environment for contraceptive market initiatives*. Increased pharmaceutical company activity has stimulated the demand for low-priced contraceptives among the poor and very poor segments of the population, but more can be done. Moving forward, the DOH, as the principal agency responsible for ensuring access to basic public health services, may consider providing presence, direction, and influence to grow the low-priced contraceptive market. This includes tracking commercial sales data, market trends, market segmentation, and pricing to gain better knowledge of the commercial market; identification of factors that increase CPR; and development of appropriate interventions to fill identified gaps in service delivery or supply.
- *Promote a business orientation among family health private practitioners*. Private sector midwives should be considered a key component in government strategy implementation. They can provide a rapid, low-cost, sustainable response to the strategy at the community level, offering a good fit with current government health initiatives. Efforts should be continued to promote a business orientation for private practice midwives tied in with Philippine Health Insurance Corporation (PHIC) accreditation and development of a variety of birth home business models adapted to specific local circumstances.
- *Promote a comprehensive approach to private sector mobilization*.
 - Mainstream behavior change communication (BCC) in all components of PPPs to expand FP/MCH services.
 - Promote private sector involvement through a consultative and participatory PPP approach from policy to implementation at both at the national and local levels.
 - When working with national and local government to develop and implement market-driven initiatives, focus on policy formulation and guidelines.
 - Promote synergy and coordination among activities related to markets (supply), communications (demand), and partnerships (policy) to achieve project objectives at the national and local levels.

I. BACKGROUND

Toward Philippine Self-Reliance in FP/MCH Service Provision

At the start of the PRISM project in 2004, only half (49 percent) of married Filipino women were using any family planning method. In the Autonomous Region in Muslim Mindanao (ARMM), the regional CPR was only 12 percent. Although the private sector was significantly larger than the public sector in terms of service delivery, the vast majority (67 percent) of contraceptives were supplied by the public sector. The Philippine Government encouraged couples to make their own decisions about contraceptives, but it also heavily promoted natural family planning methods.

The USAID Response

For decades the U.S. Government provided the Philippines with contraceptive commodities as part of its development assistance programs in health. After the Philippine Government adopted a contraceptive self-reliance strategy, USAID began phasing out contraceptive donations to the DOH in 2002. Launched in September 2004, PRISM was intended to engage the private sector in providing FP products and services to those able to pay, enabling the public sector to better target and serve poor and very poor. An MCH focus was added to PRISM in project Year 3.

PRISM – A Pioneer

“PRISM was the first concerted effort in the country to move substantial numbers of FP/RH/MCH users and services out of their traditional home in the public sector into different private sector settings.”

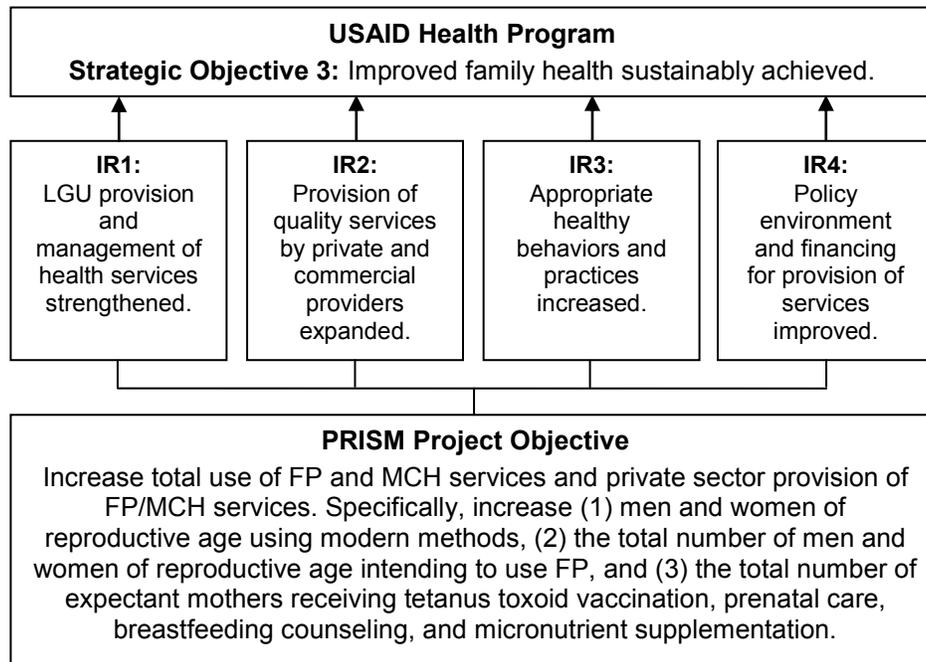
— *End-of-Project Evaluation Debrief*

PRISM Results Framework

The results framework (next page) illustrates how PRISM supported USAID/Manila’s Strategic Objective (SO) 3, “Improved family health sustainably achieved,” and intermediate result (IR) 2, “Provision of quality services by private and commercial providers expanded.” To achieve the overall project objective of increasing total use of FP/MCH services and increasing the private sector’s share in service provision, activities were designed around the following key results:

- Workplace initiatives to provide FP/MCH products and services strengthened.
- Viable commercial market for FP products developed.
- Private sector health care provider capacity to provide high-quality, affordable FP/MCH products and services strengthened.

Although each component was distinct in its definition, the components were integrated at the implementation level. PRISM used a set of six criteria to identify provinces and cities (SIAs) with the greatest potential for immediate and lasting impact.



SIA were selected based on the status of phaseout of donor contraceptive provision; population size and CPR; poverty rate; level of urbanization; the level of local government unit (LGU) support for FP initiatives; and the presence of other USAID-supported projects, including Local Enhancement and Development for Health (LEAD) or the Social Acceptance Project. PRISM identified and worked in 32 SIAs, as follows:

- *Luzon*: Pangasinan, Baguio City, Bataan, Pampanga, Olongapo City, Tarlac, Bulacan, Batangas, Quezon City, Cavite, Laguna, and the National Capital Region
- *Visayas*: Iloilo, Negros Occidental, Negros Oriental, Cebu, Bohol, and Leyte
- *Mindanao*: Davao del Sur, Davao del Norte, Saranggani, General Santos City, Cagayan de Oro City, Agusan del Norte, Lanao del Sur, Lanao del Norte, South Cotabato, Compostela Valley, Sharif Kabunsuan, Bukidnon, Maguindanao, and Basilan

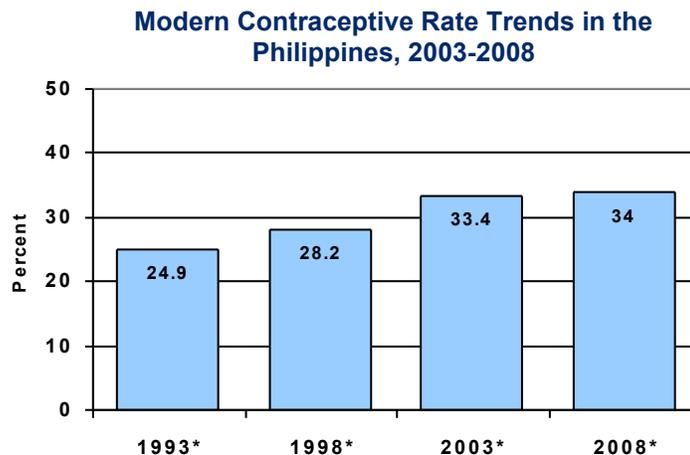
In the early stages of implementation, PRISM implemented activities almost solely along component lines. Workplace initiatives, commercial market activities, and private practitioner initiatives were originally pursued as separate, stand-alone efforts through both direct technical assistance and grants. In Year 3, PRISM began to advance the concept of the Total Market Approach (TMA) — looking at the strengths and weaknesses of partners in providing products and services to poor segments of the population. In Years 4 and 5, the project implemented the Local Market Model (LMM) approach, which aimed to institutionalize comprehensive PPPs integrating all partners and business operations in SIA cities and towns. The LMM focused on policy, service delivery, procurement, M&E, and sustainability. The results of PRISM’s TMA work are described under the three main strategic areas (workplace, market, and private practice initiatives, presented in Chapters III, IV, and V, respectively). The results of the LMM approach in representative SIAs are described in Chapter VI.

II. PRISM'S ACHIEVEMENTS

Improving Family Health through Private FP/MCH Service Provision

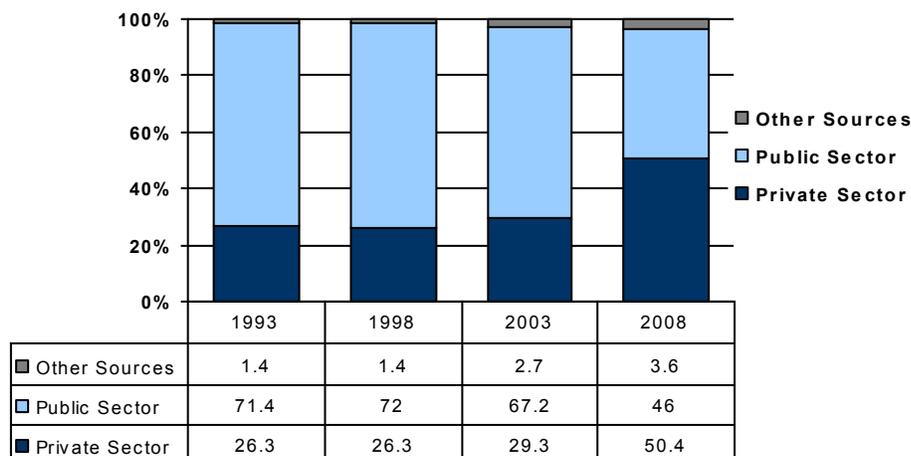
Contributions to USAID Strategic Objective 3

Between 2003 and 2008, the private sector played an important role in sustaining the contraceptive prevalence rate (CPR) at approximately 34 percent by filling the supply gap resulting from the phaseout of donated FP commodities. In fact, the CPR for modern methods obtained from the private sector showed an increasing trend, almost doubling from 2003 to 2008. For example, according to the NDHS, the use of unsubsidized (private sector) pills increased from 38.6 percent in 2003 to 73.9 percent in 2008, and of unsubsidized injectables from 7.5 percent to 12.8 percent over the same period.



Today, more people are buying FP products of their choice from private stores or health facilities and are no longer dependent on government for their family planning needs.

Percent Distribution of Married Women Using Modern FP Methods by Most Recent Source of Supply, 1993-2008



Achievements under USAID IR 2 (PRISM Indicators)

PRISM met and surpassed the majority of its end-of-project targets. Results achieved against PRISM's core indicators are presented below.

PRISM Outcome Indicators				
No.	Indicator	Baseline (Year 1)	End of Project Target	End of Project Results
1	Number of deliveries with a skilled birth attendant (SBA) in USG-assisted facilities	8,696	26,966	44,899
2	Number of cases of child diarrhea treated in USG-assisted programs	856	5,406	7,925
3	Number of people who availed of FP and MCH services through USG-supported financing arrangements	2,892	118,187	117,026*
4	Number of pregnant women with at least four (4) antenatal care (ANC) visits by skilled providers from USG-assisted facilities	4,133	17,216	40,599
5	Couple-years of protection (CYP) in USG-supported programs	37,590	592,992	784,762
6	Number of people that have seen or heard a specific USG-supported FP/RH message	1,202,951	1,681,230	3,329,684
7	Number of individuals counseled for FP/RH as a result of USG assistance	2,157	70,581	118,790
8	Average increase in the proportion of employees in participating companies/cooperatives reporting use (or partner's use) of a modern FP method	n/a	10%	16.8%
9	Proportion of pregnant employees (or wife of employees)/mothers of infants (0-12 months old) provided MCH information and/or services	n/a	60%	87.7%
10	Sales volume (Php) of hormonal contraceptives (oral cycles and injectables)	10.32 million	87.23 million	67.29 million*
11	Sales volume (pieces) of newly introduced IUDs	n/a	100	802

* NOTE: IMS data is available for only two quarters of the last project year.

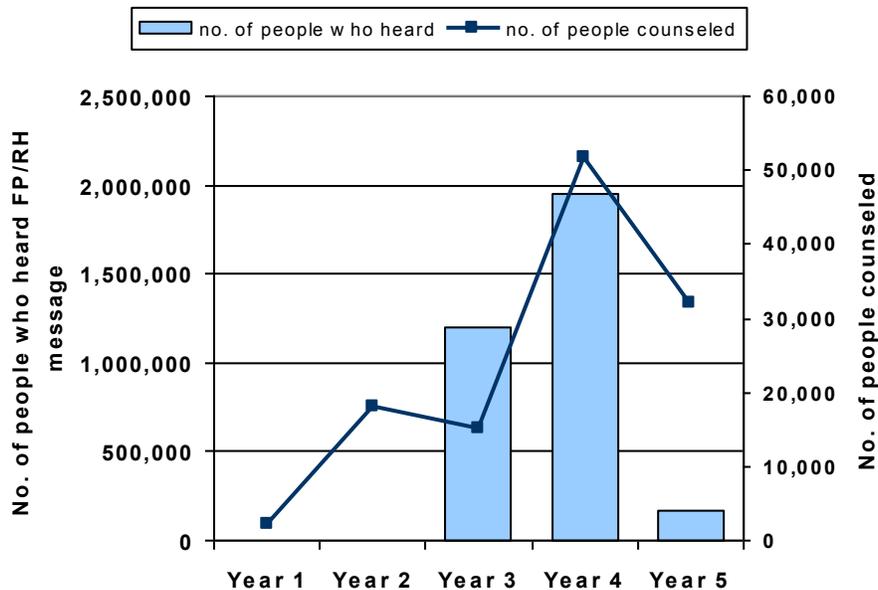
Family Planning

The team noted an increase in couple-years of protection (CYP) due to the increasing market share of PRISM-supported products. The project exceeded its CYP target of 592,992 by almost 32 percent, with the greatest increase occurring between Years 3 and 4. CYP levels continued to increase in Year 5.

Project impact (FP method use) can best be measured at the level of the ultimate beneficiaries, such as company employees and midwife clients. Modern FP use among a total of 343,948 company employees reached by PRISM showed a 16.8 percent increase between the start and end of the project, while traditional FP methods declined by 28 percent among the same group.

PRISM worked to generate increased demand for FP services using a two-pronged approach: widespread dissemination of information on FP services, and improving the capacity of service providers (especially private sector midwives) to provide FP counseling. Workplace programs and clinics were the predominant channels through which PRISM worked to disseminate FP/MCH information.

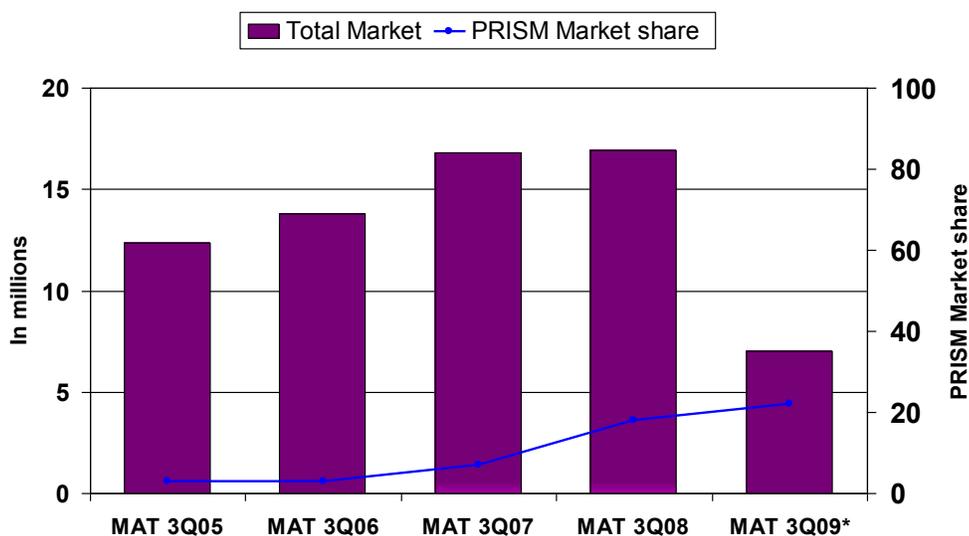
Generating Demand: Number of People Who Received FP/MCH Information and FP Counseling, Years 1 to 5



The number of people receiving FP/reproductive health (RH) information and counseling reached its peak in Year 4, when grant projects across all 32 SIAs were in full implementation. This was primarily the result of delivering FP/RH messages through mass media channels. In Year 5, with the closeout of grants and the concentration of efforts in LMM areas, data collection was refocused toward actual FP service delivery, namely dispensing of commodities, provision of clinical methods, and setting up referral systems (where services are unavailable in-plant).

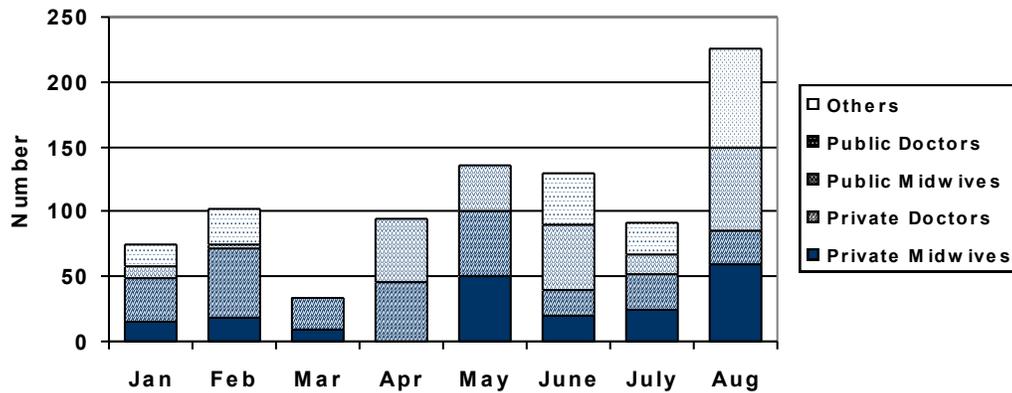
On the supply side, PRISM supported grants to distribute affordable contraceptive products through pharmaceutical companies. As indicated below, the data show that the market share of PRISM-supported products increased from a baseline of 3 percent to 22 percent.

**Ensuring the Supply: Sales of Hormonal Contraceptives,
(Total Market and PRISM-Supported Products)**



**NOTE: IMS sales data and grantee internal data are for two quarters of the year only.*

IUD Sales, January-August 2009

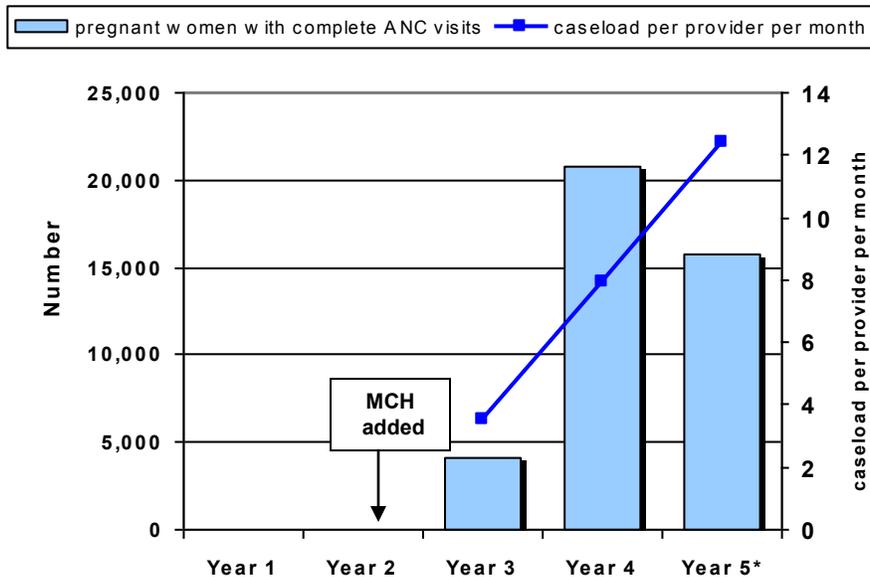


A small grant (three months) supporting distribution of intrauterine devices (IUDs) via private midwives exceeded its target of 100 units, with total sales of 802 units.

Maternal and Child Health

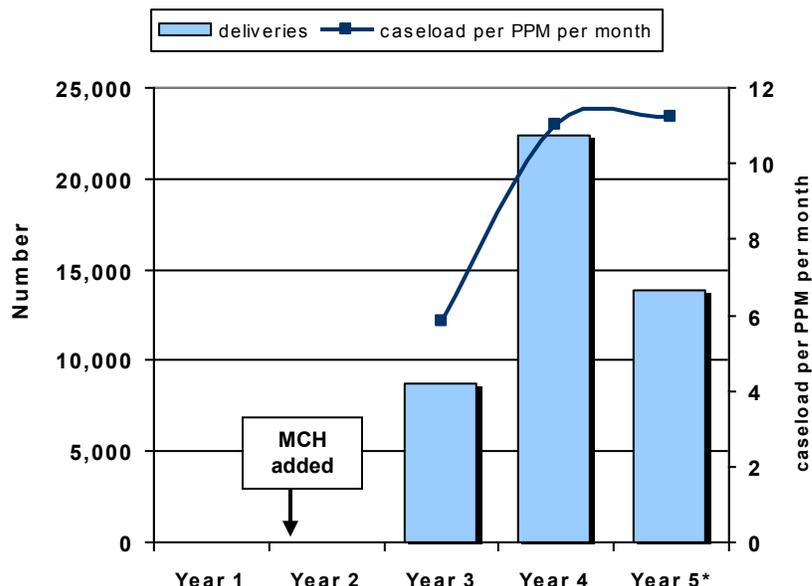
MCH services, added in Year 3, picked up quickly in both volume and caseload per provider. The number of pregnant women with at least four antenatal care (ANC) visits in Year 4 quadrupled to 20,766 from the Year 3 baseline value of 4,133, and in Year 5, the number was 15,700, or 75 percent of Year 4 levels, after only two operating quarters. Likewise, the caseload per trained provider increased from around 3 per provider per month during Year 3 to 12 per provider per month by Year 5.

Pregnant Women with ANC Visits, PRISM-Assisted Providers, Years 3 to 5



* NOTE: Year 5 data is from two operating quarters.

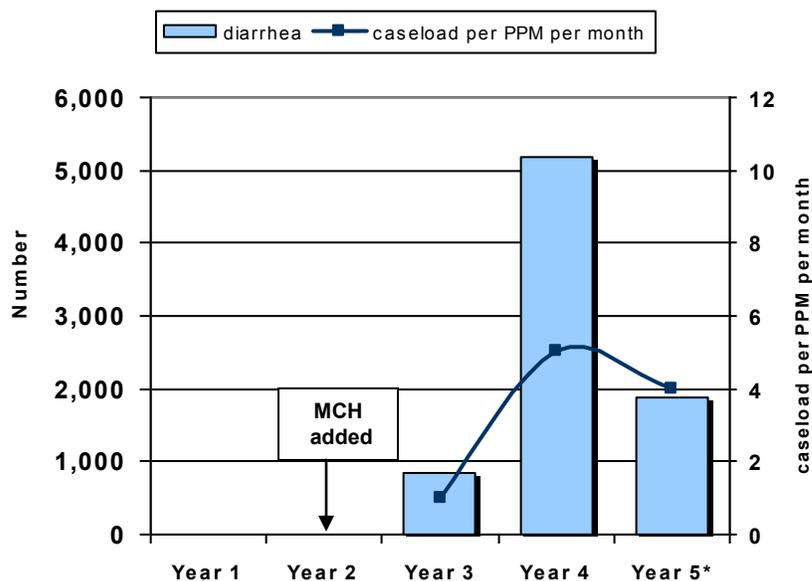
Trend of Deliveries Attended by PRISM-Assisted Providers, Years 3 to 5



The indicator for the number of deliveries attended by PRISM-assisted providers mirrored the trend in the number of pregnant women with complete ANC visits. However, the caseload leveled off from Year 4 to Year 5 at 11 deliveries per month per provider, as shown above.

The number of diarrhea cases seen and treated by PRISM-trained providers was also significant, as shown in the figure below.

Trend of Diarrhea Cases Treated, PRISM-Assisted Providers, Years 3 to 5

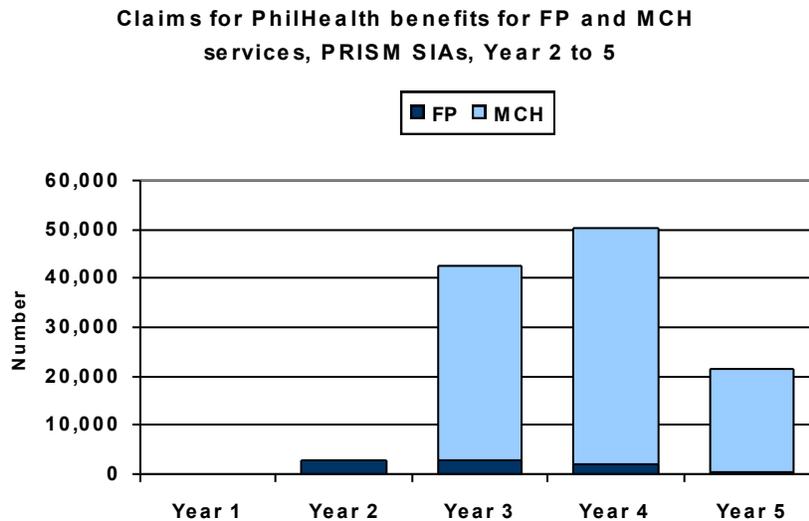


* NOTE: Year 5 data is from two operating quarters.

Financing FP/MCH Services

PRISM demonstrated a large resource flow from the government insurance corporation, PhilHealth, to private service providers, a key component of sustainability. As shown below, the number of claims filed for reimbursements from PhilHealth for covered FP services jumped rapidly. Most claims were for MCH services. This is expected, as cost of FP services, easily shouldered via “out-of-pocket,” is quite minimal compared to MCH services, especially birth deliveries.

Between Year 2 and Year 5, the number of claims filed for reimbursements from PhilHealth for covered FP services jumped from 2,892 to 21,328 in SIAs.



III. GROWING THE MARKET FOR FAMILY HEALTH

Workplace Platforms for Delivering Family Health Information and Services

Situation

In 2005 the total Philippine labor force reached 35.1 million,¹ of whom an estimated 13.2 million were in the private sector. Approximately 50 percent of these workers were women. The 2004 Family Planning Survey estimated that only 36 percent of gainfully employed married women of reproductive age (MWRA) used modern contraceptive methods. Among working women, unmet need for family planning was high. The 2003 NDHS reported that 66 percent of employed married women of reproductive age did not want more children, yet 38 percent of them were not using any form of contraception.

The National Statistics Office (NSO) reported approximately 825,000 registered private enterprises in the Philippines. Only a few of these enterprises (4,125, or 0.5 percent) were large companies, but they employed a significant 29 percent of all workers in the private sector. Large companies provided strategic targets for reaching a sizable segment of the population with an unmet need for family planning and other health services. They provided the organizational structure needed to institute FP programs and were mandated by Article 134 of the Labor Code to deliver certain basic health services to their employees.



Employees of Smart Shirts, one of 500 companies supported by USAID, can turn to a USAID-trained peer or clinic staff for FP/MCH information.

Challenges and Opportunities

A PRISM family planning practice and interests mapping exercise of 1,040 large companies in 2005 (implemented by Philippines Business for Social Progress-PBSP) revealed that only 44 percent (462) had health programs, 14 percent (142) of which included FP services. Of the companies with FP services, only 5 percent (55) had written FP policies. The survey revealed that 23 percent of large companies were interested in setting up workplace programs for FP services but needed technical assistance to do so.

¹ Philippine Labor Force Survey 2005, National Statistics Office.

Another independent survey of business process outsourcing (BPO) companies, such as call centers, where the workforce comprises predominantly younger employees of reproductive age, showed better results. Implemented in 2006 by the Philippine Statistical Association, the survey showed that around 38 percent of call centers wanted to set up new FP/MCH programs or improve their existing health programs.

Projecting the PBSP survey results to the universe of more than 4,000 registered large companies, PRISM estimated there were 920 large companies (23 percent of 4,000) interested in implementing an FP program if they were provided with tools and expertise. By Year 2, PRISM's focus began expanding to include cooperatives and small or medium enterprises.

Strategies and Activities

PRISM introduced FP/MCH programs in the workplace through a number of strategies and activities.

- *Development of a program model and tools.* Based on a review of lessons from earlier efforts in workplace-based FP services by the Philippine Center for Population and Development (PCPD),² PRISM derived a model for pilot testing in various industries and geographic settings. The program model consisted of (i) leadership commitment explicitly declared in a written FP policy; (ii) making FP/MCH services available in the workplace and/or through a referral system; (iii) mechanisms to finance the provision and use of FP/MCH products and services either by company, through a cost-share with employees, or through health insurance or health maintenance organization coverage; (iv) engaging internal and/or external institutions and management systems to support program implementation; and (v) creating policy and financial mechanisms to ensure sustainability. This framework allowed flexibility for companies to add other health services related to HIV/AIDS, avian flu, and tuberculosis (TB), among others.
- The project developed training manuals to enable the above conditions to be realized. These are:
 - *Managing Family Health Programs in Workplaces.* This is a guide for companies on how to set up, manage, and monitor an FP/MCH program. It includes M&E tools to generate baseline data and track program progress, including an FP/MCH needs assessment survey to gauge employee needs; an FP index to determine the kinds of services currently available in the workplace; a protocol for cost-benefit analysis; and M&E tools and software designed for quarterly project monitoring.

² USAID assisted PCPD in establishing family planning programs in selected companies, creating a network of midwife clinics, and helping an NGO set up family health clinics as a way to expand access to FP and MCH services through the private sector.

Championing Employee Health

Corporate wellness program helps workers have a better life.



Photo: PRISM/Deo Bugaoisan

Free of the anxiety of an unplanned pregnancy, Lopez Group employee Ryan Ramos and his wife Lisa can now concentrate on the challenge of providing for the needs of their four children.

“Our partnership with USAID allowed us to acquire the technology and know-how to implement a corporate wellness program that would deliver to the Lopez Group of employees a wide scope of options in family health.” — Oscar M. Lopez, Chairman and CEO, Lopez Group

Ryan Ramos, 27, walks with the quiet confidence of a man in better command of his life. Ryan recently had a non-scalpel vasectomy after he realized that his monthly salary of \$288 is barely able to provide for the basic needs of his family, which includes himself, his wife, and their four children ages 5, 3, 2, and 1. Lisa, his 23-year-old wife, is proud of his decision. “He cares for me and the children a lot, that’s why he had the procedure,” she says.

In partnership with USAID, the Lopez Group of Companies — one of the largest business conglomerates in the Philippines — made it possible for employees like Ryan to learn about various family planning methods available to him and his wife and receive appropriate counseling and services on the method of their choice.

In 2006, the Lopez Group Foundation was awarded a \$41,600 grant from USAID to set up workplace family health programs in five member companies, targeting a predominantly male workforce of approximately 7,000 employees. The grant included assistance to build the capacity of the medical staff of the Meralco Corporate Wellness Center to provide an in-house clinic for all Lopez Group member companies.

Eventually, four doctors were trained to become certified providers of non-scalpel vasectomy and nine nurses became certified family planning counselors. USAID then linked the center with the FriendlyCare Foundation, also a USAID-supported service organization, as a referral clinic for family planning services and products not available in the center. Having more than 100 volunteer employees trained as peer educators, the Lopez Group launched educational campaigns to raise acceptance of family planning as a healthy practice. More than 1,000 male workers, including Ryan, attended the seminars and orientations.

Inspired by the project’s initial success, the foundation used its own resources to expand to nine more companies with a combined workforce of 5,000 and continued its partnership with USAID. To help with the expansion, USAID linked these companies with resource persons from the government’s labor and employment agency and a medical association and trained them to help companies implement family health programs in the workplace.

- *Peer Education*.³ This is a guide to enable selected employees to provide responsive and medically correct information on FP/MCH, address barriers to action, negotiate for and support health-promoting behaviors, and make appropriate referrals to qualified service providers.
 - *FP/MCH for Nurses*. This manual updates the clinical knowledge and skills of company nurses to provide FP/MCH counseling and services.
 - *Contraceptive Technology Updates for Doctors*. This manual updates the clinical knowledge of company doctors on FP/MCH.
- *Capacity building for partners to set-up FP/MCH programs*. Through a grants program, PRISM worked with business associations, nongovernmental organizations (NGOs), human resources management groups, and a foundation to engage the private sector in FP/MCH workplace program implementation. A total of 30 organizations⁴ were engaged to promote and implement FP/MCH workplace programs. This resulted in the following:
 - FP/MCH programs were implemented in 458 companies.
 - 1,715 human resources officers, rank-and-file employees, health providers, and managers from participating companies were trained as members of family health management teams.
 - 2,128 volunteer employees were trained as peer educators.
 - 530 company doctors and 444 company nurses were trained in PhilHealth FP and maternity care packages, advocacy to set up breast milk collection or breastfeeding rooms, and setting up referral systems with private midwives and doctors for services that could not be delivered in the workplace.
 - *Ensuring program sustainability through policy, institutional, and association support*. In Year 4, PRISM introduced its Strategic Technical Assistance Resource (STAR) program to expand the range of technical assistance available to firms and cooperatives interested in investing in FP. The project encouraged companies to write policies integrating FP/MCH into the standard benefits package for employees. These policies defined the coverage of each FP/MCH program and provided budgetary allocations for program implementation, including service provision and management support.

³ The curriculum emphasized behavior change through interpersonal communication (one-on-one and group sessions) to help coworkers make independent decisions to meet their FP/MCH needs.

⁴ Twenty seven grantees provided technical assistance to firms and cooperatives, two specialized groups provided training of trainers to grantees and medical service providers, and one umbrella organization initiated an annual awards program to recognize FP program excellence in companies. Among these grantees, only four had prior experience with health-related activities. A total of 458 companies and cooperatives participated in the project; 51 percent of these belong to the manufacturing industry.

Clicking Their Way to Better Health

For call-center companies, protecting employee health is good business.



With assistance from USAID, Sitel-Baguio is reaching out to young employees to help them improve their future by protecting their health today.

“We’re committed to keeping our employees healthy and productive at work. But we’ve got to talk their talk and find the means to get them into the program in a way that’s acceptable and relevant to them.” — Olivia Mandapat, Sitel-Baguio company doctor

Challenge

The number of call centers in the Philippines is growing rapidly as more and more international companies outsource customer call services. Attracting predominantly recent college graduates and young professionals, call centers provide an environment for social interactions that can lead to risky health and sexual behaviors. A survey of 14 call centers indicated that 74 percent of employees had had sexual relations. Most were single (68 percent) and of childbearing age (99 percent), with almost half (47 percent) practicing unsafe or unprotected sex.

Initiative

USAID is helping call-center companies keep their competitive edge in this global business by working with owners and managers to protect the health of their employees through family health programs in the workplace. Sitel-Baguio, one of 18 major call-center companies that received technical assistance from USAID, used its intranet to educate employees on reproductive health and other health concerns. Employees can approach trained volunteer peer educators or clinic staff for more information on reproductive health issues and services. In clinics and in designated areas, volunteers and health providers confidentially inform their colleagues about responsible decision-making in sexual and reproductive health.

Results

More employees now visit the company clinic for FP/MCH consultations, counseling, and referral. Clinic records show that about 800 female employees received counseling assistance on FP. For the period July to December 2008, the number of FP users rose by 11 percent. The number of pregnancy notifications declined considerably from 47 to 28 within just a year of program implementation.

- *Through the LMM and PPPs*, the project encouraged business associations and local governments to work together and promote FP/MCH to other companies operating in the same areas. At the national level, in Year 4 PRISM signed a tripartite agreement with the DOH and DOLE to promote joint programs to support FP/MCH workplace programs. The two agencies defined their roles in providing technical assistance providers for FP/MCH workplace programs and issued two policies to guide joint activities in this context (DOH Administrative Order 2008-0012 and DOLE Advisory No. 3 Series 2009).⁵ The project also trained more than 100 DOH and DOLE staff on providing technical assistance to private firms to implement workplace FP/MCH programs.

Results

- *Private sector participation.* The tables below show the scope of workplace programs over the five-year project period. PRISM reached a total of 518 firms and cooperatives covering a workforce of 353,948. Most of the firms with large workforces were in Luzon. Most firms fell into the “large” category (73 percent), with 10 percent classified as small or medium-sized enterprises (SMEs) and 11 percent as cooperatives.

Number of PRISM Participating Firms/Cooperatives and Ultimate Beneficiaries

Region	Firms/Cooperatives	Employees
Luzon	264	177,040
Visayas	132	124,704
Mindanao	115	48,196
ARMM	7	4,008
Total	518	353,948

Types of PRISM Participating Firms and Cooperatives

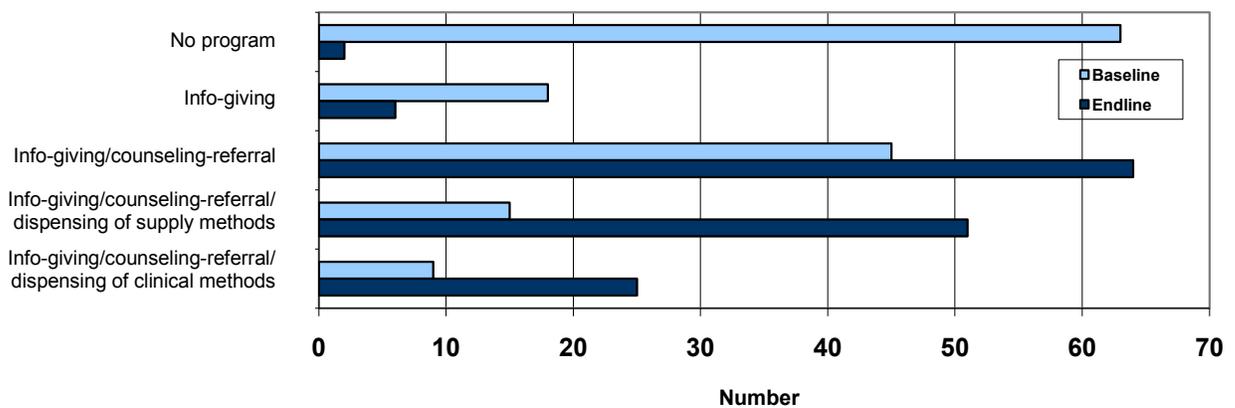
Region	Large Firms	SMEs	Coops	Business Support Orgs.	Size	Total
Luzon	225	29	4	0	6	264
Visayas	87	6	36	0	3	132
Mindanao	62	25	23	3	2	115
ARMM	5	0	0	0	2	7
Total	379	60	63	3	13	518

⁵ Please access DOH AO 2208-0012 at the DOH Web site (www.doh.gov.ph) and DOLE Advisory No. 3 Series 2009 at the DOLE Web site (www.dole.gov.ph).

Improved service availability. This section analyzes project data from 150 companies that participated in the program.

- *Progress on the FP Index.*⁶ Where almost no FP/MCH workplace programs existed at the onset of the project, the number of companies in the “no program” category dramatically diminished over the course of PRISM. Many companies began providing FP/MCH services such as counseling, referrals, dispensing contraceptives, and offering clinical long-acting and permanent methods (LAPM). Assisted companies now provide a wider range of FP services to employees in the workplace or through a referral system.

Distribution of Companies by Service Type, Baseline, and Endline



⁶ The Family Planning (FP) Index is a planning tool used to evaluate program type (O=no program, A= complete services, including voluntary surgical sterilization); the comprehensiveness of services available; and progress from a baseline (Month Zero) to one year or more after program initiation. This tool was used prior to and after PRISM implementation to measure progress. A positive change in the FP index indicates improvements in the components it measures, including the mix of services, the presence of service providers, and the presence of trained personnel to manage the program.

- *Family planning information.* Overall, the percentage of the workforce in targeted companies who had received (or were aware of) FP information increased from 77 percent at the onset of PRISM to 91 percent at the close of the project. A significant shift in the source of FP information was observed, moving from less reliable sources of information, such as friends/colleagues or boyfriend/girlfriend, to qualified personnel trained by FP/MCH. This clearly indicates a positive change in information-seeking behavior.

Source of FP and MCH Information, Baseline and Endline Surveys

Source of Information	FP (%)		MCH (%)	
	Baseline	Endline	Baseline	Endline
Peer educators	20.9	34.7	19.8	46.3
Company nurse/doctor	13.1	36.0	45.9	45.1
HR personnel	3.5	10.4	9.8	19.4
Friends/colleagues	12.0	16.0	31.9	18.7
Boyfriend/girlfriend	17.6	7.8	2.7	1.9

- *Improvement in contraceptive prevalence rate (CPR).* In companies that instituted FP/MCH workplace programs under PRISM, a notable increase in modern contraceptive prevalence rate (CPR) — defined as the proportion of employees using a modern method of contraception — was observed among the workforce.⁷ Provision of information on available FP methods and where to access services and products, in conjunction with provision of services and products, contributed to an increase in the uptake of modern methods of contraception and a decline in the percentage of individuals using traditional methods or no methods.

Prior to PRISM, among the workforce of PRISM-supported companies, 41 percent of married women were already using modern contraceptives. By the end of the project, 51 percent of married women were using modern contraceptives. This level is considerably higher than national numbers, where a national survey in 2006 reported 37 percent of gainfully employed women using modern CPR, and the gain also exceeds the 0.6 percent increase in modern CPR among this population reflected in the preliminary data from the 2008 NDHS. The drop in CPR for traditional methods is a major contribution of PRISM, especially when viewed against the preliminary data from the 2008 NDHS showing that CPR for traditional methods increased by 1.2 percent. PRISM successfully shifted employees in assisted companies to more effective methods of contraception.

⁷ The definition of CPR used is the proportion of married women who are using any method of family planning.

Making Time for Health

Daily wage workers benefit from employer investments in family health programs.



Photo: PRISM/Tanya Hisanan

Angelie Nalupa, a daily-wage earner at BQ Mall in Bohol, no longer takes a whole day off from work for her prenatal checkups. With assistance from USAID, she is in a better position to plan her next pregnancy.

Alturas and BQ Mall reap a return on their investments with fewer employee absences due to outside health checkups. Couples are able to avoid unplanned pregnancies, and consequently, workers avail less maternity and paternity leave.

Taking time off for health is no easy decision for daily-wage earners like Angelie Nalupa. When Angelie was pregnant with her first baby, prenatal checkups meant waiting in line for hours at the Bohol provincial general hospital. Each one also meant a whole day of missed work with no pay. Earning less than \$6 a day, Angelie and others like her struggle to provide for their families' basic needs.

With help from USAID, the Alturas Group of Companies (Alturas) and the Best Quality (BQ) Mall in Bohol made family health information and services more accessible to Angelie and 8,300 other workers. Alturas and BQ mall trained selected employees to implement and monitor a family health program tailored to employee needs. Volunteer peer educators became trusted sources of information on family health issues and services. Pre-employment orientation, general assemblies, and team-building activities also served to promote family health to workers.

Further progress was achieved when Alturas and BQ Mall linked with an association of midwives, also receiving support from USAID. A symbiotic relationship ensued. The midwives provided free seminars, family planning counseling, and prenatal checkups on company premises during work hours. In turn, workers purchased family planning commodities and accessed services from the midwives. Since the establishment of this program, approximately 2,900 workers have adopted modern family planning methods, and more than 250 pregnant employees have completed the recommended four antenatal checkups to detect and address possible pregnancy complications.

Time for health is no longer synonymous with time off from work for Angelie and her fellow daily-wage earners. "This is something that could really be sustained. Companies need healthy workers, while midwives need clients," said Evangeline Baytong, one of several midwives serving the needs of Alturas and BQ Mall.

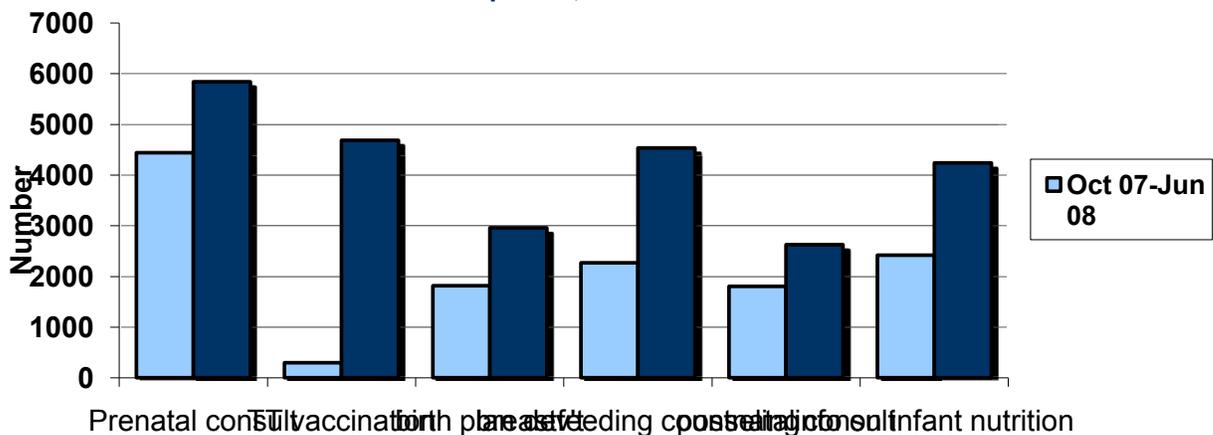
The data gathered on the supply of contraceptives further reveals an increase in contraceptive use among the workforce of targeted companies. While there was no increase in the number of employees accessing public sources of contraceptives, a significant increase (16.2 percent) in the use of private sector sources was observed.

Source of FP Supplies, Baseline and Endline Survey

Source	Baseline No. of clients		Endline No. of clients	
	No. of clients	%	No. of clients	%
Private sources	3,445	34.3%	4,987	50.5%
Public sources	1,416	14.1%	1,420	14.4%
Others	192	1.9%	61	0.6%
No specified source	1,241	12.4%	927	9.4%
Non-supply method	3,747	37.3%	2,746	25.1%

— *Maternal and child health outcomes.* Data showing comparative levels of specific MCH services over a period of 15 months indicates that as a result of FP/MCH programs implemented in PRISM-supported companies, pregnant employees at these companies began to turn to the workplace for information, services, and referrals on maternal and child care, particularly for prenatal checkups, vaccinations, breastfeeding counseling, and information on nutrition.

MCH Services in Companies, October 2007-March 2009



Survey results further showed that prenatal consultation by pregnant spouses of male employees increased from 79.8 percent at baseline to 87.8 percent at the end of the project. The use of government-subsidized (PhilHealth) MCH services increased from 55.9 percent (baseline) to 66.4 percent (endline) during the same period.

- *Private sector resources leveraged toward workplace programs.* Each grant agreement targeting workplace programs that was administered under PRISM required grantees to match 25 percent of the total grant value in implementation of the grant scope of work. This goal was far exceeded, as grantees’ cost share under grant agreements reached 71 percent by the project’s end. This cost share was comprised of (i) “in-kind” contributions (65 percent) in the form of personnel time and operations costs and (ii) company budget allocations (35 percent).
- Funds Leveraged from Grantees**

Grant amount:	Php 68.3 million
Obligated cost share:	Php 35.0 million
Actual cost share:	Php 48.8 million
- *Benefits to companies.* The financial benefits to companies implementing FP/MCH workplace programs under PRISM are displayed below. Benefits are measured in terms of savings due to reduced leave time resulting from pregnancies. The results cover a period of approximately one year. Despite the brevity of the analysis period, the results demonstrate that some companies experienced a swift return on FP/MCH program investments.

Cost-Benefit Ratios⁸ among Beneficiary Companies

Company	Costs (Php)	Benefits (Php)	Cost-Benefit Ratio
Bohol Quality	131,226.80	44,639.69	PhP1.00 : 0.34
Mondrian Aura	200,055.00	79,566.48	PhP1.00 : 0.40
Nicera	281,770.00	641,610.99	PhP1.00 : 1.28
LIPC CAT	134,461.00	566,486.41	PhP1.00 : 4.21
LIPC IWSP	585,840.00	1,623,475.23	PhP1.00 : 2.77
LIPC PDPEP	86,159.00	25,499.30	PhP1.00 : 0.30

Written FP/MCH policies are considered critical to the sustainability of FP/MCH programs. Of the 150 PRISM-supported companies evaluated at the end of the project period, 145 had written and approved FP/MCH policies. These policies incorporated provisions that aligned with the five components of PRISM’s FP/MCH workplace program framework.

- *Scale-up of FP/MCH workplace programs.* TMX, an American manufacturer of Timex watches, working with a midwives association, allocated Php 800,000 to set up three midwife clinics in communities where employees and their families reside.

⁸ Program implementation costs include: information and education campaign costs; the cost of contraceptives subsidized by the company; program management and implementation costs; and the cost of annual data collection for FP/MCH. Benefits from program implementation are calculated in terms of maternity and paternity leave expenses saved because of pregnancies averted due to increased use of FP methods.

The company intended to maintain these clinics as part of its FP/MCH workplace program. The Lopez Group Foundation Inc. scaled up implementation of its workplace program in nine subsidiary companies using its own resources. PBSP scaled up technical assistance to ShoeMart, a leading retailer in the Philippines, spending more than Php 200,000 to defray the cost of their assistance. PBSP planned to integrate the expertise it developed through providing this assistance into its business model as a service other companies may purchase.

The FP/MCH workplace model for large companies and cooperatives appears to offer an effective strategy for promoting and delivering FP/MCH services. The rapid uptake and acceptance in a wide variety of workplace settings, the investments that companies are ready to make in these programs, and the readiness of people to access services from these sources all suggest that the workplace is an effective venue for delivering FP/MCH services. Preliminary financial data also suggest that companies perceive and appreciate the “double bottom line” of social good and financial benefits. Finally, the development of a PPP context at the national and local levels provides a structure for national ownership of FP/MCH promotion strategies, as well as space for scaling up.

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IV. EXPANDING CHOICES FOR LOW-INCOME WOMEN

Growing the Low-Price Segment of the Contraceptive Market

Situation

For decades the U.S. Government provided the Philippines with contraceptive commodities as part of its development assistance programs in health. These commodities were used to supply public sector health care facilities, which provided them at no cost to the population. According to the 2004 Family Planning Survey (FPS), the public sector was supplying contraceptives to three out of every four married women using contraception. It was further estimated that 54.4 percent of married women of reproductive age (MWRA) using birth control pills and 93.4 percent of those using injectables received their supplies from the public sector.

U.S. donation of FP commodities began phasing out in 2002. This raised concerns over how the Philippine government could continue to meet the demand for contraceptives, most notably from those with limited ability to pay — the poor and very poor — who represented approximately 2.7 million contraception users.

PRISM approaches to increasing the use of FP/MCH services and commodities were based on the experience of subsidized and commercial contraceptives projects, which suggested that lower income groups are able to pay for FP commodities if they are appropriately priced and placed. Commercial suppliers could tap this potential market with affordable, high-quality FP products, while the public sector would need to continue targeting the very poor through subsidies and/or social health insurance. Meanwhile, since the government now had to rely on the private sector as a source of contraceptive supplies, it also represented a potential market for affordable, high-quality FP products.

Challenges and Opportunities

The first challenge was maintaining the supply of contraceptives. Birth control pills were the leading contraceptive method. Used by 15.6 percent of married women, they served as a “gateway” for users to other modern methods of contraception. The drop in supplies resulting from the phaseout of donated commodities held the potential for a significant decrease in use of the pill and a subsequently drop in the CPR. Therefore, it was critical to grow the hormonal contraceptives market to ensure that use of the pill would continue to maintain and increase the national CPR.⁹

The second challenge was providing a range of low-priced contraceptive choices. In 2004, the contraceptive market had a significant number of high-priced brands (i.e.,

⁹ Prior to PRISM implementation, there were indications that the market for contraceptives was growing. The 2004 FPS reported that 94.8 percent of married women were willing to pay Php 75 for a cycle of oral contraceptive pills. The survey further illustrated that among women in the “poor” socioeconomic groups, 72 percent were willing to pay up to Php 39 for a cycle of pills, while 68.5 percent of “non-poor” women were willing to pay up to Php 89 for a cycle of pills.

brands priced more than Php 100 per cycle). There were 14 brands available at an average price point of Php 260¹⁰ per cycle and 6 low-priced brands available at an average price of Php 30.55 per cycle. The low-priced contraceptives market was dominated by two brands marketed by the social marketing organization DKT International. Limited competition and brands available in the low-price segment of the market thus offered great potential for growth.

Strategies and Activities

To cover the supply gap created by the cessation of international donations and to increase access to affordable, high-quality contraceptives, PRISM worked closely with international and local pharmaceutical companies to enable market entrance and growth. This included providing direct technical and financial support to identify business opportunities for low-priced contraceptives and to develop products and brands.

Technical assistance. To support pharmaceutical company activities to grow the commercial market for low-priced FP products, PRISM provided the following technical assistance:

- *Regulatory support for commercial products.* In 2006, PRISM conducted a study on the “Feasibility of a New Express Lane for Hormonal Contraceptives” for regulatory review and approval and a study on tariff reduction for contraceptives. Short-term, medium-term, and long-term recommendations were communicated to the Food and Drug Administration (FDA) for action. As the FDA considered these recommendations, PRISM provided technical assistance to pharmaceutical companies to navigate the regulatory process required for legal registration and marketing of their FP/MCH products. Through this support, PRISM was able to secure product registration certificates for two new brands of contraceptives, Norifam and Famila 28, reducing the amount of time typically required for registration from two years to four months.
- The project worked to facilitate inclusion of more and newer formulations of FP commodities on the Philippine National Drug Formulary (PNDF). PRISM also worked to raise pharmaceutical companies’ awareness of Executive Order No. 49 (January 21, 1993) “Directing the Mandatory Use of the PNDP” Volume 1. This executive order provides that for drugs not listed in the PNDP, LGUs may submit a written request with corresponding justification to the head of the National Drug Policy Office and proceed with purchase upon receipt of approval.

In Year 4, a PRISM consultant studied the feasibility of changing the prescription status of oral contraceptives (OCs) to over-the-counter (OTC) drugs. The results indicated the products did not meet government requirements as they were not classified as OTCs in their countries of origin. This question should be revisited in a few years.

¹⁰ Price to patient = distributor price+12 percent VAT+15 percent drugstore margin.

Ensuring Access to Affordable Contraceptives



Photo: PRISM/Ben Frazer

Arsenia Fernandez, 23, buys the contraceptive pill of her choice from a local pharmacy. With USAID's help, the Philippine market now offers a wider range of affordable contraceptive choices for Filipino women.

For the past 36 years, many low-income Filipino women relied on contraceptive supplies provided free at government facilities in order to delay or space their pregnancies.

When donations of free contraceptives were being phased out, there was concern that the family planning needs of many Filipinos would no longer be met, and that the already low contraceptive prevalence rate for modern methods (35.1 percent) would further decline.

Through a simple market analysis, PRISM helped three pharmaceutical companies realize the business opportunity created by the phaseout. These companies invested heavily to enter the market, creating, selling, and distributing three new low-priced oral contraceptives and an injectable.

Sales of the four USAID-supported products increased significantly from 731,000 cycles in 2004 to approximately 2.9 million in 2008. Today, one in two women gets her contraceptive supplies from the private sector compared to just one in three in 2004.

- *Market research.* PRISM conducted an assessment of the IUD market and carried out annual analysis of the hormonal contraceptive market, supported by the Intercontinental Medical Statistics (IMS) market audit, used by pharmaceutical companies to respond to market opportunities.
- *Evidence-based medical detailing of hormonal contraceptives.* In Year 4, PRISM provided a grant to the Foundation for Reproductive Care Inc. (FRCI) under the obstetrics and gynecology department of the University of the Philippines-Philippine General Hospital to pilot-test and train pharmaceutical company trainers to train medical sales representatives to use evidence-based medicine (EBM) modules for hormonal contraceptives. For a fee, FRCI can provide training to pharmaceutical companies without in-house training capabilities.
- *FP training modules for drugstore owners and clerks.* In Year 1, PRISM established a partnership with the Drugstores Association of the Philippines to train drugstore staff. Training focused on the reproductive system and FP methods to equip pharmacy owners and clerks with enough knowledge to be able to address questions from customers.
- *Behavior change communication (BCC) materials.* In Years 1, 3, and 5, PRISM supported production of BCC materials — posters, pamphlets, and job aids — to increase market acceptance of family planning among FP and family health providers. This included placing advertisements for contraceptive methods in a popular pharmaceutical directory.
- *Business linkages and networks.* In Year 2, PRISM convened CEOs of pharmaceutical companies to formulate a consensus strategy to grow the FP market. In Year 3, the project organized a trade mission for manufacturers of contraceptives operating in Southeast Asia to meet with local pharmaceutical marketing companies to introduce more brands and new methods of contraception.

Grants. Over five years, PRISM provided grants totaling \$250,000 to five pharmaceutical companies to support the marketing of low-priced FP brands and products to doctors and midwives. These products included:

- Marvelon 28 by Schering Plough-Organon, an oral contraceptive (relaunched at a reduced price, 225 percent lower than the original market price)
- Seif by Bayer-Schering, an oral contraceptive
- Daphne by ECE Pharmaceuticals, a progestogen-only birth control pill
- Lyndavel by ECE Pharmaceuticals, a progestogen-only three-month injectable
- Norifam by Alphamed Pharma Corporation, a monthly injectable
- Famila 28F by Alphamed Pharma Corporation, an oral contraceptive
- Enova by BF Merren Pharmaceuticals, an IUD

The cost of advertising and promotion was estimated at 51 percent of gross sales, which reflected the high level of activity needed to enter the market. Product promotion consisted of giving out samples to health providers to initiate patient trial usage; conducting continuing medical education activities on updates to family planning best practices and World Health Organization (WHO) medical eligibility checklists on contraceptives; brand awareness activities through booth sponsorships during medical conventions; and placement of ads in medical journals. It also included using medical literature as a BCC approach to address patient fears about side effects and other health concerns about using contraceptives. Additionally, company representatives delivered lectures on FP methods and products in clinics and health centers.

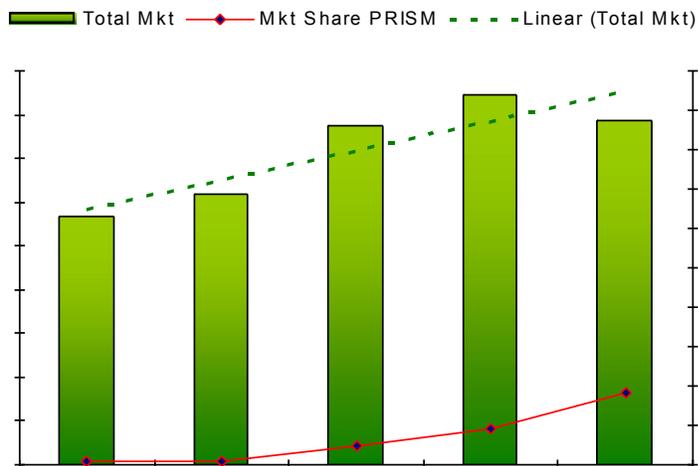
Market penetration. PRISM provided technical support pharmaceutical company market segmentation activities for:

- *Off-patent FP products.* Three of the products previously noted were off-patent, or generic, products/drugs sold under their official nonproprietary name.
- *A separate field sales force.* Pharmaceutical companies expanded and/or trained approximately 45 members of their sales workforce to promote low-priced FP products, assigned them sales territories, gave them sales targets, and provided incentives. Sales workforce costs, including financial incentives, averaged 31 percent of targeted gross sales.
- *A master list of “new” health providers.* More than 2,000 new names of midwives, nurses, and doctors in private clinics, birthing homes, and health clinics catering to low-income patients were added to medical representatives’ call lists.
- *A separate product portfolio.* To maximize the return on workforce costs, medical representatives also carried other MCH (maternal and child health) products that were being prescribed by the health providers along with PRISM-supported brands of FP and MCH products, which were assigned “primary-mention” during MD calls. This strategy was based on the premise that doctors tend to recall the first product mentioned by the medical representative and tends to “tune out” other products mentioned (often called “reminder” products).
- *New distribution channels identified.* Although the low-priced FP products were made available in drugstores nationwide, pharmaceutical companies also sought to expand distribution through alternative channels, such as cooperatives and birthing homes.
- *Trade deals to target market.* Special deals ranging from 5+1 (buy 5, get 1 free) to 12+1, (8-12 percent discount from the selling price) were extended to drugstores and dispensing health providers as an incentive to help push low-priced FP products.

Results

Commercial sales of USAID-supported products. IMS moving annual total (MAT) sales data in December 2008, which incorporates sales data from PRISM grantees, demonstrated that the total commercial contraceptive market had grown during PRISM implementation. Sales and market share of PRISM-supported products continued to increase, suggesting that the market for these products had been firmly established. Specifically, the market share of PRISM-supported FP products increased from 1 per cent in 2004 to 18 percent in 2008. During this period, total sales of PRISM-supported products amounted to Php 206 million, or more than six times the investment of the project.

IMS Sales Data from (MAT 2004-2008)
Total Market & PRISM-Supported Products (2004-2008)



In 2006, a total of Php 31.5 million invested by PRISM through its grants program was used by three pharmaceutical companies to launch or relaunch FP products priced below Php 100 per cycle. These companies invested Php 53 million as their cost share in launching these products. Total sales of PRISM-supported contraceptives after their first year on the market amounted to Php 29.4 million.

Total Sales of PRISM-Supported Contraceptives, 2006

Pharma Grantee	Grant	Cost Share	Sales in Php (Year 1)	No. (?) of Cycles
Pharma A	12,822,500	16,890,760.00	13,582,946	229,791
Pharma B	5,737,602	19,617,760.00	3,170,844	74,573
Pharma C	12,930,000	16,577,453.00	12,641,265	182,235
Grant amount/cost share	31,490,102	53,085,973.05	29,395,055	486,599

NOTE: Company names have been omitted to preserve confidentiality.

Sales increments of these products reported by grantees in succeeding years after the close of the grant were also promising.¹¹ Sales grew by 400 percent in 2006, 80 percent in 2007, and 100 percent in 2008. In other words, start-up investments in PRISM-supported FP products were recouped within three years. However, there was concern over whether these results could be maintained. Two grantees underwent reorganization, which resulted in a temporary lag in promotion of their low-priced FP products and reductions in their sales workforce budgets. There was intense competition from DKT, which also assumed promotion and distribution responsibilities for one PRISM-supported FP product. Even without marketing support, pharmaceutical companies continued to make these brands available as they gained market share.

Women are getting their FP supplies from the private sector. Based on the 2003 NDHS, 2 out of 3 women were getting their FP supplies from the public sector. The 2008 NDHS indicated that dependence on the public sector dropped to 1 woman in 2. The results reflect the overall growth of private sector sales through PRISM partnerships with pharmaceutical companies. Private sector contraceptive sales are defined as sales of contraceptives to pharmacies, hospitals, and other channels that provide a direct point of contact with FP users. Public sector sales are commercial sales to LGUs and other levels of government. Since 2003, the commercial sector has also been the source for FP commodities for the public sector, which purchases FP commodities through public bidding and procurement processes. Hence, the private sector has become the predominant source of FP products even for low-income users who either obtain contraceptives free through the public sector or buy them as low-priced products at pharmacies or from private healthcare facilities.

¹¹ Base figure is minimal (only one PRISM-supported product was in the market prior to the grant).

Commercial sector reaching new users. Through its grants program, PRISM supported pharmaceutical companies in launching FP products with previously limited availability in the Philippines, such as IUDs and injectables.

Increased demand for low-priced FP products. Three years after the launch of the low-priced brands, this segment of the market grew annually at an average of 5.6 percent. By the end of the project, six low-priced FP brands were being sold at an average price point of Php 35 per cycle — below the Php 39 per cycle price that the majority of consumers classified as “poor” were willing to pay. In contrast, the average price of high-priced contraceptives was Php 349 per cycle during the same period.

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Increased availability of products in alternative channels. Alternative distribution channels for FP products, such as cooperatives, workplaces, and birthing homes, were identified and supplied by pharmaceutical companies. PRISM-supported pharmaceutical companies were able to sell their products to LGUs that were already purchasing FP commodities in response to the DOH CSR (contraceptive self-reliance) strategy.

V. INCREASING COMMUNITY-BASED SERVICES

Improving Business Value for Private Practice Midwives

Situation

Despite four decades of development programs targeting MCH, the Philippines continues to have among the region's highest maternal mortality rates (162 per 100,000 live births, according to the 2006 FPS) and infant mortality rates (25 per 1,000 live births, according to preliminary 2008 NDHS data). The government is committed to achieving the country's millennium development goals (MDGs) by reducing the maternity mortality rate (MMR) to 52 per 1,000 live births and the infant mortality rate (IMR) to 19 per 1,000 live births by 2015. However, while attaining the targeted IMR appears to be within reach, achieving MMR goals will be difficult unless significant attention and resources are dedicated to address the four main drivers of maternal mortality, summarized below.



Juliette and Julian Corona originally planned on having their child delivered at home. When they heard about the high-quality service and affordable rates being offered in a USAID-supported midwife clinic, they decided to try the clinic out. The proud new father, Julian, said that he'll spread the good word about the clinic.

- More than half of the 3.4 million pregnancies each year are unintended, with 92 percent occurring among women who use either traditional contraception or no contraceptive method. According to a recent study, “expanding access to contraception could result in 800,000 fewer unplanned births, 500,000 fewer induced abortions, and 200,000 fewer miscarriages each year. Moreover, it could prevent as many as 2,100 maternal deaths each year — as nearly half of all maternal deaths result from pregnancy-related causes.”¹²
- Although 91 percent of mothers received ANC from a doctor, nurse, or midwife during their pregnancy, many deliveries (38.2 percent) were still attended by unskilled birth attendants (38.2 percent), according to 2008 statistics.

¹² “Low Levels of Contraceptive Use Threaten Filipino Women’s Health and Undermining their Childbearing Desires,” Guttmacher Institute news release, April 29, 2009, New York.

- Despite the high ANC rate, more than half of Filipino mothers (56.2 percent) still chose to deliver at home in 2008.
- The quality of care during the immediate postpartum period needs to be improved.

Given this situation, the government's strategy to reduce MMR aims to increase the number of deliveries managed by skilled birth attendants to 70 percent by 2010 and to 100 percent by 2015 while also increasing the percentage of births taking place in health care facilities from 37.9 percent in 2003 and 43.8 percent in 2008 (per the NDHS) to 100 percent by 2015.

The public sector has always been the primary source for FP and MNCH services in the country. However, the number of currently existing national and local government health facilities alone cannot accommodate all of the country's estimated more than two million deliveries per year. If the strategy to increase the number of facility-based deliveries is to succeed, government must get all the help it can from other sectors.

Challenges and Opportunities

Midwives are among the most numerous and widely dispersed professional health workers in the Philippines. While the Professional Regulations Commission listed 150,722 registered midwives in 2007, various recognized midwives associations estimate a total of 63,000, with approximately 24,000 in public practice and 39,000 in the private sector. Midwives provide a wide range of MCH services, such as ANC care during labor and delivery and postpartum care. Given the number, geographic coverage, and services of midwives, it is critical that they be included in initiatives to make pregnancies and deliveries safer.

Midwifery is a low-income profession that tends to attract people with limited means. Midwives are frequently from poor communities and tend to serve these same communities. Their clients often include the populations most affected by maternal morbidity and mortality. Women from poor communities tend to give birth at home and seek assistance from unskilled providers. These factors influenced USAID's design of PRISM, which recognized an opportunity to improve maternal and child health while increasing the skills and income of private practice midwives. The goal was to involve midwives in the provision of family planning services, counseling, and motivation; to add the sale of high-quality yet affordable MCH products — such as multivitamins, folic acid, and ferrous sulfate — to their practices; and to equip them to help the DOH reach its goal of at least four prenatal visits during pregnancy.

Private sector midwives are permitted to provide services even if they do not own and operate a birthing facility. Providing home delivery services typically garners a low fee, and midwives often receive tokens of appreciation in lieu of payment. Birthing facilities tend to link midwives in the private sector with clients who can pay more while providing an environment that enables higher quality care.

Providing Safer Options for Women

Empowered midwives help curb maternal and infant deaths through safer, high-quality services.



PRISM/Tanya Hisanan

Arsenia Tagaro is just one among a growing number of women opting for USAID-trained midwives who offer affordable, professional care in homey birthing facilities.

“For so long, midwives were considered as unskilled birth attendants. Through USAID assistance, we are now health professionals in the eyes of the communities we serve.” — Corazon Paras, CEO, IMAP Lying-In Clinic, Bohol

Like many mothers before her, Arsenia Tagaro put her life and that of her baby in the hands of a *hilot* (traditional birth attendant) when she gave birth to her firstborn at home. In Bohol, the island province in the Philippines where Arsenia resides, three out of four women still give birth at home. Although the majority (85 percent) of these births are attended by a skilled provider, homes are not equipped to address potential birth complications. The cost of services and the distance of birthing facilities from home dissuade low-income women from seeking services in hospitals or clinics.

When Arsenia gave birth to her second child, it was very different. Assisted by a member of the Integrated Midwives Association of the Philippines (IMAP), Bohol Chapter, she delivered in a midwife birthing facility just a 15-minute ride away from her village. “I’m glad they’ve put up this place, and doubly glad we could afford their rates,” she said.

The realization that women seeking safer options for delivery represented a large market spurred the entrepreneurial spirit of some 200 midwife members of IMAP Bohol. With USAID support, they took training to enhance their knowledge and clinical skills in maternal and child health, including family planning. They also attended business management seminars to learn about recordkeeping, business planning, and marketing.

The midwives recognized the value of professional and caring service as a way of attracting and nurturing client loyalty. They established and enhanced eight birthing clinics to qualify for government accreditation. This allowed clients with government health insurance to avail the high-quality services offered by these clinics. The midwives also established formal relationships with doctors for referrals and to protect the lives of mothers in cases with complications.

From 2007 to 2009, the midwives were able to assist 2,454 deliveries, and 85 percent of their pregnant clients completed at least four prenatal check-ups. Now serving five towns in Bohol, with an estimated 320,000 residents, midwife birthing facilities are gradually replacing homes as the preferred and safer choice for delivery.

Strategies and Activities

To increase their capacity to provide FP/MCH services, PRISM developed a comprehensive program of training, marketing support, and PhilHealth accreditation called Business Enhancement Support and Training (BEST) for private sector midwives. The approach was implemented through both direct technical assistance and grants to local organizations, which in turn helped contribute to sustainability.

Training. Aimed at enhancing private midwives' FP/MCH knowledge and skills, BEST training for midwives was initially offered as an integrated five-day course that included contraceptive technology updates (CTU), FP counseling using the GATHER¹³ approach, and basic business skills development. The course was later expanded to include other MCH topics and was subdivided into separate, focused modules to minimize participants' loss of income due to long periods of time away from their practice.

According to the project database, PRISM trained 2,259 licensed midwives using DOH-endorsed curricula under the BEST program from 2004 to 2009. Of those trained, 1,030 received training using PRISM's integrated curriculum. The others were trained through distinct courses on contraceptive technology (115), FP counseling (122), basic business/entrepreneurship (17), updates on maternal/child health (536), and clinic management (113). Other courses organized by PRISM included newborn screening (216), IUD training (28), and a postgraduate course for midwives (110).

Marketing and business support initiatives. PRISM used a multipronged approach to demonstrate and improve the financial viability of FP/MCH services offered by midwives. The team provided technical assistance in marketing; facilitated sustainable relationships with financial institutions and pharmaceutical suppliers; helped establish referral networks to clinic and hospitals; and advocated adherence to quality standards to enable midwives to obtain PhilHealth accreditation.

To make their services and products more attractive to clients, midwives targeted by PRISM were assisted in developing flyers, posters, logos, and billboards. Those with limited resources were linked with sources of financing to improve or renovate their clinics and birthing homes. Through four conferences, PRISM matched 1,176 private sector midwives with 27 financial or microfinance institutions, although few of the midwives who attended these events subsequently pursued loans through these relationships. Other events linked midwives with pharmaceutical suppliers, and PRISM shared lists of midwife participants in BEST events with pharmaceutical partners to give participating midwives greater access to contraceptives.

¹³ G=Greet respectfully, A=Ask/Assess needs, T=Tell information, H=Help choose, E=Explain and demonstrate, R=Return and reinforce/refer.

Frontliners of Quality Health Care

Midwives close the gap between accessibility and safety in maternal and newborn care.



PRISM/Tanya Hisanan

Midwife Liza de Castro (foreground) watched her clientele and revenues grow after applying what she learned from USAID training. She now owns a government-accredited birthing facility. Meanwhile, her daughter Lyle (background) has decided to shift from nursing to midwifery to help her mother in her budding business.

Challenge

High-quality, accessible, and affordable care at the time of greatest risk — during childbirth and the first few days of the baby’s life — still eludes many Filipino women and their babies, particularly the poor. Only one in four births is delivered by a professional attendant. The Philippine government’s strategy to reduce maternal deaths is to increase the number of deliveries in birthing facilities by skilled providers. The public sector has always been the population’s primary source for health services. However, the existing national and local government health facilities alone cannot accommodate all the country’s more than 2 million deliveries per year.

Initiative

USAID developed a comprehensive program to enhance private sector midwives’ capability to provide quality family planning and maternal and child health services in birthing facilities. A total of 1,030 midwives around the country received clinical training and updates on FP/MCH services and products. They also received business skills training to help them better manage and grow their clinics. Midwives learned how to market, promote, and advertise their birthing homes and services effectively. As a sustainability and quality control strategy, USAID supported midwives to become government-accredited providers for the maternal and newborn care package provided under the national social insurance program, allowing them to offer services at subsidized rates.

Results

Through USAID assistance, 211 private sector birthing clinics around the country attained government standards of quality care, making good care more accessible to people in their communities. USAID-trained midwives reported a significant increase in clientele for birth deliveries and family planning services. Half of USAID-supported midwives who participated in a revenue survey reported doubling their income between 6 and 12 months after they received training provided by USAID.

PRISM helped midwives grow their client base by enhancing their referral networks. The project linked PhilHealth-accredited midwives with USAID-assisted institutions in the public and private sector to enable them to receive referrals from employees seeking services covered under PhilHealth's maternity and newborn care packages. The project also linked partner midwives with LGUs, which enabled some midwives to provide services in public health facilities.

PRISM continuously emphasized the point that "good quality means good business" among partner midwives and their clinics. Partners were encouraged to meet established quality standards that would ensure their continued accreditation with PhilHealth. The project organized 35 clinical case conferences with 1,712 midwives in attendance, as well as pediatricians, obstetricians, hospital administrators, and midwife association officials. PRISM also used a customized tool to assess the quality of services provided by 212 midwives, and the PRISM team led many USAID and DOH policy compliance activities.

PhilHealth accreditation. Demonstrating that midwives could earn more by becoming PhilHealth-accredited was critical to overcoming their initial reluctance to apply for accreditation, which involves application fees and completion of numerous documents. Potential revenues from PhilHealth's maternal and newborn care packages made the provision of FP/MCH services a more financially viable and attractive investment for private sector midwives. The minimum reimbursements for providing services covered by these two PhilHealth packages were significantly higher than what midwives typically charged for similar services. Further, accreditation enabled midwives to expand their revenue-generating clientele base to the poor and very poor who were unable to pay, but who were covered by PhilHealth.

PRISM developed a technical assistance package to help midwives complete the accreditation requirements for PhilHealth. It included in-service training, such as newborn screening, and a tool for tracking midwives' progress in complying with accreditation requirements. Selected midwives were also provided financial support for minor renovations to their clinics to meet PhilHealth specifications. At the onset of PRISM, only 71 birthing facilities were accredited by PhilHealth. PRISM facilitated PhilHealth accreditation of an additional 211 private sector birthing clinics, of which 22 received direct technical assistance from PRISM and 189 were supported through the project's grants program. Geographically, 126 of the clinics supported were located in Luzon, 50 in Visayas, and 35 in Mindanao. Several more clinics were in the final phases of obtaining accreditation as the project drew to a close.

Despite PRISM's progress increasing access to birthing homes, the need for opening more accredited outlets is apparent, with home deliveries estimated at 1,330,560 in 2009.

**Number of Accredited and Accreditable Birthing Homes by
PRISM Region and Mode of Technical Assistance, August 2009**

Region	Accredited	Accreditable	Total
Luzon	57	64	121
IMCH	42	50	92
TRIDEV	-	13	13
BCYA	-	5	5
JVO	-	1	1
Direct TA	15	-	15
Visayas	38	12	50
NORFI	16	1	17
IMAP Bohol	8	11	19
IMAP Cebu	12	-	12
Direct TA	2	-	2
Mindanao	18	17	35
KsFI	12	14	26
APMID	2	2	4
Direct TA	4	1	5
TOTAL	113	98	211

Results

Increased provision of FP/MCH services by private sector midwives. Technical assistance provided by PRISM to midwife partners resulted in 44,899 deliveries performed by skilled birth attendants. Representing 2.2 percent of the average total annual deliveries in the Philippines; this shows the start of potentially significant market penetration. Additionally, 78,423 individuals received FP counseling from PRISM-assisted midwives and workplace programs or company clinics. Increased provision of FP/MCH services by PRISM-assisted midwives also resulted in completion of the recommended four prenatal visits by 39,242 pregnant mothers. Actual FP services from PRISM-assisted health care providers and facilities were provided to 48,785 new and 215,600 continuing patients during the course of the project.

Increased revenues from FP/MCH provision. A study conducted among 170 midwives who completed the BEST program prior to 2008 revealed the potential for sustaining private midwife strategy in service delivery. Respondents' revenues before PRISM were compared to revenues generated 6 months and 12 months after they completed the BEST program. The study revealed that mean monthly revenues had increased from a baseline of Php 29,676 before training to Php 45,537 6 months after training, and to Php 49,266 12 months after training, a statistically significant increase.

Additionally, revenues from providing FP/MCH services and products had increased for 76.2 percent of respondents 6 months after completing the BEST program, and for 79.2 percent of respondents 12 months after completing the program.

Percent Distribution of Respondents by Change in FP and MCH Monthly Revenues 6 Months and 12 Months after Completion of the BEST Program

Change in FP and MCH revenues	6 Months after Training		12 Months after Training	
	Number	%	Number	%
With decreased revenues	29	22.3	27	20.8
With increased revenues	99	76.2	103	79.2
No change in revenues	2	1.5	0	0
TOTAL	130	100.0	130	100.0

NOTE: Only 130 respondents who had complete records were included in the analysis.

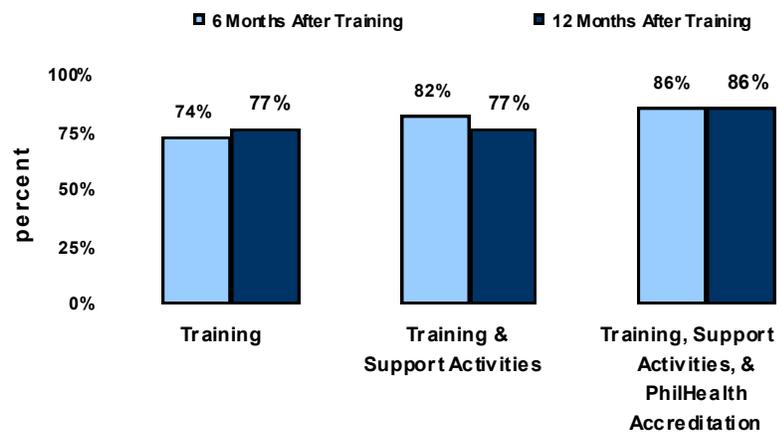
The magnitude of increase in revenue was also examined. Fifty percent of the 170 respondents had doubled their incomes from baseline values between 6 months and 12 months after completing the BEST program.

Percent Distribution of Respondents by Percent Change in Monthly Revenues from Baseline to 6 and 12 Months after Completion of the BEST Program

% Change in Monthly Revenues	6 Months after Training (%)	12 Months after Training (%)
Below 25 percent	18.0	11.7
25%-49 percent	14.0	11.7
50%-74 percent	11.0	13.6
75%-99 percent	5.0	9.7
100 percent and above	52.0	53.4
TOTAL	100.0	100.0

As noted previously, the primary support provided by PRISM to midwives was training in FP/MCH and business management. For some midwives, additional technical assistance was provided in marketing or in accessing PhilHealth accreditation. The exhibit below demonstrates the impact of one or a combination of these interventions.

Percentage of Respondents with Increased Monthly Revenues 6 and 12 Months after Completion of the BEST Program



Building private midwife capability through training increases the availability of good quality, affordable FP/MCH services. Marketing support helps midwives attract clients, opening the way for a shift from home-based to facility-based deliveries. PhilHealth accreditation enhances midwives' economic viability, thus increasing sustainability.

References

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VI. ENABLING LOCAL PPPs FOR FAMILY HEALTH

Building a Sustainable Local Market

The Local Market Model

Although PRISM’s main focus was the private sector, increased private sector activity began to involve local public health systems. Some localities responded vigorously to the commercial opportunities for meeting family health needs. This led to the recognition that some of PRISM’s 32 strategic intervention areas (SIAs) could become models for local market development. In Year 5, the team embarked on a more focused local market approach in 12 of the 32 strategic intervention areas. Referred to as Local Market Model (LMM) areas, these 12 localities established a former PRISM grantee or partner that had expressed interest as an “LMM driver,” leading local market initiatives for family health in that geographic area. Most LMMs were led by private sector or civil society organizations. In some LMM areas, however, public-private FP initiatives were spearheaded by local government or government-created groups. Through the LMMs drivers, PRISM worked to secure private sector presence in FP policy, commodity procurement, service delivery, and monitoring and evaluation (M&E) in public health systems and programs.

Examples from Luzon, Visayas, Mindanao, and ARMM illustrate a variety of strategies for developing, implementing, and sustaining the Local Market Model.

Luzon: Bulacan Province

Policy. In response to a provincial health office request to develop a PPP model, PRISM facilitated the signing of Executive Order (EO) No. 14 s.2009, entitled “Engaging private sector participation to improve Bulacan health outcomes.” The EO recognizes the private sector’s contribution to improving family health and acknowledges the opportunity to better focus its limited resources on providing health supplies and services to poor families. The EO created the Private Health Desk (PHD), for which PRISM developed operational guidelines that served as the basis for implementing rules and regulations. The guidelines defined working relationships between the public and private sector in implementing health programs and monitoring private sector reports.

Service delivery. PRISM was able to expand the number of skilled service providers and reliable health facilities in Bulacan. The project helped establish six accredited birthing homes and five accreditable birthing clinics in just one year while upgrading the skills of 48 midwives in delivering FP/MCH services. PRISM trained Family Health Management Teams in 17 assisted companies to provide workers with FP/MCH information and counseling. Five companies entered into an agreement with

Stronger Partnerships

“PRISM helped strengthen the partnership between the public and private sector. We came up with new ways of implementing family planning despite limited resources of the City Health Department.” — *Dr. Betzaida Banaag, City Health Officer, San Jose Del Monte Bulacan*

PRISM to train midwives to operate referral clinics for their workers. As a result of the project, two SMEs set up their first in-plant clinics, and the city of San Jose Del Monte was able to demonstrate how the public sector can refer clients to private drug stores (Grotto Drugs) for the purchase of affordable FP/MCH commodities.

Procurement. PRISM pharmaceutical partners continue to supply 19 LGUs in Bulacan to augment the phaseout of free commodities.

Monitoring and evaluation. Through the PHD, all companies, business, and professional associations and NGOs were mandated to submit quarterly reports using the Field Health Service Information System (FHSIS) form. Private sector organizations were encouraged to submit annual reports using their own forms since not all of their accomplishments could be captured using the FHSIS. The Bulacan chapter of the Integrated Midwives Association of the Philippines (IMAP) agreed to consolidate the reports and accomplishments of their private practice midwife members for integration into the provincial FHSIS.

Sustainability plan. Creation of the PHD to monitor and oversee implementation of six priority health programs by partner NGOs and civil society organizations will help sustain the interest of the private sector, and signing memoranda of understanding (MOUs) between the private sector and LGUs will help cement health PPPs. The PHD will continue consolidating private sector accomplishments for integration with the FHSIS and planned to pursue an addendum to EO No. 14 s.2009 to engage all private organizations to collaborate with PHD and to submit report of accomplishments as recommended by the governor.

The empowered IMAP Bulacan chapter will continue to conduct, facilitate, and coordinate the various PRISM training programs, including clinical case conferences, MCH updates, FP/MCH counseling, and Intravenous (IV) insertion and suturing, among others. It will continue consolidating private midwives' accomplishments and submitting reports to the PHD. The newly organized private birthing home owners association will continue providing technical assistance to midwives interested in setting up private birthing homes, facilitating PHIC accreditation, and distributing FP/MCH supplies and minor equipment.

DOLE, PHO, and BCCI are committed to working together to help companies set up family health and welfare programs.

Visayas: Bohol Province

Policy. Appreciating the demonstrated advantage of building alliances with the private sector in various human development initiatives, Bohol Governor Eric Aumentado involved private sector partners in the development of a provincial master plan for integrated health services. In a discussion with DOH undersecretaries and directors, the governor directed creation of a technical working group to spearhead master planning together with PRISM partners such as BANGON and IMAP Bohol. Meanwhile, the

provincial legislative branch carried out two public consultations on the proposed provincial Reproductive Health Care Ordinance of 2008.

Service delivery. The Tinago Health Center, a publicly owned facility previously having very limited resources, is now being operated by the private midwives of IMAP Bohol. Bound by a memorandum of agreement between the LGU and IMAP Bohol, the health center caters to the FP/MCH needs of Dauis and neighboring towns. The LGU generates income as a percentage of the center's revenue. Another emerging model is public-private midwives collaboration in establishing the IMAP Lying-in Clinic, Loon Branch, in Barangay Catagbacan, Loon, Bohol. The chief executive of the municipality gave verbal permission to 12 of the 14 government midwives to engage in private practice after performing 40 hours per week of government service.

Procurement. Private sector representatives, especially IMAP Bohol, were linked to various government initiatives, including CSR action planning. Around 48 LGUs formulated one-year CSR action plans and later updated and expanded the same to six years. They also developed commodity forecasts for FP, MCH, and TB products. Of the 48 CSR plans, 3 were approved and supporting ordinances were passed (in Mabini, Calape, and Garcia Hernandez) while another 14 were awaiting local chief executive approval (Guindulman, Alicia, Candijay, Anda, Panglao, Dimiao, Baclayon, Lila, Cortes, Loboc, Antequerra, Duero, Inabanga, and Carmen). Another 7 had their first drafts reviewed and returned for finalization. The remaining 24 were in the process of completing their narrative plans with guidance from DOH representatives.

Monitoring and evaluation. A program implementation review in Bacolod helped push the provincial government to establish a mechanism to report on the overall health

Strengthening Health Performance Through Public-Private Partnerships

Problem
In Bohol 74% of deliveries occur at home although 85% of these are attended by skilled providers (2007). Contraceptive use has remained low (27%) over the past several years. Insufficient government investment in the health sector, coupled with pervasive poverty hinder access of women to MCH and FP services.

Initiative
USAID/PRISM laid the foundation to mainstream private sector efforts to the provincial health system:

- Built the capacity of private practice midwives and their organization to provide better quality care
- Facilitated Phil-Health accreditation of midwives' birthing clinics
- Formed partnership with DOH on the use of Family Planning Action Sessions (FPAS) to increase number of new acceptors of FP methods in workplaces
- Formed partnership with DOH/LGUs to establish/strengthen public and private sector referral systems
- Linked with local distributors for affordable FP/MCH commodities

Results

- Formulation of provincial guidelines on the utilization and management of MNCHN Grant
- Adoption of FPAS by workplaces
- Promotion of midwifery profession
- IMAP lying-in clinic as FP/MCH product distributors to fellow members, LGUs and BnB express counters
- IMAP lying-in clinics in the province are one of the reporting units to the provincial health systems

Province of Bohol

situation in Bohol province, this time including data from the private sector. A technology transfer workshop for senior DOH officials and regional directors helped motivate the provincial health officer to include data from the private sector, particularly FP/MCH data from IMAP lying-in clinics. IMAP Bohol was directed to report quarterly accomplishments starting in April 2009 and thereafter. To ensure prompt and reliable reporting, the PRISM local market driver hired a part-time consultant to collect the information and consolidate the reports from eight lying-in clinics in Bohol.

Mindanao: General Santos City

Policy. Given that General Santos City already had policies supportive of a robust health service delivery system, PRISM focused on raising awareness and promoting compliance with these policies among private sector groups. Local policies on health included a CSR ordinance, an RH code, and an STI/HIV/AIDS ordinance. PRISM, together with LMM driver Socskargen Fishing Federation and Allied Industries Inc. (SFFAIL), helped member companies become aware of approved local policies on workplace family health program implementation. SFFAIL, through the South Cotabato Purse Seiners Association (SOCOPA), advocated creation of such a program as part of the nonwage benefits employers may extend to workers to improve productivity and encourage a healthy lifestyle. Private practicing midwives of General Santos City were diligent in submitting quarterly on their activities to comply with the CSR ordinance and RH code.

Service delivery. Private practice midwives, through the local IMAP chapter, became strong allies of the City Health Office in providing high-quality, affordable, and accessible FP/MCH services. Their participation was especially valuable in relieving public health midwives of some of their immunization burden. Private practice midwives accessed vaccines at minimal cost from *barangay* health centers and

Empowering Families Through Company's Family Health Program

Problem
With assistance from USAID, a major fishing company established a family health program to help its predominantly male workers better manage the health and financial situation of their families. Too often, companies bear the brunt of workers' fight against poverty through loans and cash advances. Realizing the bigger role women play in the health and well-being of families, the company saw the need to reach out to the wives of their workers.

Initiative
USAID/PRISM helped the company expand family health program in a fisherman's village:

- Conducted focus group discussions, series of family health sessions and youth classes to increase families' awareness on birth spacing and how to save and augment their income
- Organized leaders and wives as a group and linked them with local health offices and public and private health clinics
- Assisted wives of workers prepare business plans to access livelihood programs from the company

Results

- Organized village residents into a mother's club with 35 members headed by five village leaders
- Organized 26 youth leaders as peer educators to provide correct information on family health among fellow youth
- In coordination with DOLE, provided basic sewing training to mother's club members
- Two midwives' clinic as referral facilities for the provision of family health services

General Santos City

were provided with forms to report their activity every month to the rural health midwife. Among SFFAI member firms, four were able to access tetanus toxoid vaccines from the City Health Office for administration during the launch of workplace FP/MCH programs (Alliance Tuna International, NH Agro Industrial Corporation, Mommy Gin Tuna Resources, and South Cotabato Integrated Ports Services). The City Health Office provided staff to administer the vaccines while the company purchased the syringes, cotton, and alcohol.

Procurement. PRISM continuously linked pharmaceutical companies such as ECE Pharma, Organon, Schering Phils, DKT, and Alphamed to support LGU and private sector efforts to improve the quality of service provision at public and private health facilities. In 2009, the purchase of commodities included 1,400 cycles of pills (Daphne) and 3,000 vials of injectables (Depotrust).

Monitoring and evaluation. Data from PRISM-supported private practice midwives was recognized and integrated into the local health reporting system beginning in 2008. During the second quarter of 2009, a new reporting tool was introduced. Since not all private practice midwives were able to attend the training, PRISM provided technical assistance in using the new reporting form. Private practice midwives were directed to submit their reports to the City Health Office or through partner *barangay* health midwives on a quarterly basis.

Sustainability plan. Through the City Health Office, DOH will provide technical assistance and logistical support in providing FP/MCH services and integrating the private sector into health sector reform. DOLE will continue to address the productivity concerns of the companies and their employees. SFFAI is committed to making family health a core service among member firms. These partnerships will ensure sustainability of improving family health in General Santos City.

ARMM Strategy

Policy. PRISM provided technical assistance in developing the ARMM-wide Investment Plan for Health (AIPH), particularly by defining the possible involvement of the private sector in health service delivery in the region. As a result, the AIPH includes a PPP strategy section. PRISM also contributed to consultative discussions between DOH and PhilHealth regarding universal enrollment and utilization of capitation in ARMM, given its non-devolved setup. These consultations led to draft guidelines on the utilization of capitation funds.

Service delivery. In collaboration with DOH-ARMM, PRISM set up workplace family health programs for seven business organizations in three provinces. A series of capacity-building activities were carried out for the program management teams, health educators, and referral service providers.

Through an established partnership between the assisted business organizations and integrated provincial health offices (IPHOs), workplace family health programs were expanded to include health education and promotion of public health programs related to TB, malaria, filariasis, and dengue.

Procurement. PRISM helped develop the market for FP commodities to address access, availability, and affordability issues facing underserved communities in ARMM. Alphamed was linked with assisted business organizations to meet their commodity requirements, and to DOH-ARMM and the different IPHOs, to build on well-established relations with these partners.

Monitoring and evaluation. A simplified referral slip was developed to track the accomplishments of assisted business organizations. At the same time, PRISM organized consultation sessions between public and private health sector representatives in the localities where the project operated. These sessions provided the venue for reporting private sector health initiatives and sharing public sector health priorities, resulting in initial PPP agreements.

Promoting Health in the Workplace Through Muslim Religious Leaders

Problem
Misconception that Islam is against the practice of family planning persists in ARMM, particularly in the rural areas, despite a fatwa on Reproductive Health and FP. In fact, most workers of project-supported agricultural plantations in ARMM do not know of the existence of the fatwa.

Initiative

- Consulted members of the Lanao del Sur Provincial Ulama Council for partnership in the dissemination of the fatwa
- Held dissemination activities on the fatwa for local Imams in Wao and Bumbaran (Lanao del Sur) and in Buluan and Datu Paglas (Maguindanao)
- Oriented health educators on the fatwa and mobilized them as primary source of health information of plantation workers and their families as well as community members
- Supported planning session for health educators, targeting individuals (co-workers) with misconceptions on FP

Results

- 13 local Imams, 11 ustadzes, 36 health educators, 11 KLGU and rural health unit representatives oriented on the fatwa
- Fatwa orientation and family health education incorporated in the weekly values formation sessions of assisted companies
- Dissemination of the fatwa through weekly radio program of La Frutera
- Local Imams tapped as point persons for questions on acceptability of FP in Islam

VII. LOOKING AHEAD

Recommendations for Follow-Up

Workplace Initiatives

- *Strengthen the DOH and DOLE roles in promoting workplace FP/MCH programs to companies and cooperatives*, with an eye to achieving the right mix between regulation and technical assistance. Government must budget for capacity building. There is also a need to harmonize DOH and DOLE M&E indicators and tools. Relationships with local government units should be strengthened to implement national initiatives locally. Enhanced networking with private sector partners will help sustain successful FP/MCH programs and replicate them in more companies.
- *Increase the self-financing participation of large companies to replicate the model*. Partners should be encouraged to replicate the program in more companies using their own resources, and by networking with each other.
- *Invest in developing viable models for SMEs and cooperatives*. SMEs and cooperatives offer opportunities to make the provision of FP/MCH services more widespread, but due to time constraints, these opportunities were not fully explored under PRISM. Funding that targets SMEs and cooperatives can help them install and tailor workplace programs to their organizations.
- *Disseminate best practices*. Best practices and models that stood out from the PRISM experience should be further analyzed and promoted. Tools, including training materials and M&E methods, should be simplified and disseminated to facilitate private investment in FP/MCH programs, policies, plans, and operational systems. Interesting models and best practices included the following:
 - Mobilizing DOLE
 - Engaging the regional DOH for training and supplies
 - Appealing to companies for community outreach (ARDEXCOR, Timex)
 - Working through local organizations and institutions
 - Promoting sustainability at the onset

Market Development Initiatives

- *Develop the enabling environment for contraceptive market initiatives*. Increased pharmaceutical company activity has stimulated the demand for low-priced contraceptives among the poor and very poor segments of the population, but more can be done. Moving forward, the DOH, as the principal agency responsible for ensuring access to basic public health services, may consider providing presence, direction, and influence to grow the low-priced contraceptive market. This includes tracking commercial sales data, market trends, market segmentation, and pricing to gain better knowledge of the commercial market;

identifying factors that increase CPR; and developing appropriate interventions to fill identified gaps in service delivery or supply. Specifically:

- DOH can leverage its role in distribution and sales in government hospitals and village pharmacies, particularly in remote areas not easily reached by the commercial sector.
 - DOH might finance and support the promotion of FP practices and services in partnership with private players who market their own contraceptive brands.
 - Subsidies for FP supplies and services to the poor and very poor segments of the population should be increased.
 - Carry out frequent market research to update the data companies need to develop pricing and market penetration strategies.
 - Create alliances with pharmaceutical companies to engage them in market development.
 - Expand incentives to local companies that show interest in developing new markets. Work with international companies to expand existing markets.
 - Continue public sector engagement of the pharmaceutical industry through (i) programs to facilitate and support national and multinational pharmaceutical companies and social marketing organizations so as to expand choices and penetrate all segments of the market, and (ii) encourage competition among suppliers to keep prices low and expand coverage.
- Focus on market potential for reaching out to consumers with unmet needs rather than just switching acceptors from free to purchased contraceptives. Evidence from PRISM suggests that the market for new contraceptive users grew faster than the total market rate.

Private Practice Initiatives

To maximize gains and ensure sustainable private sector involvement in FP/MCH:

- The government needs to develop a strategy and policy statement that categorically promotes private sector service delivery contributing to the attainment of MDGs.
- Private sector midwives should be considered a key component in government strategy implementation. Private sector midwives can provide a rapid, low-cost, sustainable response at the community level, offering a good fit with government health initiatives.

- Efforts should be continued to promote a business orientation for private practice midwives tied to PHIC accreditation and development of a variety of birthing home business models adapted to specific local circumstances.
- Analyze and disseminate best practices for private practice midwives, such as:
 - Seeking accreditation
 - Providing training and technical assistance to local partners
 - Providing tools and skills to partners who can continue serving birthing homes
 - Providing midwives with business skills
 - Building linkages with LGUs and other local health providers
- Increase support from the medical profession for FP/MCH services as an essential part of high-quality provider practice.
- Collaborate with associations to increase the number of participating private practice midwives to build the critical mass needed to affect major indicators.

A Comprehensive Approach to Private Sector Mobilization for Family Health

- Mainstream BCC into all PPPs for expanding FP/MCH services.
- Promote private sector involvement through a consultative and participatory approach at both the national and local levels through all phases of implementation.
- When working with national and local government to develop and implement market-driven initiatives, focus on policy formulation and guidelines.
- Promote synergy and coordination among activities related to markets (supply), communications (demand), and partnerships (policy) to achieve project objectives at the national and local levels.
- Use a bottom-up Local Market Model to build up to a national approach so as to leverage effective multi-player coordination and to identify best practices for specific market, social, and economic conditions.