

**MIDTERM ASSESSMENT OF INTERMEDIATE  
RESULT 3 OF STRATEGIC OBJECTIVE 3:  
‘INCREASED PRIVATE SECTOR PROVISION  
OF CONTRACEPTIVES AND  
FAMILY PLANNING/MATERNAL AND  
CHILD HEALTH SERVICES’**

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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## LIST OF ABBREVIATIONS

AIDFI	Associates for Integral Development Foundation, Inc.
AVSC	AVSC International
BFAD	Bureau of Food and Drugs
BINHI	Bukidnon Integrated Network of Home Industries, Inc.
BTL	Bilateral tubal ligation
CA	Cooperating Agency
CARE	Cooperative for Assistance and Relief Everywhere
CBDO	Community-Based Distribution Outlet
CBFP	Community-Based Family Planning project
C/D	Mid to low income levels on a scale of A to E
CDLMIS	Contraceptive Distribution Logistics and Management Information System
CHDC	Community Health and Development Cooperative Hospital (in Davao City)
COMDEV	Community Health and Development, Inc.
CPR	Contraceptive prevalence rate
CSM	Contraceptive social marketing
CU	Continuing user
CV	Community volunteer
CYP	Couple year of protection
DKT	DKT Philippines, affiliated with DKT International
DMPA	Depo-medroxy progesterone acetate, an injectable contraceptive
DMSF-IPHC	Davao Medical School Foundation-Institute of Primary Health Care
DOH	Department of Health
DOLE	Department of Labor and Employment
DTI	Department of Trade and Industry
FCB-LFI	First Consolidated Bank-Livelihood Foundation, Inc.
FHCC	Family Health Care Center
FMPI	Feed My People International
FP	Family planning
FPOP	Family Planning Organization of the Philippines
FPPO	Family planning program officer
FPS	Family Planning Service (DOH)
GOP	Government of the Philippines
HMO	Health maintenance organization
IEC	Information, education, and communication
IFPMHP	Integrated Family Planning, Maternal Health Program
IMCCSDI	Integrated Maternal Child Care Services and Development, Inc.
IMCH	Institute of Maternal and Child Health
IMS	Information Medical Statistics

IPHC	Institute of Primary Health Care, Davao Medical School Foundation
IPPF	International Planned Parenthood Federation
IR	Intermediate Result
JHPIEGO	Johns Hopkins Program in Reproductive Health
JSI/RTI	John Snow International/Research and Training Institute
LGU	Local Government Unit
LPP	Local Government Unit Performance Program (Component of IFPMHP)
MCH	Maternal and child health
MIS	Management information system
MOA	Memorandum of Agreement
MCRA	Married couple of reproductive age
MWRA	Married women of reproductive age
NA	New acceptor
NFP	Natural family planning
NGO	Nongovernmental organization
NORFI	Negros Occidental Rehabilitation Foundation, Inc.
NSO	National Statistics Office
OB/GYN	Obstetrician/Gynecologist
OCP	Oral contraceptive pill
PAAD	Program Assistance Approval Document
PCPD	Philippine Center for Population and Development
PCSMP	Philippine Contraceptive Social Marketing Program
PHILHEALTH	Philippine Health Insurance Corporation
PHN	Center for Population, Health and Nutrition (USAID)
PMAP	Personnel Management Association of the Philippines
POPCOM	Population Commission
POPTECH	Population Technical Assistance Project
RHU	Rural Health Unit
RP-MCH	Responsible Parenthood-Maternal and Child Health project
SDI	Integrated Maternal Child Care Services and Development, Inc.
SO	Strategic Objective
SOMARC	Social Marketing for Change
SOW	Statement/Scope of Work
SpO	Special Objective (USAID)
SUEP	Silliman University Extension Program
TANGO II	Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations II project
TFGI	The Futures Group International
TFR	Total fertility rate
TLDFI	Tribal Leaders Development Foundation, Inc.
TMFI	Ting Matiao Foundation, Inc.

TUCP	Trade Union Congress of the Philippines
UNFPA	United Nations Fund for Population Activities
USAID/W	United States Agency for International Development/Washington
VS	Voluntary sterilization
VSC	Voluntary surgical contraception
WESADEF	Western Samar Development Foundation
WFMC	Well Family Midwife Clinic
WHO	World Health Organization



# EXECUTIVE SUMMARY

## Project Description

The subject of this assessment is USAID/Philippines's *Strategic Objective 3 (SO 3), Reduced Population Growth Rate and Improved Maternal and Child Health (MCH)*, and specifically its Intermediate Result (IR) 3, increased private sector provision of family planning (FP) and MCH services. The primary mechanism for achieving the SO and IRs is the USAID-funded, six-year, \$153 million (\$65 million bilateral, \$62 million Global Bureau, and \$26 million Government of the Philippines [GOP]) Integrated Family Planning Maternal Health Program (IFPMHP) begun in April 1994 and ending in February 2001.

IR 3 provides assistance for (1) strengthening nongovernmental organizations' (NGO) capability for FP/MCH service delivery, (2) expanding industry-based FP/MCH programs, (3) developing private sector channels for services and commodities through social marketing, and (4) achieving policy reforms that will shift public sector users who can afford to pay to the private sector and increase the overall participation of the commercial private sector in the FP program.

Five principal activities are underway to achieve program goals: John Snow Inc./Research and Training Institute (JSI/RTI) is implementing NGO capacity building under the Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations II (TANGO II) project and through CARE Philippines's NGO-Support Project Phase II, Sustainable Community-Based Family Planning. Industrial sector activities are carried out by the Philippine Center for Population and Development (PCPD). The Philippine Contraceptive Social Marketing Project (PCSMP), implemented by The Futures Group International (TFGI), is working to expand access to and the supply of contraceptive products through commercial channels. Finally, AVSC International is working in conjunction with JSI/RTI to strengthen and make the provision of voluntary sterilization (VS) services sustainable in the private sector. In addition, the POLICY Project, implemented by TFGI, is engaged in research and policy reform activities that directly support the NGO program, the employer-based program, social marketing, and the commercial sector.

## Purpose of this Assessment

The Scope of Work (SOW) for this assessment identifies eight objectives for the IR 3 midterm review. These objectives focus on measuring progress in achieving the objectives of each activity and evaluating their relative cost-effectiveness; assessing the validity of the IR 3 benchmark indicator, that "private sector contribution [of contraceptive prevalence rate (CPR)] increases from 27 percent to 34 percent between 1993 and 2000," and recommending revisions in the level and monitoring of the IR 3 benchmark; and recommending modifications in design and implementation of projects and follow-on activities.

The assessment team used qualitative and quantitative rapid appraisal methods, including interviews with key informants, direct observation, document review, and cost-effectiveness analyses. The team conducted interviews with Cooperating Agency (CA) and USAID/Washington staff in the United States and carried out field work from March 5 to April 1, 1998, in metro Manila and ten sites around the country.

### **Philippine Contraceptive Social Marketing Program**

The PCSMP has not met expectations. Original agreements with manufacturers failed to introduce a typical contraceptive social marketing (CSM) range of low-cost contraceptives; overly ambitious sales benchmarks were established without the manufacturers' concurrence, and these benchmarks were not met; costs per couple-year of protection (CYP) declined slowly between 1993 and 1997 (and will rise sharply in 1998) and have not led to a sustainable model of efficiency.

A new Social Marketing for Change (SOMARC) management team has been put in place. They have addressed one of the primary weaknesses of the program—the lack of a strong promotional effort by the manufacturers and their distributors directed toward their CSM brands—by introducing their own promotional field force and a major advertising and public relations campaign. This campaign is beginning to show positive results, but because the team had been fully operational for only four months prior to this assessment, it is too early to determine the impact that their activities are having on sales.

Sales forecasts were revised downward in 1998 but are still optimistic. A conservative sales estimate shows that if a long-term exit strategy is developed that gradually reduces SOMARC's expenditures, the project could achieve a level of cost-effectiveness by 2003. However, a more significant level of commitment is essential from manufacturers and distributors if the program is to achieve its aims.

Five areas of concern for PCSMP are identified in this report. These five areas will require attention if the program is to achieve long-term sustainability: pricing, brand differentiation, sources of information for non-FP users and users of free public services, sales through NGOs and industrial clinics, and the IUD market.

## **Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations II Project**

The success of Well Family Midwife Clinics (WFMC) will greatly depend on their ability to attract potential FP acceptors who are willing and able to pay for quality FP/MCH services. TANGO II's progress indicates that the pricing of quality services is largely on the mark and that the provision of high-quality services in well-equipped, midwife-operated clinics has considerable appeal to those who can afford to pay.

Tango II's accomplishments over the past 15 months far outweigh the problems noted in this assessment. TANGO II's progress indicates that a successful model has been developed that is widely applicable throughout the country. Although the current benchmark of 330 WFMCs by the end of the program is a good start, the potential exists for considerably more WFMCs in areas where TANGO II is already operating, as well as in other parts of the country. USAID needs to consider expanding this effort under the current Cooperative Agreement and including similar assistance in its program beyond 2000.

JSI/RTI's proposed phasing of first-year FP benchmarks—four months for WFMC start-up—followed by quarterly CYP benchmarks increasing by quarter from 30, 40, 50, and then 60 CYPs per month per clinic for temporary methods, reflects the experience of clinics that performed well in the 1997 group. This schedule should be adopted for the new 1998 and 1999 WFMC program entrants. MCH benchmarks need to be increased substantially—perhaps tripled for the first year—and increased every six months thereafter to encourage business development. Benchmarks must take into account that some WFMCs will drop out of the program and be replaced by new clinics, which will reduce the overall accomplishment of CYPs for the NGO.

The lack of business development training (as opposed to technical training for FP/MCH services and facility operation) and technical assistance in business development is a serious weakness that JSI/RTI needs to address. JSI/RTI has scheduled a business development planning workshop during the third quarter of 1998.

Although sponsorship by locally recognized NGOs lends public credibility to the WFMCs, the clinics would benefit from being more readily identified as part of the WFMC network. The NGOs should continue to be associated with the WFMC network; however, in some cases linking the WFMC with the sponsoring NGO virtually overwhelms the franchise or network association, making the WFMC appear as yet another variation of a NGO-supported clinic. USAID, JSI/RTI, and the participating NGOs need to reconsider the nature of the NGO-WFMC relationship that is evolving as NGOs move toward becoming technical and management service providers for their WFMC clients.

Public recognition of the WFMCs will be facilitated by maintaining the standards and appearances of the facilities, including the WFMC signs, which set WFMCs apart from public facilities. Furthermore, greater uniformity in appearance, such as the recognizable standard appearance,

logos, and signs of other types of franchise networks, will contribute to this end. In short, JSI/RTI needs to establish and enforce standards for the WFMCs' physical appearance, just as standards are in place for technically sound, quality FP/MCH services.

NGO technical and management service provision to the WFMCs is crucial to maintaining clinic standards in the coming years. Without such support, WFMCs could quickly experience falling levels of FP/MCH service provision, declining quality of care, increasing reliance on government subsidies (that is, free contraceptives), and diminishing appeal to those who can pay for services. If by the end of 1998 NGOs prove unable to make the transition to business-like relations with the WFMCs they sponsored, alternative approaches for servicing the clinics' needs should be tried.

### **CARE's Community-Based Family Planning Project**

The Community Based Family Planning project (CBFP) has made progress in developing community-based FP services in underserved areas. The Cooperative for Assistance and Relief Everywhere (CARE) program was a worthwhile undertaking when originally envisioned; however, activities like CBFP, in general, and the CARE FP program, in particular, no longer fit within USAID/Philippines's strategic objectives in the population sector. Increasing the national CPR by at least 1.5 percent annually over a five-year period requires reaching large numbers of people as quickly as possible.

As CBFP shows, activities that focus on underserved communities—many of which are in rural areas with scattered populations—cannot generate the number of family planning acceptors and continuing users needed to have an impact on the national CPR. This is not a criticism of CBFP or other similar projects, nor is it a criticism of those involved with CBFP. It is the nature of the problem such projects address that accounts for these results. In CBFP's case, the problem was compounded by working through non-FP NGOs. Developing FP service delivery capabilities in these non-FP organizations to service rural communities was not cost-effective.

Although sustaining FP service delivery through community-based mechanisms was a major element of CBFP, a significant part of CBFP's accomplishments are likely to decline or cease operating over time, particularly in rural, isolated areas, because of a lack of further support. CARE and its NGO partners have attempted to obtain financial support from various Local Government Unit (LGU) levels, but they have had limited success. A number of LGU officials responded that they simply lack adequate funds. Therefore, the suggestion that the NGOs sustain their program activities with funding through the Local Government Unit Performance Program (LPP) grant program or other government channels appears to have little or no prospect of success. The same lack of funds that accounted for inadequate government services in the first place undercuts the chances of these NGOs obtaining new government funding.

Some opportunities may exist to increase the likelihood of sustaining some CBFP elements. FP services in densely populated areas supported by a NGO with an equipped clinic and trained staff



could become self-sustaining. Combining cross-subsidization of services to underserved areas from for-fee clinic operations, support from the LGU for a service site in barangay facilities, supply of free contraceptives from the government, and collection of minimal fees and charges for contraceptives might be a viable approach in these cases.

### **AVSC International**

Because this project began in November 1997, it is premature to evaluate the effectiveness of the project design. However, the success of the project will greatly depend on good working relationships among the project's key players: AVSC International, JSI/RTI, NGOs and their franchised clinics, and private practitioners. Difficulties may arise if roles and responsibilities are not clarified among all partners and accepted early in the project, and if no effort is made to assess how this new partnership is congruent with existing ones.

The following issues may also emerge in project implementation. First, in areas where VS sites are near public facilities that are also being strengthened by AVSC under its public sector project, the two facilities may turn out to compete with each other unless their respective services and prices are well differentiated. Second, any disagreement regarding fees should be addressed immediately to avoid having providers opt out of the project midstream. Third, the reporting and monitoring system has to be assessed with regard to franchised clinic's midwives to ensure that they are not overburdened with reporting and monitoring visits.

### **Responsible Parenthood-Maternal and Child Health Project**

The Philippine Center for Population and Development (PCPD) has developed a model of an industry Responsible Parenthood-Maternal and Child Health (RP-MCH) project that works well in certain environments. In the companies where it has been successfully installed, PCPD has been able to set up a structure and a system that ensures the institutional sustainability of the program before PCPD withdraws. PCPD has also succeeded in creating networks of RP-MCH committees from various companies. This mechanism can work as a support structure for institutional sustainability.

However, in modifying the same basic model over 10 years, PCPD may have overlooked other ways of bringing the program to companies. Management support, both in initially accepting the program and in continuing program activities after involved managers resign, has remained a problem throughout the project's long life. No defining strategy has been developed to address this problem.

Similarly, the search for new partners and new entry modes has not been pursued as vigorously or as creatively as may be warranted by a program that can invoke support from government agencies such as the Department of Health (DOH), the Department of Labor and Employment

(DOLE), and the Philippine Health Insurance Corporation (PHILHEALTH); market partnerships with dynamic private sector companies and health care industry NGOs; and obtain support from labor unions (through collective bargaining agreements). These partnerships do not only offer ways of reinforcing their work; they will ensure that the RP-MCH programs are lodged in institutions that can nurture them should the project end.

Over a decade, PCPD has accumulated experience implementing work-based programs, and other countries can benefit from its knowledge. An in-depth analysis and documentation of different aspects of the RP-MCH program would contribute to the field.

## **Program Environment**

The Program Assistance Approval Document (PAAD) for IFPMHP, designed in 1993 for program start-up in 1994, had ambitious goals for the growth of the private sector share of family planning services and supplies. The 1993 Philippines National Demographic Survey (NDS) showed that 71 percent of contraceptive users obtained services from the public sector, while 27 percent met their needs through private providers. The PAAD projected that by the end of IFPMHP, the proportion of users at government clinics would drop to 40 percent. It also projected a new distribution of users in the private sector: 25 percent to be served by nonprofit NGO outlets, 25 percent to be served by social marketing, and 10 percent to be served by private doctors and other sources. At the same time, the PAAD projected an annual growth of 1.5 to 2.0 percent in the use of modern contraceptives, implying a rise from about 25 percent in 1993 to 34 to 37 percent (35.7 percent is mentioned in the Results Framework) in 1999.

In hindsight, these goals, particularly regarding expansion of the private sector market share, were not attainable in the short term. Although growth in each sector was feasible, it was expected to take place within a context of major change for the national family planning program, as authority for monitoring and coordination shifted from POPCOM to the DOH, and as frontline responsibilities were devolved to LGUs. Furthermore, the overall program had been moribund during the Aquino administration and was only recently regaining political support as a result of the 1992 election of President Fidel Ramos. The expected growth in the private sector implies a linear increase in program activity each year, which is highly unlikely during a period of such large-scale expansion to previously nonparticipating organizations.

In late 1995, results from the first rider to the annual labor survey of the National Statistics Office (NSO), showed a drop of nearly eight percentage points in the share of contraceptive users using private sector sources. The DOH and USAID could not easily determine whether the shift represented a growth in the absolute numbers of public sector users, thereby reducing the proportion using the private sector, or whether the baseline data were flawed. Within this context and considering experiences in other countries, new assumptions for private sector growth were negotiated, reducing overall growth during the program period to one percent annually.

USAID and the DOH estimated that a 35.7 percent modern method contraceptive prevalence rate is equivalent to 3.94 million CYPs. A goal of 2.60 million CYPs was set for the public sector and 1.34 million for the private sector to be achieved by 2000. Shifts in the proportion of users accessing different segments of the private sector were assumed, with private hospitals, clinics, and NGOs growing from 16.4 percent in 1993 to 20 percent by 2000, and pharmacies and stores growing from 7.5 percent to 10 percent. The remaining 4 percent of the market share would be taken up by private doctors, midwives, and industry-based clinics.

The assessment team did not have access to the assumptions of method mix underlying the CYP calculation, and thus cannot comment on its appropriateness. Given the vitality of the private sector in the Philippines, the income level of residents, and the widespread availability of a variety of private sector health services, the projected growth of its market share seems reasonable. Not yet apparent during the development of the IR 3 benchmarks were the obstacles to program implementation that became evident during 1996 to 1997: weak NGO capacity, stunted growth of the social market, slow inroads to the industrial sector, and small proportions of private doctors and midwives trained to provide family planning services.

Fieldwork for the 1998 round of the National Demographic Survey (NDS) was underway as this assessment was taking place. Collected data will provide a new picture of the distribution of private sector sources for contraceptive users and will indicate whether perceptible growth is taking place in the sector.

### **Future Role of Private Sector and Follow-on Private Sector Strategies**

The private sector's potential to deliver family planning commodities and supplies and other RH services remains largely untapped. The midwife franchise system supported by TANGO II can increase significantly and should be encouraged to do so. This system's growth should be monitored, however, to maintain minimum standards of quality. A set of inspection criteria should be developed and a routine system instituted to ensure that participating midwives adhere to a set of common practices and services that are delivered with appropriate care. Once midwives graduate from direct NGO support, they must agree to regular annual or biannual inspections, perhaps coupled with an association registration, to verify their continued qualification as a WFMC.

The industrial sector also presents a large potential market for contraceptive users. The current program lacks attention to unmarried workers. Although there may be cultural inhibitions against providing FP services to women before marriage, NDS data show that 30 percent of women aged 20 to 24 were sexually active by age 20, usually within the context of marriage. Opportunities are being missed to inform, educate, and motivate young women to choose contraceptives early in their childbearing years to plan and space their pregnancies. Although participation in on-site seminars is usually open to all workers, little extra effort is made to encourage attendance by unmarried women.

Industrial programs must also give more emphasis to family planning. For most sites visited by the assessment team, family planning and RH are included as one component of the company's family welfare program. As such, it is typically given concentrated attention during only one month per year, as part of an annual agenda including such topics as dental care, eye care, exercise, sport, and cardiovascular disease. Company staff must recognize that RH and FP are daily needs for women and that these areas warrant more consistent attention throughout the year.

Of the IR 3 program components, PCSMP presents the most puzzling dilemma. After nearly six years of development, the public still has little demand for socially marketed contraceptives. The team believes this may change if a longer-term, revised marketing strategy that involved greater commitments from manufacturers was coupled with a more consumer-oriented approach to establish clear brand recognition through price differentiation, to motivate new users, and to draw existing users away from public sector sources. Unless revised strategies are put in place, it cannot be recommended that this project be extended beyond September 1998.

## LIST OF RECOMMENDATIONS

### PCSMMP

1. The project should be terminated at the end of 1998 unless a long-term, sustainable strategy containing realistic projections is developed in cooperation with manufacturers.
2. Couples Choice OCP brands should become a more explicit range of social marketing brands—that is, high-quality products differentiated from competitive commercial brands by price. Therefore, manufacturers providing brands to the project should discount their prices or provide new, lower-cost CSM brands or new, domestic brands.
3. The project may have to give some support to pricing, at least for an initial period. This support could come from existing promotional budgets, with an acceptable mechanism worked out to transfer these funds from the project to the manufacturer.
4. A clear exit strategy needs to be worked out between SOMARC and the manufacturers that would involve longer-term commitments from both USAID and the manufacturers—at least a five-year period is recommended. Over this time frame, prices may be gradually raised and SOMARC expenditures gradually reduced.
5. The program needs to better understand how a new user or an existing free-service user may be motivated to procure contraceptives from the commercial sector, and how they may be better motivated to do so.
6. Changes in the law are needed that would permit doctors to dispense hormonal contraceptives.
7. Some forms of direct subsidy by SOMARC, taken from promotional budgets, for supply to NGOs and midwives should be considered for a few years to assist in the weaning process from free supplies, particularly for the IUD.

### TANGO II

8. The Cooperative Agreement for TANGO II should be amended to increase funding to support establishing additional WFMCs in areas (regions) that have NGOs operating, but that could support more clinics. (This does not mean that NGOs should expand their area of operation nationally.)
9. The overall potential for the WFMCs' expansion should be estimated to develop as wide a network of sustainable clinics as possible—that is, identify potential new areas and family planning NGOs working in those areas, and estimate how many WFMCs might be viable

as a basis for designing an expanded activity, such as TANGO III. The POLICY Project can assist JSI/RTI in this situational research.

10. WFMC benchmarks should be revised as proposed by JSI/RTI for the first year of operation for new 1998 and 1999 clinics and a schedule of gradually increasing benchmarks should be developed for the second and third years of operation, reaching 90 or more CYPs per month per clinic for FP methods. MCH benchmarks should be increased based on first-year (1997) results. Benchmarks should be adjusted in light of expected drop-outs and replaced clinics.
11. JSI/RTI should provide technical assistance in small business development to both the NGOs and the WFMCs. Initially, such services could be provided by a local consultant, but as the project expands, JSI/RTI should consider adding a small business development specialist to its staff. Simple business development plans covering a one-year period should be developed for each clinic by JSI/RTI and its partner NGOs as part of this activity. These plans should include activities that will expand FP services to make them more profitable.
12. JSI/RTI and the NGOs need to expand efforts to facilitate access to local industries and agribusinesses, particularly those that employ large numbers of women, for WFMC midwives.
13. NGOs should provide specialized technical assistance to midwives to improve record keeping and accounting. NGO staff should work directly with midwives to accomplish this recommendation. No more general training should be conducted until each midwife can maintain records unassisted. JSI/RTI should train NGO staff and midwives in simple analytic uses of the data they are generating to improve follow-up efforts and to expand business and income.
14. Clinic standards for appearance, signs, and other elements should be established to identify the clinic as part of the WFMC network. Such efforts could include emphasizing the blue and white color combination when painting clinics to correspond to the WFMC signs. Although signs should include identification of the sponsoring NGO (name and logo), large signs and logos, monogrammed sheets, and other materials clearly associated with the NGO should be eliminated. All new participating NGOs should adopt the same standards, such as those for appearance and signs, associated with the WFMC network. In the annual agreements between JSI/RTI and the participating NGOs, the NGO/WFMC service provider-client relationship should be clarified.
15. The use of government-supplied contraceptives should be eliminated in all existing WFMCs by the end of 1998. Supply or use of government-supplied contraceptives should not be permitted in any new clinics.

16. JSI/RTI should evaluate the effectiveness of its radio campaigns by surveying WFMC clients. It should pilot television marketing in metro Manila and Cebu by mid-1998 and evaluate its effectiveness. JSI/RTI, NGOs, and WFMCs should emphasize low-cost, high-impact marketing and advertising.
17. Each NGO should carefully review the performance of its poorly performing clinics and replace those that have not improved significantly by the end of April 1998. Replacements should be in addition to (not substitutes for) the new 1998 WFMCs.
18. NGO association fees for WFMCs should be increased to at least P300 per month by the end of April 1998 for the 1997 WFMCs. Lower rates should be maintained for first-year WFMCs. Service plans, service provision costs, and service prices to be paid by the WFMCs should continue to be refined expeditiously.

### **CBFP**

19. In line with its current Strategic Objective for the population and health sector, USAID should cease further funding for the CARE FP program. USAID's program support should end with the current grant in June 1998.
20. CARE and its NGO partners should continue their efforts to gain LGU support for community volunteers (CV) where such support is currently lacking. If the barangay is unwilling or unable to provide support, assistance should be pursued at higher government levels.
21. If analysis of CBFP sites in locations with dense populations, an NGO with a FP clinic, strong LGU support, and a minimal capacity for clients to pay for services and supplies are possibilities for self-sustaining FP services from the CBFP project, JSI/RTI should consider CARE's NGO partners for participation in TANGO II.

### **AVSC International**

22. Agreements and subagreements must clearly define roles, responsibilities, and accountabilities of the key players in the project, especially for the important evaluation indicators. Process activities should be held (workshops, meetings, formation of task forces, and working committees) if the working relationships on which the project is premised require clarification or negotiation.
23. The screening of the locations for VS referral sites should not only consider their proximity to the midwife clinics to be served, but also their proximity to public facilities that may compete for the same clients.

24. The project should help the VS sites develop services that can be differentiated by their target clientele from the free services available at public facilities. Characteristics of such services could include shorter waiting times and more frequent scheduling of VS services. Such a differentiation may help increase the family planning market segment of low-income, female, permanent-method users who go to public hospitals and clinics for VS services. These users are estimated to be 8.2 percent of the market share, or about 411,000 women in 1997.
25. To avoid possible dissatisfaction with the standard fees, a more rigorous costing method should be used to come up with the schedule of fees; some flexibility in fee-setting, within limits, should also be allowed to accommodate variations in catchment areas, market incomes, and facility standards. In addition, the project should facilitate the VS site's access to VS reimbursements available under the PHILHEALTH benefit package.
26. Record keeping by the midwife at the franchised clinic should be kept simple and manageable. NGOs should be held responsible for most record keeping.

#### **PCPD**

27. Design an IEC program for unmarried people in Cycle 4 companies. Program implementation must abide by company-specific policies that may limit availability of contraceptives and services to unmarried workers. PCPD reportedly undertakes IEC efforts for unmarried workers, but the assessment team believes more can be done to reach this population to prepare them for decisions they will make regarding reproductive health and family planning.
28. Before the project ends in December 1999, the following documentation should be completed:
  - An analysis of project strengths and weaknesses, including lessons learned;
  - A report on the work done to meet the three "innovation" objectives;
  - A manual containing all procedures, systems, and structures related to the company-based institutional sustainability of the program;
  - A manual containing all procedures, systems, and structures related to the networking of participating companies in RP-MCH program-related activities;
  - An industry-disaggregated performance analysis and benchmarking of participating companies.



29. Efforts to increase the family planning contribution of the industry-based private sector should continue. Based on the results of the documentation of Cycle 4, more findings and conclusions can be drawn about the types of companies and industries that the RP-MCH program is most suited for. For other companies and industries, some considerations for a redesigned project include the following:
- Going beyond the basic RP-MCH model that has been used for over 10 years to consider other implementing partners, entry strategies, and program implementation modes, as well as special requirements of target industries and target market segments.
  - Packaging and marketing the RP-MCH program as a business case proposition to get management support (promotional package with testimonials from respected business leaders, with professional, sophisticated cost analyses and productivity indices). Industry-specific business cases can be used as marketing tools and as monitoring frameworks for regular reports to top management.
  - Strengthening existing alliances and developing new links with organizations with a legal mandate for FP (DOH and DOLE), organizations interested in a shared market (HMOs, and health insurance companies, including PHILHEALTH), and mission-driven groups such as unions and NGOs. Develop strategies to use these alliances to ensure the sustainability of the program.
30. Any future project should be worked out in close cooperation with pertinent offices of the Department of Labor and Employment with the long-range view of lodging the project within an institution whose mandate ensures its continuing implementation beyond USAID assistance.

The results of the evaluation team's field visits to the DOLE offices were not particularly encouraging in terms of ongoing cooperation, possibly because ongoing cooperation was not clearly stated as an objective in the current project. The project to be designed can have as a deliverable a partnership in place between the DOLE and the implementing organization, building on DOLE's present work, involving an exchange of resources and technical assistance, and supported by a clear memorandum of agreement.

## **Program Environment**

31. Given that IFPMHP subprojects are not reaching benchmark CYP output and will not do so by the end of the project, USAID should revise its benchmark in light of the actual subproject performance and data obtained from the 1998 NDS.
32. USAID and its service delivery partners should reemphasize use and interpretation of measures of continuing users and new acceptors for monitoring (not performance) purposes, to ensure appropriate counselling and client follow-up, thereby reducing program drop-outs and method failure.
33. Growth of the midwife franchise system should be monitored to ensure that standards of quality are maintained. A routine inspection system should be developed—perhaps implemented by a professional association—and participating midwives should agree to regular audits to verify their continued qualification as a WFMC.
34. Industry-based programs should exert greater effort to reach young, unmarried women. An IEC program targeting the needs of young women should be developed and implemented in partner companies with large unmarried workforces. Negotiations should be undertaken with companies to secure specific times, for example during shift changes, when such programs can be presented.
35. Industrial programs must further emphasize the family planning content of the RP-MCH program. Company staff should recognize that RH and FP warrant more consistent attention because women want and need to learn more about these issues.
36. Renegotiation of the SOMARC contract or development of a new procurement with a different contractor must include a long-term marketing strategy that requires greater commitment and participation from manufacturers coupled with a more consumer-oriented approach.

## **CHAPTER 1. INTRODUCTION**

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### **1.1 Project Description**

The goal of USAID/Philippines assistance is to support the Government of the Philippines's (GOP) effort to achieve the status of a newly industrialized democratic country by the year 2000. Toward this end, USAID/Philippines is supporting six Strategic Objectives (SO) and two Special Objectives (SpO). The focus of this assessment is *SO 3, Reduced population growth rate and improved maternal and child health (MCH)*, and specifically its Intermediate Result (IR) 3, increased private sector provision of family planning and MCH services.

The primary mechanism for attaining these SOs and IRs is the USAID-funded, six-year, \$153 million (\$65 million bilateral, \$62 million Global Bureau, and \$26 million GOP) Integrated Family Planning Maternal Health Program (IFPMHP), which was initiated in April 1994 and has a completion date of February 28, 2001. IFPMHP was developed in 1994, prior to USAID reengineering efforts. A new Results Framework was developed in 1996, setting forth how SO 3 would contribute to sustainable development in the Philippines, how each IR would contribute to achieving SO results, and how the IRs would be achieved.

IR 3 expands assistance for (1) strengthening nongovernmental organizations' (NGO) capability for FP/MCH service delivery, (2) expanding industry-based FP/MCH programs, (3) developing private sector channels for providing services and commodities through social marketing, and (4) achieving policy reforms that will shift public sector users who can afford to pay to the private sector and increase the overall participation of the commercial private sector in the FP program. Financial sustainability is a major objective of IFPMHP. It is hoped that expanding NGO and commercial channels of FP/MCH services will eventually shift individuals who can pay for all or part of service costs from free or subsidized government services to nongovernment channels.

Five principal activities are underway to achieve program goals: The John Snow Inc./Research and Training Institute (JSI/RTI) is implementing NGO capacity building under the Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations II (TANGO II) project and through the Cooperative for Assistance and Relief Everywhere (CARE) Philippines's NGO-Support Project Phase II, Sustainable Community-Based Family Planning. Industrial sector activities are carried out by the Philippine Center for Population and Development (PCPD), a local NGO. The Philippine Contraceptive Social Marketing Program (PCSMP) is working to expand access to and supply of contraceptive products through commercial channels. Finally, AVSC International is working in conjunction with JSI/RTI to strengthen and make sustainable the provision of voluntary sterilization (VS) services in the private sector. In addition, the POLICY Project, implemented by The Futures Group International (TFGI), is conducting research and policy reform activities that directly support the NGO program, the employer-based program, social marketing, and the

commercial sector. Their activities are being considered in this assessment because they are affecting the changing strategies and policy environment within which private providers function.

## **1.2 Purpose of This Assessment**

The Scope of Work (SOW) for this assessment (see Appendix A) identifies the following objectives for the IR 3 midterm review:

1. To assess the progress in achieving objectives of each activity, and to evaluate the relative cost-effectiveness of each activity in terms of their actual and potential contribution to IR 3;
2. To review implementation, considering strengths and weaknesses of project design, effectiveness of marketing and sustainability strategies, and efficiency in the management and implementation process;
3. To assess GOP/Department of Health (DOH)/Local Government Unit (LGU) awareness, appreciation, and support of IR 3 and their role in furthering IR 3 activities;
4. To assess the validity of the IR 3 benchmark indicator, that "private sector contribution [of contraceptive prevalence rate (CPR)] increases from 27 percent to 34 percent between 1993 and 2000";
5. To recommend revisions in the level and monitoring of the IR 3 benchmark, modifications to the design and implementation of the individual projects, strengthened linkages among project activities, and enhanced GOP/DOH/LGU support;
6. To assess the potential role of the private commercial and NGO sectors in FP/MCH, and to identify additional strategies to encourage their participation;
7. To make recommendations for follow-on activities, assuming reduced USAID resources in the 2000 to 2005 planning period.

The SOW identifies specific issues and questions to be considered for individual projects that have shaped the team's findings and conclusions for each project. These findings and conclusions are summarized in Chapters 2 through 6.

This assessment covers the period from the signing of individual project agreements to this review in March 1998. Although the program was initiated in April 1994, start-up dates vary among the component subprojects. In addition, two projects have been significantly modified since their start

dates. Thus, the review of TANGO II's performance-based service delivery strategy is from January 1997, and the review of CARE's family planning project is from July 1996.

### **1.3 National Context**

The most recent population census conducted in 1995 found a population of 68.6 million resulting from a growth rate of 2.32 percent per year from 1990 to 1995, virtually unchanged since the early 1980s. Thirty-seven percent of the population is below age 15, and nearly 56 percent is of working age (15 to 64). The total fertility rate (TFR) has declined during the past three decades from 6.0 children per woman in 1960 to 4.1 in 1991. This rate continues to exceed women's expressed ideal number of children, 3.2.

Knowledge of contraception is virtually universal, with 96 percent of all women and 97 percent of married women of reproductive age (MWRA) knowing some methods of contraception. Knowledge has not been translated into use, however; per the 1997 Family Planning Survey, in 1997 only about 31 percent of currently married women were using a modern contraceptive method (including modern natural family planning [NFP]). The most widely-used method is the oral contraceptive pill, followed by voluntary surgical contraception (VSC) and the IUD (12.5, 10.6, and 3.0 percent of MWRA, respectively). Meanwhile, 16.1 percent of MWRA rely on traditional NFP methods.

Nearly three-fourths of all users obtain their method from a public sector provider. It appears that the private sector role actually shrank from 27 percent to 24 percent between 1993 and 1997. This reduction, however, may be evidence that the private sector did not keep pace with expanding services in the public sector, thus accounting for a smaller market share. IR 3 was developed to increase the use of contraceptives and to shift a greater share of users to private sector sources. A larger, more active private sector is expected to contribute to the sustainability of the program in the face of scarce public resources and the possible election of a pro-natalist administration.

### **1.4 Assessment Methodology**

The assessment team included five professionals:

Susan Adamchak, Ph.D., Evaluation and Policy Specialist (Team Leader)  
Emelina Almario, M.A., Project Management Analyst  
Laurie Emrich, M.A., Financial Analyst  
Christopher Hermann, Ph.D., Project Management Analyst  
Richard Pollard, Marketing and Information, Education, and Communication (IEC) Specialist

The assessment team used a variety of qualitative and quantitative rapid appraisal methods, including interviews with key informants, direct observation, document review, and cost-effectiveness analyses (see Appendix B for a bibliography and Appendix C for a list of contacts.) The team conducted several interviews with Cooperating Agency (CA) and USAID/Washington staff in the United States before leaving for the Philippines, and then carried out field work from March 5 to April 1, 1998. Interviews and site visits were conducted in metro Manila, Bacolod, Bukidnon, Butuan City, Cavite, Cebu, Davao City, General Santos, Misamis Oriental, Sarangani, and South Cotabato. Before leaving the Philippines, the team debriefed USAID/Philippines, the DOH, and CA staff and amended the report to incorporate points raised during these meetings.

Chapters 2 through 6 of this report present findings, conclusions, and recommendations for each of the individual subprojects. Chapter 7 contains an assessment of the policy environment within which the program is being implemented and considers the validity of the current program benchmark. Finally, suggestions for future program activity are proposed.

## CHAPTER 2. PHILIPPINE CONTRACEPTIVE SOCIAL MARKETING PROGRAM

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### 2.1 Background

The Philippine Contraceptive Social Marketing Program (PCSMP), implemented with technical support from the Social Marketing for Change Project (SOMARC) of TFGI, supports USAID's private sector initiative in the Philippines through investments designed to open the market for commercial contraceptive brands. Table 1 shows the three oral contraceptive pills (OCP) and an injectable, sourced from four manufacturers, that are promoted through PCSMP.

**Table 1**

**PCSMP Brands and Retail Prices**

Brand	Manufacturer	Date Launched	Maximum
<b>OCPs</b>			
Nordette	Wyeth	1993	P69.25/cycle
Microgynon	Schering	1993	P65.50/cycle
Rigevidon	Gedeon Richter	1996	P42.50/cycle
<b>INJECTABLE</b>			
Depo-Provera	Upjohn	1994	P100/vial

*Source:* SOMARC

Agreements with manufacturers fix prices, outline the efforts that manufacturers' distribution systems will take to ensure products are detailed to medical practitioners and sold to pharmacy outlets, and specify the promotional efforts SOMARC will contribute. All these products are overbranded, for identification and promotional purposes, as "Couples Choice" products.

In 1996, SOMARC undertook an extensive review of its program. It noted that sales performance had not met targeted expectations. The target for 1995 had been set at a couple year of protection (CYP) of 72,169, while actual accomplishment was 42,683, or 60 percent. However, sales of Couples Choice hormonal products had increased by 32 percent from 1994 to 1995, well above the 10 percent increase in the total commercial hormonal sector. It seemed unlikely that sales would reach the target set of 51,615 CYP for 1996. SOMARC's analysis of program constraints included the following:

- **Price:** Although existing prices should be affordable to the target C/D group of consumers, they were high by international contraceptive social marketing (CSM) standards.
- **Poor Detailing:** The distributors' medical representatives were hurried and were not good at targeting messages about contraception to those most likely to be contraceptive service providers in a market where contraceptives were not seen as a priority product. Detailers also demonstrated the need for better training in family planning.
- **Consumer Attitudes:** Consumers showed low use rates, high incidence of lapsed use, fears of side-effects, and alleged concern about opposition by the Catholic Church.
- **Low Promotional Spending in 1995**
- **Lack of Commitment from Upjohn in the Launch of Depo-Provera®**

## 2.2 Implementation

SOMARC reacted to this analysis by proposing a new set of strategic objectives to guide project implementation. The implementation objectives established for 1996 to 1998 have largely been met.

The Rigevidon OCP, imported by Cuvest Pharmaceuticals from Gedeon Richter, Hungary, was launched in 1996 at P40.00 per cycle retail to offer a lower-priced brand in the product mix. The IUD launch, delayed pending approval by the Bureau of Food and Drugs (BFAD), is expected to take place mid-1998. Support activities will include provider training conducted by AVSC in three sites.

A sales manager, four regional coordinators, and 24 medical detailers<sup>1</sup> have been recruited. They have introduced significant promotional activities to providers and to the trade in all 35 major cities. An NGO coordinator is to be appointed shortly. Distributors have also recently appointed specific staff to oversee the hormonal sales effort of their detailing medical representatives.

Active efforts have been made to develop linkages with NGOs, industrial clinics, and midwives to increase sales through these developing networks. Where the distribution system cannot serve these providers, SOMARC's field staff pull stocks from distributors and sell to providers directly.

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<sup>1</sup>Twelve detailers were recruited in May 1997 and 12 in November 1997. They were hired by a personnel management firm that handles all employment issues.



New mass-media and public relations campaigns have been developed and launched. During the first three quarters of 1998, 290 television spots promoting both OCPs and injectables will be aired nationwide on a budget of \$870,000, and a new television spot is in production. A \$710,000 public relations program has been implemented, which includes the following activities.

- Booths and presentations at eight health fairs and Medical and Obstetrician/Gynecologist Association conventions
- Eight seminars for health professionals
- A one-hour radio program broadcast six days a week
- "Dear Doctor" press columns run three times per week in three cities
- Two press releases issued each month
- Consumer telephone hot lines in three cities
- Promotion and launch of a detailers' and medical representatives' cash incentive scheme
- Production of new brochures
- Point-of-sale and promotional giveaway materials
- Reserves for the launch of the IUD

Liaison continues with the POLICY Project on many areas including formation of a public-private forum to identify policies that have direct or indirect impact on the SOMARC program.

Monitoring and tracking activities have been improved through subscription to the pharmacy sales tracking studies of Informational Medical Statistics (IMS); media recall studies through Frank Small Omnibus reports; retail audits; and closer coordination of sales and market data between SOMARC, manufacturers, and distributors on all levels.

### 2.2.1 Management

The project is managed from an office in Makati, Manila with seven staff including SOMARC's resident advisor; the marketing manager, to whom the product manager, the management information system (MIS) officer, and the five regional coordinators report; and an administrator with an assistant and office messenger. Accounting and technical support is provided from SOMARC/Washington, as well as by international sub-contractors. Regular contact is made with SOMARC's regional advisor based in Jakarta. An NGO Coordinator is being recruited.<sup>2</sup>

Management and technical assistance support appear to be effective and efficient although it must be noted that all the senior managerial staff are relatively new to the program. The expatriate resident advisor arrived recently in Manila; the original sales manager, who joined the company in 1996, was promoted to marketing manager late in 1997; the product manager was employed in November 1997; and the MIS officer joined the program in August 1997.

### 2.2.2 Sales Targets and Achievements

CYP benchmarks were set in 1996 for sales through 1999, but, in response to the continued failure to achieve these benchmarks, they were lowered in 1997 (Table 2).

**Table 2**

**SOMARC CYP Benchmarks 1996-1999 and Achievement 1996-1997**

	1996	1997	1998	1999
1996 Benchmarks	51,651	208,560	421,064	527,416
Revised Benchmarks	(not revised)	177,440	283,075	452,034
Achievements	31,183	34,725		
Percent Achieved	60%	20%		

*Source:* SOMARC REPORTS

The revised 1997 benchmark was subsequently negotiated between SOMARC and USAID with the concurrence of the FP Service of the DOH, as a benchmark for project achievement. A review of total contraceptive sales is included in Appendix E, and a review of all hormonal contraceptive sales through drugstores for the past four years in Appendix F.

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<sup>2</sup>A SOMARC/Couples Choice organigram is attached as Appendix D.

Data from 1997 show that 89 percent of project OCPs and 97 percent of injectables were sold through drugstores; the remainder were sold through NGOs, industrial clinics, and dispensing physicians. This confirms the low level of sales development through non-drugstore outlets. Of the total commercial drugstore market for OCPs, total sales reached 1,706,800 cycles, of which Couples Choice brands had a 21 percent market share. From 1996 to 1997, total OCP sales climbed by 16 percent, and Couples Choice brands sales climbed by 29 percent. Couples Choice brands did better than the overall market. Depo-Provera sales climbed 76 percent and the total market for injectables climbed 75 percent, giving Depo-Provera a retained 73 percent share of the total market.

### 2.2.3 Revised Projections

Early in 1998, SOMARC reviewed the forecast for that year and lowered it to 63,958 CYP (from the original benchmark of 283,075 CYP); USAID was informed of this revised projection, but views the official benchmarks to be those included in the SOMARC delivery order with TFGI. SOMARC has not formally presented revised projections for 1999 onwards. However, to assess the project's capacity to influence the national benchmark of CYP to the year 2000, the assessment team estimated CYP to the year 2000. In conjunction with SOMARC's Marketing Manager, it was proposed that the 60 percent increase in sales predicted for 1998 over 1997 be repeated in 1999 and 2000 as a "best case" scenario. It must, however, be pointed out that this is an informal estimate and not a commitment by SOMARC.

To obtain a "worst case" scenario these projections were reviewed by manufacturers. They are more pessimistic; their estimates are reviewed in Appendix G, including a lower estimate for IUD sales. The two projections are compared in Table 3.

**Table 3**

**Best and Worst Case CYP Projections, 1998 - 2000**

Scenario	1997 Actual	Percent Increase to 1998	1998	Percent Increase to 1999	1999	Percent Increase to 2000	2000
Best	34,725	60	63,958	60	102,333	60	163,733
Worst	33,024	30	47,784	38	65,894	21	79,443

Source: SOMARC, Pharmaceutical sales records<sup>3</sup>

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<sup>3</sup>The small discrepancy shown in the 1997 actual sales figures is because SOMARC's data was based on the fiscal year, whereas manufacturers' data was based on the calendar year.

#### 2.2.4 Success in Reaching Benchmarks

The global benchmark for IR3 is to increase the private sector provision of contraceptives and FP/MCH services from 27 percent in 1993 to 34 percent in 2000 and, specifically, for the PCSMP to effect the following:

- Implement CSM in 33 urban areas by December 1999, and
- Increase annual CYPs provided from 28,837 in 1993 to at least 177,440 in 1997.

SOMARC CYP increased from 28,837 (including condoms) in 1993 to 34,725 in 1997, or 20 percent. The "worst case" scenario for CYP in 2000 (see 2.2.3) is 79,443 CYP, an increase of 175 percent over 1993. On this basis, Couples Choice product sales have fallen far short of making their contribution toward the benchmarks to shift provision from the public to private sectors up to 1997, but should exceed the benchmark up to the year 2000. That is noted even though Couples Choice product sales will fall far short of future sales projections made in 1996 and 1997.

By the end of 1997, SOMARC had expanded its CSM program to 23 urban areas; it has now expanded to 35 cities. The CSM program has more than met the benchmark established for the end of 1999.

#### 2.2.5 Sustainability

Total expenditure in 1997 was US\$827,809 for a CYP of 34,725 or a cost per CYP of \$23.84. Costs per CYP have gradually declined from a high of \$33.63 in 1994. These cost per CYP figures are high by worldwide social marketing standards. They are more typical of the first year of a new program launch than the more usual \$6 to \$12 achievable by more mature programs. Expenditure levels between 1994 and 1997 have slightly decreased. The continued high per CYP costs can be attributed, therefore, to low sales.

The budget for 1998 is \$2.23 million, with unexpended funds from prior years raising the amount available to \$3.89 million. This is a significant increase from prior years' expenditures and reflects the additional costs of the field teams, as well as increases in total promotional spending. Essentially, SOMARC is relaunching the program. The benchmark for CYP achievement in 1998 is 63,598, which would give a cost per CYP of \$61.22.

## **2.3 Findings**

### **2.3.1 Setting Sales Targets**

SOMARC has consistently set unobtainable sales targets. All manufacturers interviewed pointed out that SOMARC presented them with targets that the manufacturers knew were not realistic. In 1997, for example, even after SOMARC had revised its targets for that year, the benchmark for Couples Choice OCP brands was set at 152,154 CYP, which equates to 2,341,650 cycles. This benchmark was set when actual sales for 1995 must have been known. In that year, Couples Choice sales had been 377,400 cycles and the total sales for all OCPs through drugstores had been 1,568,000 cycles. There cannot have been any realistic basis for assuming that Couple Choice brands could have increased sales by more than 500 percent between 1995 and 1997, or that the total market could have grown to absorb this increase. In fact, sales of the three OCP brands within the program in 1997 (Marvelon had been withdrawn and Rigevidon had been added to the range in 1996) rose by only 24 percent between 1995 and 1997.

The setting of unrealistic benchmarks has been a significant weakness in the management of the project. USAID has approved program extensions and funding based on SOMARC's projections that were unduly optimistic, while encouraging the project to increase efforts to expand sales.

SOMARC's present management staff cannot explain the logic behind these past projections because they are all new to the project. They have set a more realistic benchmark for 1998 (CYP of 63,958 compared with the benchmark established in 1997 of 283,075) but have not yet formally reviewed benchmarks for further years, because the current SOMARC contract ends in September 1998.

### **2.3.2 Relationships with Manufacturers and Distributors**

SOMARC employs a "Fourth Generation" model for the CSM program in the Philippines. This model's strength is that it supports the existing brands of manufacturers. This allows for use of the significant resources of the manufacturers and the use of their marketing and distribution networks to sell their own CSM brands. Once CSM brands have reached stable sales levels, donor support can be easily withdrawn. This contrasts with earlier models where the social marketing organization imported commodities on its own account, was entirely responsible for the total effort, and may have repackaged commodities under its own brand names.

This model is only a strength, however, if the manufacturers are totally dedicated to maximizing the sales of their CSM brands and are making significant investment contributions along with the donor agency. These contributions most usually involve agreement to reduce the prices of CSM brands in return for the promotional support of the donor. That has not been the case in the Philippines. Although the original CSM brands were sold at the low end of the price range, they

were not significantly discounted below other available commercial brands. That has been a primary weakness of the program since its inception.

Manufacturers have tended to allocate SOMARC a brand and then leave it the task of enlarging its market share. Meanwhile, the manufacturers, in particular Schering, have concentrated on promoting their other OCP brands. It is worth noting that the largest selling OCP brand is Femenal from Wyeth, which in 1994 outsold its Nordette CSM brand by 25 percent. Schering's Logynon outsells its CSM brand, Microgynon, by seven times.

At present, the total pharmaceutical market through drugstore sales is about U.S.\$ one billion per year with hormonal contraceptives accounting for only about 1 percent of that amount. Meanwhile, the total Couples Choice share of that 1 percent is about 21 percent. Only Wyeth with Nordette achieves any sort of income from present Couples Choice sales through drugstores, at about \$601,000 in 1997, with Upjohn and Schering selling just over \$60,000 of product and Cuvest (the Gedeon Richter importer) selling \$2,000 of product. It should not be surprising that these companies lack interest in the CSM market or are unwilling to invest significantly in its future.

It is worth noting that USAID spent more money promoting Couples Choice brands in 1997 than the manufacturers received in total sales revenue.

The new SOMARC management has had some recent success convincing manufacturers that they are committed to expanding the program, through the introduction of the new field force and significant increases in promotional expenditures, which has led to a more proactive role for manufacturers to support their social marketing brands. All the manufacturers have allocated additional staff to oversee these brands. Nevertheless, they still give a relatively low priority to contraceptive sales, allocate significantly more internal effort and resources to their other brands than to their CSM brands, and contribute only a fractional effort to increase CSM market share when compared with SOMARC's promotional efforts.

With regard to the future, manufacturers are aware that the primary constraint to increased sales is the social attitude toward use of modern contraceptives and the availability of free public sources. As commercial firms, manufacturers do not see themselves as engaging in changing social attitudes. They are concerned that a public backlash against their promotion of family planning—which has been threatened in the past—may affect the sales of their other products, particularly their non-ethical products. They prefer simply to put a product into the market without any effort toward promotional activities directly targeting the public. They are even cautious in their approach to selling contraceptives to doctors in case of a negative response to their inclusion of contraceptives in their ethical product range. Manufacturers are unsure whether the future political climate will lead to a more positive attitude toward their products within the society. They are therefore very positive about SOMARC's role as a more open and public promoter of contraceptive products.

The manufacturers wish that the project would engage much more strongly in the area of changing attitudes and behaviors regarding modern family planning methods. They believe that such change may be accomplished by engaging more respected and authoritative figures in direct counseling and public relations events. In addition, private sector providers should be weaned away from free government-supplied contraceptives.

### 2.3.3 The Issue of Price

SOMARC has undertaken a number of in-house studies on price. They note that the average C/D market family earns about P6,000 per month and that they should be able to afford contraceptives set at 1 percent of monthly income or P60. Their present range of OCPs for a month's supply is as follows:

- Nordette-P69.25
- Microgynon-P65.50
- Rigevidon-P42.50

Depo-Provera at P100 every three months is also within this range, although the injection cost is extra and the high outlay may impede some purchasers.

It must, however, be understood that "average family income" means that half the target group earns an income below the average. Thus, the only product that is within the purchasing range of the total C/D market is Rigevidon.

A study by Eduardo Roberto, "The Survey of Pill Acceptors in PCPD's Company Based FP/MCH Program, 1996," among female factory workers found that 50 percent of respondents claimed they would not purchase the product at P65.50 per month (although almost all of them stated that they would remain acceptors through switching brands, methods, or source of supply). This research confirms a fairly high price sensitivity and suggests that the optimum monthly price should be P59.40. However, this research does not indicate the respondent's income.

SOMARC has tried to understand why Couples Choice prices are high by international social marketing standards. USAID procures OCPs ex-factory at about 25 cents or P10, and the mark-up in the Philippines between ex-factory prices and the retail price is about 33 percent, not considered high by international standards. The Nordette ex-factory price is P51.70 and the retail price P69.25. This indicates that the primary cause of relatively high prices in the Philippines is the ex-factory price set by the manufacturers.

Of the 10 OCP brands on the market, 3 are at the same or lower price than Nordette and Microgynon with only Rigevidon competing with them, and 4 are higher priced.

DKT's Trust OCP employs an older-generation model of a CSM program; they purchase the commodity from Germany under the project's own brand name and packaging and arrange its distribution in the Philippines. Their pricing shows that the ex-factory price including packaging and shipping, ex-Germany, is \$.31 per cycle. Total cost to the donor is \$9.02 per CYP including income from sales. On this basis, it can be calculated that if prices were raised to about P40 or \$1.00 retail, the product would break even and require no donor subsidy. Note, however, that these CYP costs are shared with the sale of 12.5 million condoms and their total promotional spending is less than that of the PCSMP. Direct comparisons between the DKT and SOMARC projects should only be made after more detailed analysis. Sales of Trust OCPs reached 185,000 cycles (12,021 CYP) in 1997.

An analysis of all brands on the market other than Couples Choice OCP, including Monophasics (in a price range from P 60 to P100), Low Dose (from P34 to P110), and Triphasics (over P100) indicates it is unlikely that manufacturers are selling Couples Choice products much below the standard mark-ups for their other OCP brands (even though their contraceptive lines may not be profitable), although efforts by SOMARC to slow inflationary price increases appear to have had some effect.

Price does seem to be a constraining factor in increasing Couples Choice OCP brand sales. The strategy to improve sales through a lower-priced Gedeon Richter brand has not yet matured because of the relatively low level of distribution coverage achieved by the distributor and low sales achieved through the midwives program (see Chapter 3). To resolve this problem, SOMARC has expressed interest in taking over the locally produced Micropil brand from Pascual, which retails at P33.80 and has been part of the DKT program, although it will be withdrawn this year. No direct discussions have taken place, however. In addition, it may be possible for the international manufacturers to more aggressively price their existing Couples Choice brands or, failing that, to introduce new CSM brands at lower prices. Most manufacturers have specific CSM brands that could be introduced into the market at lower prices. To date, SOMARC has not actively pursued these possibilities.

#### 2.3.4 Supporting the Sales and Distribution System

SOMARC has reacted well to their analysis of the fundamental weaknesses of the program up to 1997—the overall lack of effort by the manufacturers and distributors to significantly push Couples Choice brands into the marketplace—by providing direct field force. All manufacturers agree that the field force is having an impact on interest in Couples Choice brands by dispensing physicians and obstetrician/gynecologists (OB/GYN) and in the awareness of those brands in drugstores and among midwives. This new initiative, coupled with the incentive scheme to detailers, is a significant improvement of the new program.

The primary weakness is that it is not clear whether this "ethical" product approach to increasing sales of hormonal contraceptives is sufficient. In general, consumers awareness of ethical products



remains minimal; they simply rely on the prescription provided by the doctor and fill it at a pharmacy. The PCSMP is attempting to introduce an element of "brand awareness" into the relationship between the physician and the client, although the precise nature of that relationship is unclear:

- Do clients insist on Couples Choice products or do they leave the physician to choose for them?
- Do physicians try to switch clients from a brand they might ask for to another? If so, why would they do that?
- Do most new users seek the advice of a physician at all?
- It is possible that government doctors may be prescribing commercial brands of OCPs to those that prefer those brands to the government's brand. If so, should government doctors be called upon by detailers as well? The project might investigate the situation, and determine if this is a legal option for detailers.

The whole process whereby new clients may be introduced to Couples Choice brands and free government users persuaded to switch brands, through these authority physician mechanisms, needs to be more fully understood and the detailing effort adjusted accordingly.

### 2.3.5 Advertising and Promotional Activities

Manufacturers correctly claim that the program's major strength is its ability to engage in mass-media and public promotional activities. A number of monitoring studies have, however, underscored some weaknesses.

#### Couples Choice Brand Differentiation

Overbranding of a number of product brands is usually undertaken for one of two reasons: (1) to link all products that adhere to one high-quality standard or (2) to link a range of products that possess some intrinsic advantage over all other products. At present, no convincing rationale exists that distinguishes Couples Choice brands from other brands. The most usual way that CSM brands are defined as distinctive is that they are high-quality products that are sold at low, subsidized prices. This is not convincingly the case with Couples Choice brands.

"The Couples Choice Awareness and Usage Study," undertaken in Manila by Frank Small and Associates in November 1997, underscores this problem. The study reports that over 60 percent of women interviewed were unaware of the brands under the Couples Choice umbrella, and only 1 percent could name Nordette and Depo-Provera as Couples Choice brands. In addition, over 70 percent of women interviewed were aware of Couples Choice as a brand and 3 percent of C

target groups claimed to have ever used that brand. Furthermore, 19 percent were aware of Nordette and 8 percent of C target groups had used it.

Clearly, consumers are confused about Couples Choice as an overbranding mechanism; this confusion must be resolved.

### Message Strategies

Present message strategies concentrate on promoting Couples Choice brands as safe, reliable, high-quality, reversible contraceptives. The weakness of this strategy is that it does not sufficiently differentiate Couples Choice brands from any other brands. No "unique selling point" is discernable for these brands. In addition, because specific brands cannot be promoted through television and radio, it is proving difficult to explain which brands are actually Couples Choice brands. Thus, there tends to be an impression that Couples Choice is a brand itself. There is insufficient research to guide SOMARC in finding solutions to this program weakness.

Message strategies go some way toward addressing the need for nonusers of contraception to use modern methods. However, these messages are superficial at best because the development approach is toward "product selling." Recent research is insufficient to indicate the extent to which this message development approach sufficiently attracts new users (or users from the public sector). This approach appears to be based on the complex behavioral issues that are addressed when the consumer comes into contact with a prescribing provider, particularly an OB/GYN. That may not be the case. One potential weakness of the program is that mass media may not motivate a nonuser to obtain Couples Choice products and to seek out an OB/GYN when there is no other reason to visit one. In addition, OB/GYNs may not actively pursue the issue with clients if they are unsure of their clients' commitment to use contraception.

## **2.4 Sustainability**

No market experience exists to predict the effects on the sustainability of Couples Choice brand sales should the program cease at the end of September 1998. The products could remain on the market but promotional activities would not be continued (or would be continued only minimally), and it is likely that sales would suffer as a result. Manufacturers could not estimate what sales would have been if SOMARC had not supported them, nor could they estimate what would happen to sales if SOMARC support ceased. Commercial and social marketing markets are still too immature and the political and social environment too uncertain to be able to predict the level of sustainability for Couples Choice brands if SOMARC withdrew its support.

Organon's 1996 withdrawal of Marvelon from the Couples Choice program to raise prices, pushing the product up-market, resulted in an increase in sales from 44,000 cycles in 1996 to 104,000 cycles in 1997. However, sales are still at a low level and there is no certainty that Organon will sustain sales of the OCP in the long term.

SOMARC and the manufacturers have no plan to work toward a program that could be assumed and sustained by the manufacturers. The present program is, therefore, untenable; it could be made tenable only if USAID and the manufacturers make a long-term commitment that contains a prearranged exit strategy.

## **2.5 Lessons Learned**

### **2.5.1 Promotions through Drugstores**

Efforts to promote sales growth directly at the drugstore level are impeded because product choice is rarely made or influenced at this level. Most sales are either through prescription, refill, or new requests for specific products. Brand switching through the influence of drugstore sales staff does not seem to occur. The main influence on method and brand use appears to be medical providers, in particular OB/GYNs, with regard to prescription purchase, or the recommendation of friends or family, in the case of nonprescription purchases (although this is not legal).

### **2.5.2 Obstetricians/Gynecologists**

SOMARC emphasizes promoting Couples Choice brands directly to OB/GYNs through both their own sales teams and in support of those of distributors. However, little recent evidence exists that this effort is increasing contraceptive use, rather than simply switching consumers from one brand to another. In addition, as most OB/GYNs do not have an in-house dispensary, distributors will not sell products directly to them. Clients must, therefore, rely on prescriptions and a visit to a drugstore, which spoils the immediacy of having OB/GYNs directly dispense contraceptives.

### **2.5.3 NGO Networks**

Sales are seriously constrained by the NGOs' capacity to obtain contraceptives from free or low-cost sources (the DOH or International Planned Parenthood Federation [IPPF]), although this is changing. In general, NGOs supply contraceptives and services at one fixed price. Even if NGOs purchase Couples Choice products at wholesale prices, they make significantly less income from these sales, which affects their efforts towards self-sustainability.

#### 2.5.4 Through Industrial Clinics

The primary constraint that SOMARC has faced is the low level of participation that has materialized from efforts to open up family planning services through industrial clinics. SOMARC has only a limited capacity to introduce contraceptives to industrial clinics that do not currently provide them. They have to rely, primarily, on supply to clinics already stocking commercial product. SOMARC believes that the present economic downturn has discouraged firms from adding to free services for their workers.

#### 2.5.5 Midwives

SOMARC has faced some difficulties in identifying midwives who are independent of free government service. In the Cebu Province, for example, out of 1,000 midwives only 10 (outside of Family Planning Organization of the Philippines [FPOP] networks) appear to be independent enough to have volunteered to stock OCPs—primarily the lower-cost Rigevidon brand. In addition, sales to independent midwives (those not under the wing of an NGO program) are constrained because distributors will not sell directly to them and SOMARC's team finds it difficult to serve them directly.

#### 2.5.6 The Level of Consumer Contact

SOMARC's promotional efforts are directed more at the provider systems than at consumers; SOMARC achieves a low level of direct client contact through its promotional efforts. The level of effort that SOMARC staff can put into localized events (at fairs, for example) only has a limited impact on national sales levels. Furthermore, Drugstores are not ad source of information. No ethical product advertising or point-of-sale material can be placed in drugstores (although some Couples Choice leaflets were on display in some drugstores in Manila). The presently low level of direct consumer contact through NGOs and midwives is evident. The telephone hot line covers a very small percentage of potential customers and needs to be promoted daily through the local media. Furthermore, it is unclear how many women of reproductive age regularly visit OB/GYNs, unless they are pregnant or have some medical difficulty. That leaves television and radio as the primary sources of contact between SOMARC and its clients. This mass-media effort would be significantly improved if it supported a stronger direct communications effort.

#### 2.5.7 Couples Choice Branding

Promoting the specific brands under the Couples Choice umbrella has proven difficult. Promotional material indicating which brands are Couples Choice brands cannot be put up in drugstores (although SOMARC is handing out leaflets and fans to drugstore staff). The same constraint exists with media advertising. Generic messages are permitted but brands cannot be

mentioned specifically. It is not clear how consumers can readily understand which brands are Couples Choice brands or what, specifically, differentiates these brands as products of choice from other brands.

## **2.6 Conclusions**

The PCSMP has not met expectations. Original agreements with manufacturers failed to introduce a typical CSM range of low-cost contraceptives; overly ambitious sales benchmarks were established without manufacturers concurrence and those benchmarks were not met; and costs per CYP declined only slowly between 1993 and 1997 (and will rise sharply in 1998), and have not led to a sustainable model of efficiency.

A new SOMARC management team has been put in place. It has addressed one of the primary weaknesses of the program—the lack of a strong promotional effort by the manufacturers and their distributors for their CSM brands—by introducing their own promotional field force and a major advertising and public relations campaign. This campaign is beginning to show positive results, but because the team has only been fully operational for the past four months, it is too early to fully assess the impact on sales.

Sales forecasts have been revised significantly downward in 1998, but are still somewhat optimistic according to manufacturers. A somewhat conservative estimate of sales potential shows that if a long-term exit strategy that gradually reduces SOMARC expenditures is implemented, the project could achieve a level of cost-effectiveness, and theoretical sustainability, by 2003. Manufacturers and distributors must support the program more fully, however, if it is to achieve its social marketing aims.

Identified in this report are five areas of concern that require attention if the program is to achieve long-term sustainability.

### **2.6.1 Pricing**

SOMARC has tried to respond to the issue of OCP pricing by introducing the lower-cost Rigevidon brand, which has not fundamentally affected the issue that their two other Couples Choice OCP brands are most unaffordable to C and D group customers. The distribution network for Rigevidon is still limited (through geographic coverage and the presently low numbers of midwives taking on the product through direct SOMARC sales). Because research indicates that prices above P60 may lead to as much as a 50 percent drop-out rate, the range of products within the Couples Choice umbrella must be adjusted to include only brands that are at P40 retail or below. Fortunately, a scenario does exist that would make this possible: a domestic brand from Pascual at P29.17 may be available; Schering may be interested in renegotiating the price of

Microgynon; and Wyeth may either be willing to do the same for Nordette or could be persuaded to introduce a new CSM brand from their international portfolio.

### 2.6.2 Brand Differentiation

Research on brand awareness indicates significant confusion as to what brands are Couples Choice brands and what clear rationale exists for choosing Couples Choice brands above other commercial brands. This issue would be resolved if the pricing strategies could be revised as mentioned.

### 2.6.3 Sources of Information to Nonusers and Free Government Users

Although increased "detailing" to OB/GYNs is providing a much stronger level of potential consumer interest in Couples Choice products, it is unclear how that might lead to a significant increase in new users and "switchers" from free government services. The whole decision-making process whereby a nonuser becomes a user and those who obtain free government services become purchasers needs to be better understood and the result incorporated into message development and promotional strategies.

### 2.6.4 Sales through NGOs and Industrial Clinics

Sales through NGOs and industrial clinics have been disappointing, but SOMARC has responded well by committing to hire a specialist NGO coordinator to oversee this market segment. However, with the project due to end within a few months, it may not be feasible to pursue this approach. A move away from free government procurement of contraceptives by private providers has been noted and it is hoped that this initiative may lead to more commercial sales as it matures. Price, however, is still a factor in NGO commitment to move toward self-sustainability. The industrial clinic market is not expected to show a great deal of promise. SOMARC believes because the economy has slowed down and manufacturers are laying off people, this could change.

### 2.6.5 The IUD Market

SOMARC is highly dependent on the anticipated launch of the IUD to achieve CYP sales benchmarks. However, the commercial IUD market is undeveloped and no track record exists to estimate the level of sales that might be achieved. Success in the market will more likely depend to a very high degree on whether clinics that insert IUDs are willing (or obliged) to purchase the commercial product rather than receive them free from the DOH.

## **2.7 Recommendations**

1. The project should be terminated at the end of 1998 unless a long-term, sustainable strategy containing realistic projections is developed in cooperation with manufacturers.
2. Couples Choice OCP brands should become a more explicit range of social marketing brands—that is, high-quality products differentiated from competitive commercial brands by price. Therefore, manufacturers providing brands to the project should discount their prices or provide new, lower-cost CSM brands or new, domestic brands.
3. The project may have to give some support to pricing, at least for an initial period. This support could come from existing promotional budgets, with an acceptable mechanism worked out to transfer these funds from the project to the manufacturer.
4. A clear exit strategy needs to be worked out between SOMARC and the manufacturers that would involve longer-term commitments from both USAID and the manufacturers—at least a five-year period is recommended. Over this time frame, prices may be gradually raised and SOMARC expenditures gradually reduced.
5. The program needs to better understand how a new user or an existing free-service user may be motivated to procure contraceptives from the commercial sector, and how they may be better motivated to do so.
6. Changes in the law are needed that would permit doctors to dispense hormonal contraceptives.
7. Some forms of direct subsidy by SOMARC, taken from promotional budgets, for supply to NGOs and midwives should be considered for a few years to assist in the weaning process from free supplies, particularly for the IUD.





## CHAPTER 3. TANGO II

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### 3.1 Findings

#### 3.1.1 Project Design

TANGO II's goal is to increase the availability of family planning services in the private sector by significantly expanding the number of midwife-owned clinics that provide FP and basic MCH services. Phase II of the activity runs from 1997 through 1999 with a total budget of \$3.74 million, with annual budgets increasing gradually as the program expands. Funding is provided through a Cooperative Agreement with JSI/RTI. Performance-based subagreements between JSI/RTI and local NGOs specify benchmarks to be achieved for funding disbursement. Two additional NGOs recently joined the program in 1998. Each NGO supports clinics in a geographically focused area of the country.<sup>4</sup>

TANGO II's major innovation is a private sector franchise model for midwife clinics, the Well Family Midwife Clinics, which provide FP and MCH services on a for-profit basis. The Well Family Midwife Clinics (WFMC) target individuals who can pay for FP/MCH services. By the end of TANGO II, some 330 WFMCs will be established, serving as the potential foundation of a sustainable network of midwife-owned clinics—small, profitable businesses—offering FP/MCH services in as many areas of the country as possible. Initially, the NGOs were envisioned as sponsoring their respective WFMCs, with the latter benefiting from the recognition and reputation of their sponsoring NGO. However, the NGO-WFMC relationship is evolving into one of service provider-client, as the NGOs develop their capability to provide technical and managerial support services needed by the WFMCs on a for-fee basis.

Selection criteria were established to identify suitable locations for the WFMCs and experienced midwives to operate them.<sup>5</sup> JSI/RTI provided funding for clinic equipment, training for midwives and their volunteers, NGO operating and staff costs, marketing campaigns, IEC materials,

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<sup>4</sup>The six NGOs and their areas of geographic focus are as follows: The Institute of Maternal and Child Health (IMCH), metro Manila and neighboring provinces; Integrated Maternal Child Care Services and Development, Inc. (IMCCSDI), Northern Mindanao; Cebu-Family Planning Organization of the Philippines (FPOP), metro Cebu and Cebu Province; Negros Occidental Rehabilitation Foundation, Inc. (NORFI), Bacolod City and Negros Occidental; the Davao Medical School Foundation-Institute of Primary Health Care (DMSF-IPHC), Davao City and Davao del Sur; and Community Health and Development, Inc. (COMDEV), General Santos and South Cotabato.

<sup>5</sup>See Appendix H for criteria developed by JSI/RTI to guide clinic and midwife selection by sponsoring NGOs.

operational research, and related functions.<sup>6</sup> NGOs typically have an executive director or program manager responsible for their TANGO II activities, supported by a project coordinator and two or three program supervisors who work directly with WFMC midwives. JSI/RTI also provides overall guidance and supervision for TANGO II through a core staff consisting of a resident advisor and three project coordinators who work with participating NGOs and supervise clinic operations. The 1997 funding for NGO program activities ranged from \$40,000 to \$50,000 per NGO.<sup>7</sup> Each NGO supported 15 WFMCs in 1997; 15 or more clinics per NGO will be added in 1998 and 1999.

### 3.1.2 Success Relative to Benchmarks

Funding to the NGOs is made on a performance basis using the following benchmarks for 1997:

- 15 sustainable clinics owned and operated by midwives,
- 15 midwives trained in FP and MCH service delivery,
- 10,290 CYPs from FP methods,
- 4,860 MCH services,
- Operation manual for clinics, and
- Referral doctors and hospitals for VSC and emergency cases identified.

A graduated scale of payments by JSI/RTI to the NGOs is tied to the accomplishment of these benchmarks. During the first four months of implementation, 10 percent of the approved budget was paid for accomplishing initial plans and identifying midwives; 50 percent was paid for completing training, achieving accreditation of clinics, and adapting protocols for VSC referrals, emergencies, and complications. Over each of the following three quarters, 13 percent of the NGO's budget was to be paid per quarter for accomplishing CYP and MCH benchmarks.

Experience gained during 1997 clearly demonstrated that the benchmarks established for the activity were based on unrealistic expectations on the amount of time required to establish clinic operations at levels needed to achieve quarterly benchmarks, particularly CYP benchmarks. By

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<sup>6</sup>Each midwife was encouraged to identify up to five “volunteers” to assist in making house-to-house visits to inform potential clients of the clinics services, provide basic FP/MCH information and make referrals to the clinic, motivate women to use family planning, and resupply continuing users.

<sup>7</sup>At the March 31, 1998, exchange rate of P36=US\$1.00.

December 1997, five of the six NGOs had met only 40 to 50 percent of their CYP benchmarks, with COMDEV reaching only 17 percent of its benchmark. CYP benchmarks were based on overly optimistic projections of 60 CYPs per clinic per month from temporary methods and two voluntary surgical contraception (VSC) referrals per clinic per month. Actual performance for most clinics fell far below the benchmarks. It has taken six months or more for most WFMCs to approximate the levels of operation. VSC referrals and temporary method CYPs also fell short of the projections, reflecting actual market demand and the slow start-up of AVSC's program of providing referral sites for VS procedures. Conversely, MCH benchmarks were readily exceeded, reaching more than 400 percent of the original benchmark, which indicates a gross underestimation of the demand for MCH services per clinic.

The decision was made to extend the "first year" to April 30, 1998, to give the NGOs a fairer opportunity to achieve their benchmarks. After reaching 50 percent of their benchmarks, NGOs would receive prorated payments based on the percentage of their benchmarks they accomplished by the end of April 1998. During January and February 1998, NGOs reported improved clinic performance on average, and it is likely that most reached or came close to reaching their benchmarks (with the exception of COMDEV).

### 3.1.3 Implementation Strengths and Weaknesses

The 1997 start-up period demonstrated the viability of the franchise approach for establishing for-profit, unsubsidized, midwife-operated clinics to provide FP/MCH services. This experience shows that WFMCs can become reasonably profitable business enterprises that expand FP/MCH services through the private sector. Six months to a year of operations is sufficient time to determine which clinics are likely to succeed as profitable businesses. The success of the WFMCs also indicates that market segmentation is being promoted by these clinics by offering a superior alternative to government provided FP/MCH services for those who can afford to pay. Of the 90 clinics initially established (15 per regional NGO) the following applies:

- Approximately 30 to 40 percent of the WFMCs (varying by NGO and region) are near or above FP/MCH performance benchmarks and are generating adequate to substantial income, ensuring that they will remain in business;
- Approximately 30 to 40 percent are below FP/MCH performance benchmarks and are generating acceptable but marginal income; however, they are improving their performance and operations needed to become successful service providers;
- Approximately 30 to 40 percent are failing to achieve FP/MCH performance benchmarks (particularly FP benchmarks) and are not generating adequate income to become a viable business over the long-term; while some show signs of improvement, others are very likely to cease operations or should be "de-selected" by the sponsoring NGO.

Each participating NGO has sponsored a number of WFMCs that are or will be successful. Several are "run-away" successes, far exceeding expectations for FP/MCH services, as well as generating high levels of income: P5,000 per month net and up, with one clinic reporting a monthly income of approximately P20,000 per month net from gross revenues of P24,000. Five of the six NGOs participating in the activity during 1997 produced encouraging results with respect to FP/MCH service provision and business growth.<sup>8</sup>

By providing high-quality FP/MCH services, which include accurate information and counseling about FP options and appropriate methods in a personal-service setting, the WFMCs are attracting paying clients away from free-service public facilities.<sup>9</sup> The WFMCs price their FP/MCH services below the costs of private physicians. The provision of personalized services in a comfortable, private setting enhances the client's perception of the WFMC midwife as a concerned, informed confidante or friend. Given the very personal nature of family planning, this relationship adds to the attraction of WFMCs, in sharp contrast to the hurried indifference typical of government facilities. In many locations, government doctors, nurses and midwives are referring clients to the local WFMC, recognizing the superior service these clinics now offer.

Following are key factors contributing to WFMC success:

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<sup>8</sup>COMDEV's weaker results for 1997 are because of their approach in undertaking this activity; problems with midwife and clinic assistant selection; weak technical support at the outset; some resistance by clinic assistants who had participated under the preceding TANGO I project that guaranteed regular monthly payments; and midwives who experienced serious personal or domestic problems. The other NGOs also reported similar problems to varying degrees. COMDEV's weaker performance also stems from more adverse local conditions (that is a high proportion of recent immigrants from poor rural areas who are unable or unwilling to pay for services, or who fail to pay for services provided on a credit basis) that impede establishing for-profit clinics.

<sup>9</sup>Most midwives reported that the majority of their clients are between 25 and 35 years of age; some extended the range from 20 to 35. Most midwives stated clients typically have had two or three children close in age before using contraceptives, and most begin FP with the intention of spacing additional children. Very few clients are recently married women. Midwives also reported having very few young, unmarried clients and some stated that they refuse to provide contraceptives to unmarried women. Most clients interested in stopping childbearing have had five or more children and are about 35 years of age or older. Income levels vary substantially by location; however, most midwives estimated the household income of their clients to be somewhere between P2,500 per month to P4,000. Several midwives reported much higher household incomes of P5,000 to P8,000 in metro Manila and elsewhere where the husband and wife both work or where there is a high proportion of government employees, factory workers, or others with regular salaried jobs.

- The determination, hard work, and business orientation of the midwife operating the clinic;
- The location of the clinic in communities that have the capacity to pay for FP/MCH services;
- The proximity or accessibility of the clinic to its clientele;
- Good working relations with the staff of nearby public facilities;
- Several active WFMC assistants making house-to-house contacts in the service area; and
- NGO technical assistance, training, and continuing supervision where such assistance contributes to the preceding conditions.

Each NGO has also experienced a predictable number of poor performers, with some clinics being relocated to more promising communities. Other poor performing clinics had to be closed, with new midwives and clinics replacing those "de-selected" from the 1997 round. Although FP/MCH service delivery objectives underpin TANGO II, the WFMCs are, nonetheless, new small businesses, and like other new small businesses, a failure rate of 25 percent or more within the first year is not excessive or a sign of failure by TANGO II.<sup>10</sup> Poor performing clinics have been notified by their NGOs that they must improve; however, some NGOs are understandably reluctant to close down an existing clinic. Some clinics are showing progress as a result of more concerted efforts by the midwife, but other poorly performing clinics are unlikely to succeed because of poor location, low midwife motivation, personal problems, or lack of business acumen.

Although NGOs were provided with criteria for selecting midwives and clinic locations, the evaluation found that some WFMCs were located in relatively poorer communities where the ability and willingness to pay is marginal, or in rural locations where the service area of the clinic extends to a number of barangays and even to neighboring municipalities. Both of these conditions were explicitly discouraged in the selection process. Some NGOs apparently decided to experiment with clinic locations, reflecting prior objectives of servicing the poor (for example, opening a clinic in one of the most economically depressed areas of Manila), which resulted in predictable clinic failures.

Midwife selection varied by NGO. The approach was to recruit both new midwives and midwives who had previous experience with earlier projects with the NGO. NGO directors reported that matching midwives to suitable locations was difficult. A promising location would be identified,

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<sup>10</sup>Cebu-FPOP's experience with 1997 clinics illustrates this view perfectly. It has "de-selected" and replaced with new clinics three out of its original 15 clinics. This change reflects good program management as opposed to maintaining poor performing clinics that are unlikely to succeed in the short term.

but no suitable midwife was available in the area. Alternatively, good midwife candidates were reluctant to relocate to a suitable location, preferring to work from their home in a less-promising location to reduce costs. Selection of clinic assistants was also problematic for some midwives and NGOs. Training was budgeted for up to five assistants per clinic; however, a significant proportion dropped out of the program after being trained and new assistants then had to be trained at NGO expense. Experience now indicates that two or three active assistants per clinic provide sufficient community outreach. Poor clinic site and midwife selection was reported by one NGO as stemming from the need to meet project schedules and benchmarks.

WFMC midwives are trained in FP and MCH technical information and related skills for proper service delivery, interpersonal communication skills, and clinic operations (including costing and pricing of services). Midwives were very satisfied with the training. IUD insertion training was particularly useful to WFMC operations, because for many clinics this generates a significant percentage of their CYPs.<sup>11</sup>

Many of the midwives interviewed during this assessment were uncertain about the business development techniques needed to expand their client base and profitability. Many WFMC midwives have never operated a business prior to TANGO II; the vast majority of employed midwives work for the government. This lack of business skills is reflected in the few promotional activities undertaken, a lack of understanding about the importance of systematic follow-up on continuing users, no clear business plan or strategy for expanding their business, and a strong dependency on the NGO to tell them how to expand their business.

Such dependency is disconcerting in that the participating NGOs themselves lack small business development experience. The sponsoring NGOs are in the process of trying to transform themselves from largely donor- or donation-funded organizations to ones based on self-sustaining revenue generation. In addition, given their social service orientation (that is, servicing the poor through subsidized clinics funded by other donors), the NGOs lack staff with small business development experience who are able to assist WFMCs with business growth. Moreover, many NGO supervisors are younger and less experienced with clinic operations and service provision than the midwives they supervise. JSI/RTI's staff capabilities are also limited in the small business development area.

A number of midwives reported that earnings from non-FP and non-MCH services were important to overall income. Diversification of services is a common strategy followed by many midwives. Lying-in facilities and home deliveries are critical elements in the midwives' income. Some midwives operated lying-in facilities before working in the WMFC, or they established

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<sup>11</sup> The desire to achieve CYP benchmarks, use clinical skills, or receive a comparatively larger one-time payment may encourage midwives to promote IUDs to clients when other methods might be more appropriate. This issue cannot be resolved by the information available to the evaluation team, but deserves special study. If verified, corrective action should be taken; CYP benchmarks should be maintained.

these facilities as part of their expanding business. Others express the desire to have such facilities in the future. Other common income-generating services include ear piercing, circumcision, wound dressing, and suturing. Others engage in various business activities not related to health to generate additional income. In a number of the clinics evaluated, MCH services generate considerably more revenue for WFMCs than FP services, but midwives recognize that FP services are necessary to attain CYP benchmarks. In other words, high income is not necessarily associated with high FP performance. Although these additional services help to generate income for the midwife and sustain the clinic, they do not contribute to expanding private sector provision of FP/MCH services.

Some WFMCs are providing FP/MCH services in local industries and agribusinesses (for example, haciendas). Midwives report that these arrangements are very profitable and are important to reaching service delivery benchmarks. However, numerous other opportunities are not being pursued aggressively enough by other WFMC midwives and their sponsoring NGOs. Midwives are reportedly reluctant to make initial contact with local businesses because of inexperience or a lack of confidence about how to go about this effectively. NGOs are providing assistance, but more needs to be done in this area.

Linkages between WFMCs and other elements of the overall IFPMHP are receiving increasing attention, such as possible links with industry in conjunction with PCPD's program. NGO staff and WFMC midwives have established good relations with LGU officials and local health staff. These relationships have resulted in LGU health staff making client referrals to the WFMCs in many locations. Some LGU officials reported incorporating NGO activities into their annual FP/MCH plans as required for participation in the Local Government Unit Performance Program (LPP). However, none reported any special or separate attention to promoting WFMC business operations as a way of achieving FP/MCH performance in their annual plans. LGUs participating in the LPP could be encouraged to consider how public programs can be better coordinated with WFMCs contributing to WFMC business development. In particular, LGUs could be more active in referring clients who are able to pay for services to the WFMCs, allowing public facilities to focus on serving those who are truly unable to pay. Given the slow start-up of AVSC activities, linkages between WFMCs and AVSC physicians are only now being established in some locations.

A problem area in TANGO II's implementation concerns its mass-media marketing efforts. JSI/RTI has contracted with McCann-Erickson Philippines to conduct a radio marketing campaign to heighten public awareness of and interest in the WFMCs. Radio spots using a "slice of life" or "word of mouth" approach are broadcast daily during a prime-time news program and a popular drama on a selected local station. Three spots are aired per program per day in each of the six TANGO II regions. Three additional free broadcasts are made on Sunday at times chosen by the station, for a total of 39 announcement per week. The effectiveness of this campaign is unknown at this time, but, on the basis of evaluation interviews, the radio campaign appears to have had a rather limited impact on heightening public awareness of the WFMCs' presence and services. Midwives have been asking new clients about how they learned about the clinic, but this

data has not been used, nor has a follow-up survey of clients in broadcast areas been conducted. JSI/RTI and NGO staff believe that the radio campaign has been ineffective in major urban areas where television would be a preferable medium, particularly in metro Manila. JSI/RTI is considering the use of television despite its costing three times as much as radio advertisements; this medium is worth while if many more people are reached.

JSI/RTI, the NGOs, and individual WFMCs have marketed and promoted the clinic services by distributing leaflets, posters, and other materials. Some NGOs have printed additional FP/MCH materials and one is funding its own radio campaign to augment JSI/RTI's efforts. At the clinic level, house-to-house visits are reported to be the most effective approach. NGO and WFMC sponsored promotional activities, such as raffles, are also reported to be well received and helpful in promoting awareness of the WFMCs. Some midwives have sponsored their own promotional activities, such as "discount days" or free contraceptive distribution to new clients on the anniversary of the clinic's opening or the midwife's birthday. These promotional efforts are infrequent, however, and many other opportunities to advertise and market the WFMCs at relatively low cost are being missed. A good example is the lack of adequate directional signs on busy roads or at key intersections, an inexpensive but useful way to attract public attention. Stickers in tricycles, advertisements at waiting sheds and public health facilities, or distribution of fliers on FP/MCH services at the local public market are other marketing techniques not currently being used.

#### 3.1.4 Management Strengths and Weaknesses

Management of TANGO II and the relations among its various components is a refreshing change in comparison to many other projects. JSI/RTI has been highly responsive to the need to modify TANGO II in its present direction. Good working relations characterize the USAID-JSI/RTI partnership. Similarly, despite having to exercise control over NGO activities, including the withholding of budget releases when benchmarks were not met, the relationships between JSI/RTI and its NGO partners and among the NGOs themselves is positive and highly constructive. All participants make a concerted effort to share information, experience, and lessons learned. The project is also being directed at all levels with a commendable degree of flexibility in recognizing the need to learn from experience and make necessary modifications. A perfect illustration of these conditions is that, without exception, each NGO indicated considerably greater confidence in its clinic location and midwife selections for 1998 as a result of its 1997 experiences.

The evaluation did, however, identify several areas where management improvements in systems and operations are needed.

Despite project efforts to simplify WFMC record-keeping and reporting requirements, most midwives fail to maintain adequate service records and business accounts. Other than the reporting on progress toward FP and MCH benchmarks, virtually no analytic use is made of clinic data. Despite training and NGO supervision, few midwives appear to be using such records for



client follow-up or business development. A disturbing number of midwives could not provide total monthly expenditure and income data to determine their profits.

Distinguishing the WFMCs from public health facilities is critical to WFMCs' success and to establishing a sustainable network of WFMCs widely recognized as sources of affordable, high-quality FP/MCH services. A common WFMC "look" is emerging across clinics sponsored by the Negros Occidental Rehabilitation Foundation (NORFI), Cebu-FPOP, DMSF-IPHC, and COMDEV; however, the clinics' appearances still vary considerably. In part, this is unavoidable because of the different locations used for the clinics. Some clinics are in rented spaces, others are the midwife's house (or her relative's); some have ample space and are bright and attractive, others are cramped, dark, and unappealing. IMCH and Integrated Maternal Child Care Services and Development, Inc. (SDI) clinics visited during the evaluation are readily identifiable as belonging to the NGO. Signs, posters, color schemes, labeled materials, and supplies identify the NGO, while WFMC identification is minimal. In at least two of the clinics visited, one could easily miss the clinic's association with the WFMC entirely.

In line with the preceding point, provision of government-supplied, free contraceptives by the WFMCs blurs the distinction between WFMCs and public facilities and reduces the profitability of service provision where the local government prohibits charging for government-supplied contraceptives. The use of government-supplied contraceptives has resulted in some friction between the WFMC and local government FP and health staff. Some government staff reportedly resent government-supplied contraceptives being provided through the WFMCs. Midwives counter that they only charge a service or handling fee; however, these fees increase directly with the number of contraceptives provided. In at least one case, a midwife decided to stop using government-supplied contraceptives because of seriously strained relations with her local Rural Health Unit (RHU). JSI/RTI and the sponsoring NGOs report that they plan to phase out the use of government-supplied contraceptives in 1997 clinics and not use them in 1998 and 1999 clinics.

As noted, NGOs are now more closely monitoring the performances of their clinics, particularly the poor performers. Although several NGOs have already "de-selected" and replaced one or more poor performers, our review suggests that some NGOs are carrying one or more WFMCs that should be relocated or closed.

Two areas of NGO support to clinics need attention. First, NGOs suggested prices for services to the WFMCs that were appropriate at the outset. Some midwives report having adjusted their pricing based on their assessment of what the market would bear. Most actually maintain an informal "price band" for services, adjusting charges to clients based on their apparent ability to pay. However, other midwives seem reluctant to experiment with pricing, and charge what the NGO initially suggested. These midwives need to be encouraged to adjust prices as they see fit.

Second, WFMCs need to be accredited by the DOH and have business licenses. Some NGOs obtained accreditation for themselves, which is extended to their clinics as "satellite operations." In other cases, clinics obtained individual licenses and accreditations. NORFI has had difficulty

getting business licenses for its clinics, while IMCH reports slow action by the local DOH in granting accreditation. The licensing and accreditation approach via the sponsoring NGO seems a good solution because it can become a routine service offered by the NGOs to their WFMCs.

An important impending issue for JSI/RTI and the NGOs is the increasing management requirements from expanding the program to include more WFMCs in 1998 and again in 1999. NGO supervisors currently spend approximately 75 percent of their time visiting clinics. To focus on starting up and developing the 1998 WFMCs beginning operation in May, NGOs will need to realign their work assignments, substantially reducing the amount of time given to 1997 WFMCs. Although NGO staff stated they recognize that they must reduce their involvement with 1997 WFMCs, their management intensive, "hand-holding" relationship with the clinics raises a concern that their actions might not correspond with their words.

### 3.1.5 Cost-Effectiveness and Sustainability

JSI/RTI recently estimated that at current funding levels, the cost being generated through TANGO II is approximately \$20 per CYP. The activity's overhead costs are also very reasonable; JSI/RTI and NGO staffing levels are lean but adequate. Although some additional staffing might be necessary as the number of WFMCs increase, JSI/RTI and its partner NGOs should actively attempt to keep staffing levels from inflating or becoming top-heavy, with too many managers and not enough operational staff.

The major question regarding the sustainability of TANGO II's activities centers on the NGO's ability to develop and provide support services to WFMCs on a fee-for-service basis. WFMCs will continue to need various support services, such as specialized service training, refresher courses, bulk purchases of contraceptives and clinic supplies, business development assistance, and facilitation of licensing and accreditation. Funding through TANGO II for such services will be phased out, and NGOs will need to market services to WFMCs on a fee-for-service basis.

Planning of such services is currently at a rudimentary stage. JSI/RTI will conduct a business plan development program for the NGOs participating in 1998. This program should move this planning process forward. Considerably more engagement with WFMC midwives, analysis, and planning will be needed to identify marketable NGO services. For-fee service delivery will be a major transformation in the orientation and operation of the NGOs from donor and donation funding (augmented by marginal cost-recovery schemes in some cases) to a businesslike approach to servicing the needs of their WFMC clients. These services must be priced at levels midwives will pay, but they must also cover the NGOs' costs for service delivery. None of the NGOs have yet estimated what those prices should be. 1997 WFMCs will probably not be able or willing to pay the full costs of such services in 1998. Each NGO currently sponsors only 12 to 15 operating clinics, too few to bear the full costs of service provision. Perhaps when the number of WFMCs per NGO increases to 30 or more, the full costs of services might then be covered by WFMC payments.

### **3.2 Conclusions**

The success of the WFMCs will depend in large part on their ability to attract clients from a rapidly expanding segment of the Philippines population—potential FP acceptors who are willing and able to pay for quality FP/MCH services. TANGO II's progress indicates that the pricing of quality services is largely on the mark (in practice, midwives have established an informal "price band" to capture a wider clientele) and that the provision of high-quality services in well-equipped, midwife-operated clinics has considerable appeal to those who can afford to pay for such services.

TANGO II's accomplishments over the past 15 months far outweigh the various problems noted. Results are very encouraging, and the project has all the markings of becoming a genuine success in expanding private sector provision of FP/MCH services. TANGO II's progress clearly indicates that a successful model has been developed with wide applicability throughout the country. Although the current benchmark of 330 WFMCs by the end of the program is a good start, the potential exists for considerably more WFMCs in areas where TANGO II is already operating, as well as in many other parts of the country. USAID needs to consider expanding this effort under the current Cooperative Agreement and including similar assistance in its future program beyond 2000.

JSI/RTI's proposed phasing of first-year FP benchmarks—four months for WFMC start-up, followed by quarterly CYP benchmarks increasing by quarter from 30, 40, 50, and then 60 CYPs per month per clinic for temporary methods—reflects the experiences of reasonably well-performing clinics in the 1997 group. This schedule should be adopted for the new 1998 and 1999 WFMC program entrants. Successful 1997 WFMCs indicate that 90 or more CYPs per month from modern temporary methods are achievable. Therefore, second- and third-year FP benchmarks should continue to increase every six months by an additional 5 to 10 CYPs per month per clinic. MCH benchmarks need to be increased substantially, perhaps tripled for the first year, and increased every six months thereafter to encourage business development. However, benchmarks must take into account that some WFMCs will drop out of the program and be replaced by new clinics, reducing the overall accomplishment of CYPs for the NGO.

The lack of business development training (as opposed to technical training for FP/MCH services and facility operation) and technical assistance in business development is a serious weakness that needs to be addressed by JSI/RTI. A business development planning workshop has been scheduled by JSI/RTI during the third quarter of 1998.

Although sponsorship by locally recognized NGOs gives the WFMCs credibility, the clinics would benefit from being more readily identified as part of the WFMC network. The NGOs should continue to be associated with the WFMC network; however, in some cases such as several IMCH and SDI clinics visited, identifying the WFMC with the sponsoring NGO virtually overwhelms the franchise or network association and makes the WFMC appear to be yet another variation of an NGO-supported clinic. USAID, JSI/RTI, and the participating NGOs need to reconsider the nature of the NGO-WFMC relationship that is evolving as NGOs move toward becoming technical and management service providers to their WFMC clients. This relationship should be clearly defined from the start-up of each WFMC.

Public recognition of the WFMCs will be aided by maintaining the standards and appearance of the facilities, including the use of WFMC signs, which clearly set WFMCs apart from public facilities. Like other franchise networks, greater uniformity in appearance, logos, and signs will contribute to this end. Standards for minimal clinic size should also be developed and followed for all new clinics.<sup>12</sup> In short, JSI/RTI needs to establish and enforce standards for the physical appearance of the WFMCs just as standards are in place for technically sound, quality FP/MCH services.

More cost-effective mass-media campaigns are needed that will emphasize basic messages about WFMCs' high-quality personalized services, affordable prices, convenience, and well-equipped facilities. Communicating the idea of the WFMCs as a recognizable franchise should be central to this effort. More creative, low-cost marketing and advertising should be undertaken. Such efforts might include placing WFMC stickers in jeepneys, tricycles, waiting sheds, and public health facilities where target clientele will see them, or producing simple WFMC home videos to be shown at movie houses. JSI/RTI needs to move ahead with using television at least on a pilot basis in metro Manila and Cebu. Better evaluation of high-cost marketing efforts is also needed.

NGO technical and management service provision to the WFMCs is crucial to maintaining clinic standards in the coming years. Without such support, WFMCs could quickly experience falling levels of FP/MCH service provision, declining quality of care, increasing reliance on government subsidies—free contraceptives—and diminishing appeal to those who can pay for services. If by the end of 1998 NGOs prove unable to make the transition to businesslike relations with the WFMCs they sponsored, alternative approaches for servicing clinics' needs should be tried.

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<sup>12</sup> Size is an important factor with respect to client privacy, an important element of perceived service quality. Privacy will become increasingly important to the WFMC's operations as the client load increases.

### **3.3 Recommendations**

8. The Cooperative Agreement for TANGO II should be amended to increase funding to support establishing additional WFMCs in areas (regions) that have NGOs operating, but that could support more clinics. (This does not mean that NGOs should expand their area of operation nationally.)
9. The overall potential for the WFMCs' expansion should be estimated to develop as wide a network of sustainable clinics as possible—that is, identify potential new areas and family planning NGOs working in those areas, and estimate how many WFMCs might be viable as a basis for designing an expanded activity, such as TANGO III. The POLICY Project can assist JSI/RTI in this situational research.
10. WFMC benchmarks should be revised as proposed by JSI/RTI for the first year of operation for new 1998 and 1999 clinics and a schedule of gradually increasing benchmarks should be developed for the second and third years of operation, reaching 90 or more CYPs per month per clinic for FP methods. MCH benchmarks should be increased based on first-year (1997) results. Benchmarks should be adjusted in light of expected drop-outs and replaced clinics.
11. JSI/RTI should provide technical assistance in small business development to both the NGOs and the WFMCs. Initially, such services could be provided by a local consultant, but as the project expands, JSI/RTI should consider adding a small business development specialist to its staff. Simple business development plans covering a one-year period should be developed for each clinic by JSI/RTI and its partner NGOs as part of this activity. These plans should include activities that will expand FP services to make them more profitable.
12. JSI/RTI and the NGOs need to expand efforts to facilitate access to local industries and agribusinesses, particularly those that employ large numbers of women, for WFMC midwives.
13. NGOs should provide specialized technical assistance to midwives to improve record keeping and accounting. NGO staff should work directly with midwives to accomplish this recommendation. No more general training should be conducted until each midwife can maintain records unassisted. JSI/RTI should train NGO staff and midwives in simple

analytic uses of the data they are generating to improve follow-up efforts and to expand business and income.

14. Clinic standards for appearance, signs, and other elements should be established to identify the clinic as part of the WFMC network. Such efforts could include emphasizing the blue and white color combination when painting clinics to correspond to the WFMC signs. Although signs should include identification of the sponsoring NGO (name and logo), large signs and logos, monogrammed sheets, and other materials clearly associated with the NGO should be eliminated. All new participating NGOs should adopt the same standards, such as those for appearance and signs, associated with the WFMC network. In the annual agreements between JSI/RTI and the participating NGOs, the NGO/WFMC service provider-client relationship should be clarified.
15. The use of government-supplied contraceptives should be eliminated in all existing WFMCs by the end of 1998. Supply or use of government-supplied contraceptives should not be permitted in any new clinics.
16. JSI/RTI should evaluate the effectiveness of its radio campaigns by surveying WFMC clients. It should pilot television marketing in metro Manila and Cebu by mid-1998 and evaluate its effectiveness. JSI/RTI, NGOs, and WFMCs should emphasize low-cost, high-impact marketing and advertising.
17. Each NGO should carefully review the performance of its poorly performing clinics and replace those that have not improved significantly by the end of April 1998. Replacements should be in addition to (not substitutes for) the new 1998 WFMCs.
18. NGO association fees for WFMCs should be increased to at least P300 per month by the end of April 1998 for the 1997 WFMCs. Lower rates should be maintained for first-year WFMCs. Service plans, service provision costs, and service prices to be paid by the WFMCs should continue to be refined expeditiously.

## **CHAPTER 4. CARE PHILIPPINES NGO-SUPPORT PHASE II SUSTAINABLE COMMUNITY-BASED FAMILY PLANNING PROJECT**

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### **4.1 Findings**

#### **4.1.1 Project Design**

The Sustainable Community-Based Family Planning project (CBFP) is a continuation of USAID's assistance to NGO development of FP services that began in 1992. CBFP covers the period from July 1996 to June 1998 and attempts to build on NGO capabilities for FP service delivery developed during Phase I of the USAID-funded CARE project. Total funding for CBFP is \$849,499 over two years of implementation.

CBFP is designed to provide FP services in underserved areas—particularly poor, rural communities, but also periurban communities—where government facilities and services are insufficient. The model for service delivery was developed during Phase I. CARE identified and recruited non-FP NGOs active in underserved communities. The NGOs' presence in the community was seen as a means to facilitate FP service delivery in these areas. Considerable staff training and continued technical assistance—more than initially expected—was needed to establish FP program capabilities in the NGOs.

CARE manages CBFP through a FP project coordinator and three family planning program officers (FPPO) who are regionally based and work directly with participating NGOs. Nine NGOs located throughout the country participate in CBFP; annual budgets range from \$10,000 to \$14,000 per NGO.<sup>13</sup> Each NGO supports a FP coordinator and three FP Workers, most of whom are nurses or midwives. The NGO staff support community volunteers (CV) who reside in the areas covered by the NGO program; most are housewives and some are also barangay health workers. The CVs receive training from the NGOs, reimbursement for transportation costs, non-monetary incentives, and a percentage from sales of socially marketed contraceptives. CVs are responsible for identifying and counseling potential new acceptors, resupplying users with pills and condoms, and making referrals through periodic house-to-house visits. The CVs also manage Community-Based Distribution Outlets (CBDO) that augment LGU contraceptive supplies.

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<sup>13</sup> At the 3/31/98 exchange rate of P36=US\$1.00. The nine NGOs are First Consolidated Bank-Livelihood Foundation, Inc. (FCB-LFI), Western Samar Development Foundation (WESADEF), Feed My People International, Ltd (FMPI), Family Health Care Center (FHCC), Silliman University Extension Program (SUEP), Ting Matiao Foundation, Inc. (TMFI), Associates for Integral Development Foundation, Inc. (AIDFI), Bukidnon Integrated Network of Home Industries, Inc. (BINHI), and Tribal Leaders Development Foundation, Inc. (TLDFI).

Four of the NGOs have established six FP clinics with equipment provided by CARE and a staff of nurses or midwives with FP training, but CBFP services are predominantly non-clinic based. Government-supplied free contraceptives are provided through the program with the NGO receiving supplies from the Provincial Health Office or lower-level government facilities. Trust contraceptives have also been introduced. Clinics attempt to collect fees for services and socially marketed contraceptives, but many clients can only partially pay, pay only nominal amounts, or cannot pay. Some barangays or municipal governments pay small "honoraria" to the CVs, reported to be P200 or P300 a month, as an acknowledgment of their services to the community.

#### 4.1.2 Success Relative to Benchmarks

CBFP uses three key benchmarks to monitor progress: (1) number of new acceptors (NA), (2) number of continuing users (CU), and (3) CYP. Benchmarks for Year 1 and Year 2 are shown in Table 4.

**Table 4**

**CBFP Benchmarks: 1996-1997 and 1997-1998\***

Indicator	Year 1			Year 2**		
	Benchmark	Actual	%	Benchmark	Actual	%
NA	5,268	5,098	96	5,466	2,167	40
CU	9,741	7,192	73	12,442	9,144	73
CYP	7,908	2,750	68	14,443	4,477	31

\* From CARE Quarterly Reports

\*\* As of 12/31/97 - half year

Year 1 results show a vast improvement over the performance of the preceding Phase I project, which fell far short of its benchmarks (particularly for CYPs) and suffered from basic design and implementation problems. Based on the experience from Phase I, CARE was able to project realistic benchmarks, but attainment of CYPs remains elusive. Mid-Year 2 results suggest that more will be accomplished in absolute numbers for CUs and CYPs, although the percent of benchmarks accomplished will be about the same in Year 2 as in Year 1 for NAs and CYPs. Performance for CUs in Year 2 will far exceed that of Year 1, suggesting that the NGOs and CVs are doing a good job of keeping users motivated and supplied in Year 2. Performance continues to lag, however, in reaching CYP benchmarks.



Setting performance benchmarks for NGO activities is a laudable improvement over past NGO FP programs lacked this management discipline in the past. However, NGOs reported that they count as new acceptors anyone new to their program, which inflates the number of actual new acceptors being reached by CBFP. With services in 208 barangays, Year 2 benchmarks constitute 25.3 new acceptors, 46.8 continuing users, and 69.4 CYPs per barangay per year. These might be reasonable numbers for small, isolated rural communities, but several NGOs cover urban or periurban barangays and could meet higher performance benchmarks.

With respect to USAID's IR3 benchmark, CBFP is making a relatively small contribution to expanding private sector provision of FP services. USAID estimates that over three million MWRAs must be using modern methods by 1997 to achieve its CPR benchmark of 34 percent by 2000. Slightly over one million CYPs must be generated through private sector provision of modern methods to achieve its benchmark for IR3. CBFP's contributions to such levels of use and supply are indeed small.

#### 4.1.3 Project Outcomes: Strengths and Weaknesses

CARE and its NGO partners have been successful in using capacities developed during Phase I to provide FP services to underserved, poor communities. Non-FP NGOs have been able to train and retain sufficient numbers of FP staff to support program activities in their selected barangays.

The community-based approach CBFP uses for service delivery appears to be a viable means of developing an FP service delivery system to expand and support contraceptive use in underserved areas, particularly in rural, poor communities. Local governments lack adequate health budgets to expand FP services to underserved areas. That is precisely the gap in the system NGOs are attempting to fill. Field visits suggest that NGO programs are not duplicating government services to a great extent, but rather are complementing and extending them. Many LGU officials and health facility staff reported NGO activities significantly improve the availability of FP services in these communities. Barangay health workers simply cannot give adequate attention to FP services. Thus, the CBFP is basically an extension of the public sector and cannot be said to be an expansion of the availability of private sector services.

CBFP and its NGO partners have produced a number of potentially useful outputs. Some 354 trained and experienced CVs are now in place in 208 barangays. LGUs are providing modest funding to 200 of the CVs as reimbursement for their transportation costs. The CVs support 267 CBDOs, and evaluation interviews found that CVs generally have access to government facilities for resupply or will be resupplied through their NGOs. Forty-five FP Users Clubs have also been established to fund FP services through their income-generating activities. CARE reports that 109 CVs are collecting small service fees that will help sustain them after the project ends. NGOs have also generated FP trust funds from their programs that they intend to use to support their

programs after June 1998. Field visits confirmed that CBFP has given credibility to the partner NGOs in their communities as FP service providers.

These accomplishments reflect reasonable, sound progress made over 18 months of CBFP implementation. Staff turnover has been high, however, and new staff members need to be retrained and closely supervised. Fee collection has been hampered by clients' inability or unwillingness to pay even small charges. Providing VS services to clients was problematic because of clients' inability to pay for even the medicines needed for the procedure. A link with AVSC made in early 1997 is expected to resolve this constraint, but as a result, fewer CYPs were accomplished for the project in Year 1. Despite statements made to the evaluation team by LGU officials and health staff, there has been friction and competition between the NGOs and local health officials. Some NGOs felt they were working in areas where the saturation point for FP acceptors and FP service providers had been reached. Users Clubs have had some waning interest and some NGOs feel they are not adequately staffed to attempt the community organizing activities needed for such clubs. Training for community organizing was provided, but experience, not just training, is needed to be effective at this task.

An important part of CARE's strategy for sustaining CBFP activities is facilitating linkages between the LGUs—particularly, at the barangay level—and the CVs. CARE and NGO staff have tried to do that; some LGUs have been responsive, others have not. NGO presence in communities through their other programs has influenced local decisions for support. Some barangays can provide space and utilities for satellite offices in barangay facilities; others flatly state that they have no budget to support additional staff. A number of CVs may be without minimal local support after June 1998 unless reluctance by LGU officials can be overcome. Also, incorporating FP service support into LGU systems is hampered in a number of locations because the barangay lacks adequate FP facilities. Tie-ups with other peoples' organizations have also had encountered difficulty generating interest in supporting FP activities. In short, the organizational efforts to contribute to sustaining CBFP have had mixed results.

It is important to note that CARE and its NGO partners have been responsive to the problems they have encountered through CBFP. For example, CARE and NGO staff worked to improve working relations with government when friction arose with LGU health staff. Additional training was provided when NGOs reported a lack of experience with community organization. In line with CBFP's basic strategy of institutionalizing the CVs and the CBDOs they manage into local government operations, CARE and NGO staff have made considerable effort to win at least a modicum of support from LGUs. In general, it appears that despite difficulties arising from staff turnover during CBFP, the activity has been intelligently managed.

The NGOs participating in CBFP were engaged in various programs prior to the project. These include microlending, agricultural and fisheries activities, livelihood projects, housing, education, and assistance to marginalized urban and rural people. These programs were reported as

facilitating their work in FP. It appears that engaging non-FP NGOs to implement a FP program has been advantageous; their presence and credibility in underserved communities gave the project quick access to these areas. The major disadvantage of using non-FP NGOs has been the substantial training and supervision required to develop technically sound, efficient service delivery capacities. However, these efforts seem to have been worthwhile. Several NGOs visited during the course of the evaluation intend to stay engaged in FP programs after the CARE project ends, and in one case, the director intends to make FP a high NGO priority in the future.

#### 4.1.4 Cost-Effectiveness and Sustainability

CARE estimated that its program costs approximately \$22 per CYP, a figure less than that calculated by the assessment team (see Section 7.3.4).<sup>14</sup> Regardless of the final cost, it is difficult to envision a less expensive approach to provide quality FP care to underserved communities whose residents are largely unable to pay the full cost of services or contraceptives. Although the cost is reasonable, the outputs have been minimal.

Prospects for sustaining NGO FP services after June 1998 in rural communities are not promising. As CARE frankly stated in its progress report for October to December 1997,

If we compare revenue generated by all partners with their operating expenses, sustaining their FP services at their level is impossible. The economic situation of their clients hinders the collection of service fees by the FP providers.

Although the sustainability of NGO activities is bleak, there is hope that the focus on community-based service provision and efforts to build linkages with the LGUs will prove successful. NGOs plan to reduce the number of supervisory staff to one and "endorse" their activities to the LGU for future financial support to community volunteers. Some highly committed community volunteers and the CBDOs they maintain are likely to continue; however, it is expecting too much for that to occur in most locations without giving some minimal support and encouragement to volunteers. As noted, LGUs' acceptance of the NGOs endorsement of CVs is mixed. Furthermore, current LGU financial support can quickly end if new officials are elected. Users groups and trust funds might help sustain activities over the short-term, but their longevity is uncertain. Perhaps the two cooperatives established under the program will prove successful, but the Philippines has a long, checkered experience with efforts to establish independent, self-sustaining cooperatives as a sustainability strategy, especially new organizations that are likely to need continuing support and supervision.

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<sup>14</sup> The estimate of \$22 per CYP was provided by CARE during its initial briefing with the assessment team.

In retrospect, a major program design flaw is the lack of cross-subsidization schemes to support programs after USAID funding ends. FP services in poor communities are simply not financially sustainable, especially where local governments are unable or unwilling to fund community volunteers needed to support these activities. However, NGOs with clinic facilities could follow a modified version of the TANGO II model and target their services at more prosperous communities to generate revenue. Income from such services could be used to support services to poorer communities by paying small expense reimbursements to CVs to keep them active where no support from the LGU is provided. Schemes to support staff and services in urban communities where there is some capacity to pay for services are also lacking. Although these strategies might not have been suitable for all of CBFP client communities, they might have been worth trying under the right conditions.

One possibility for sustaining FP services developed under CBFP is to establish financially self-sustaining, barangay-based services in densely populated, periurban communities. Discussions with NGO staff and LGU officials suggested that FP service delivery might be sustainable where the barangay contributes space and utilities; where the service uses government-supplied free contraceptives; and where services are provided on a marginal (or higher) for-fee basis to cover the costs of one NGO-supported FP staff person (a trained nurse or midwife) and two or three community volunteers. This appears to be a possibility for those NGOs that have established a fully equipped clinic with trained FP staff capable of performing clinic-based services (IUD insertions or PAP smears). At least one NGO—Family Health Care Center (FHCC) in Bacolod—has already taken steps in this direction.

## **4.2 Conclusions**

CBFP has clearly progressed in developing community-based FP services in underserved areas. The CARE program was a worthwhile undertaking when originally envisioned; however, activities like CBFP, in general, and the CARE FP program, in particular, no longer fit within the USAID/Philippines's Strategic Objectives in the population sector. Increasing the national CPR by at least 1.5 percent annually over a five-year period requires reaching large numbers of people as quickly as possible.

As CBFP shows, activities that focus on underserved communities—many of which are in rural areas with dispersed populations—simply cannot generate the number of acceptors and continuing users needed to have an impact on the national CPR. That is not a criticism of CBFP as some failing on the part of those involved with this particular project; it is the nature of the problem that such projects address that accounts for such results. In CBFP's case, the problem was greatly compounded by working through non-FP NGOs. Developing FP service delivery capabilities in these non-FP organizations to service rural communities has not proved cost-effective.

The difficulties CBFP has encountered during implementation are not unusual or atypical of projects targeting poor communities and underserved areas. Rather, such locations where the government system is simply not functioning adequately and where people need heavily subsidized or free services are the most difficult environments in which to operate. Therefore, NGOs who have access to and credibility in these communities are engaged to implement the activity. Encountering problems during these projects is not unusual; a lack of such problems would be a cause for concern.

Although sustaining FP service delivery through community-based mechanisms was a major element of CBFP, a significant percent of CBFP's accomplishments are likely to decline or cease over time, particularly in rural, isolated areas, because of a lack of further support. As mentioned, CARE and its NGO partners have already attempted to obtain financial support from various LGU levels. However, these efforts have had limited success. A number of LGU officials simply responded that they lack adequate funds. Therefore, suggesting that these NGOs sustain their program activities with funding through the LPP grant program or other government channels appears to have little or no prospect of success. Despite having extended FP services to poor, marginalized people not adequately served by government facilities, there is simply a lack of sufficient funding to sustain a number of these NGO programs with government revenues. The same lack of funds that accounted for inadequate government services in the first place undercuts the chances of these NGOs obtaining new government funding.

Opportunities may exist to increase the likelihood of sustaining some CBFP elements. FP services in densely populated areas supported by an NGO with an equipped clinic and trained staff could become self-sustaining. A combination of cross-subsidization of services to underserved areas from for-fee clinic operations, support from the LGU for a service site in barangay facilities, supply of free contraceptives from the government, and collection of minimal fees and charges for contraceptives might be a viable approach in these cases.

### **4.3 Recommendations**

19. In line with its current Strategic Objective for the population and health sector, USAID should cease further funding for the CARE FP program. USAID's program support should end with the current grant in June 1998.
20. CARE and its NGO partners should continue their efforts to gain LGU support for CVs where such support is currently lacking. If the barangay is unwilling or unable to provide support, assistance should be pursued at higher government levels.
21. If analysis of CBFP sites in locations with dense populations, an NGO with a FP clinic, strong LGU support, and a minimal capacity for clients to pay for services and supplies are possibilities for self-sustaining FP services from the CBFP project, JSI/RTI should consider CARE's NGO partners for participation in TANGO II.

## **CHAPTER 5. AVSC INTERNATIONAL**

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### **5.1 Project Background**

AVSC International's "Strengthening Voluntary Sterilization Services in the Private Sector" project parallels AVSC'S efforts in the public sector to strengthen the VS service component of the family planning program at the central-, regional-, and local-government-unit levels. In this project, AVSC International works through the franchised clinic networks of the NGOs that participate in JSI/RTI's Modified Tango II project. The project began in November 1997 and is covered by a Cooperative Agreement that has recently been extended to August 1999.

### **5.2 Findings**

#### **5.2.1 Project Objectives and Design**

To help fulfill the unmet need for FP services in the private sector, the project seeks to sustain and strengthen VS service provision by establishing a VS services referral system between NGO-franchised clinics and private, LGU, and DOH VS service sites and providers; upgrading the VS service capability of selected private VS service sites and providers; and establishing and maintaining a quality assurance system for VS services in private VS service sites.

To meet the project objectives, AVSC International provides a package of technical and financial assistance to NGOs, private hospitals, private practitioners, and midwives working at the franchised clinics. The assistance consists of the following:

- Funds to upgrade or renovate surgical areas and acquire essential pieces of equipment;
- Training for physicians and nurses on minilaparotomy under local anesthesia;
- Training on counseling, including follow-through support, for midwives; and
- Support for strengthening quality assurance sites in VS service systems.

Participating hospitals have to meet criteria set by AVSC International that relate to their actual or potential capacity to provide surgical sterilization relative to the demand for VS services in their catchment communities. The project design also includes advocacy activities directed toward relevant organizations, such as the Philippine Obstetrics and Gynecology Society, the Philippine Health Insurance Corporation (PHILHEALTH), and the DOH; support for research to generate policy and operational guidelines in providing VS services; meetings among local providers; and orientation for volunteer workers.

General oversight and management of the project at the national level rests with AVSC International, in close coordination with JSI/RTI. AVSC International signs subagreements with the NGOs, who in turn sign a Memorandum of Agreement (MOA) with their respective VS referral hospitals and clinics. Thus, the NGO has the primary responsibility for implementing the VS referral system in its geographic area. Evaluation indicators are monitored at the franchised clinic and VS site levels.

### 5.2.3 Project Implementation

Table 5 indicates the VS referral sites that have been identified for JSI/RTI's six NGOs.



**Table 5****VS Referral Sites for JSI/RTI's Six NGOs**

<b>NGO</b>	<b>Geographic Sites</b>	<b>Private Hospitals/Clinics</b>
COMDEV	General Santos City South Cotabato Sultan Kudarat Sarangani	Rosendo Diagan Hospital Panayaman Hospital Tamondong Well-Family Midwife Clinic Our Lady of Lourdes Hospital
FPOP	Cebu City Cebu Mandaue City	Dr. Norman Santos Clinic
NORFI	Bacolod City Negros Occidental	Medical Village Hospital Elumba Emergency Hospital
IMMCCSDI	Butuan City Cagayan de Oro City Misamis Oriental Bukidnon	Polymedic General Hospital Bukidnon Doctors' Hospital
DMSF-IMCH	Davao City Davao del Sur	Community Health and Development Cooperative Hospital (CDHC)
IMCH	Rizal Cavite	Reyes Clinic De La Cruz Maternity Hospital

Source: JSI/RTI

AVSC International has signed subagreements with the six NGOs; each NGO in turn has entered into individual subagreements with the VS sites. Training for most of the doctors and nurses have been completed, as well as for all the midwives of the NGOs' Year 1 franchised clinics.

Doctors selected for training in minilaparotomy under local anesthesia had the surgical capability (to open the abdomen) or were already performing bilateral tubal ligation (BTL) under different anesthesia. Doctors who had surgical capability but were not performing BTL were prioritized for training in a DOH-accredited VS training center. For those doctors currently performing BTL, on-site VS training was conducted to ensure they learned how to perform the procedure under local anesthesia. To date, only the Polymedic General Hospital and the Elumba Clinic staff have not received training; on-site training for the Polymedic General Hospital is scheduled for April 1998.

The clinics and hospitals were recommended by the relevant NGO to AVSC International, which then conducted the required assessment. Selection criteria include the following:

- Availability of staff able to provide VS services or those willing to be trained,
- Willingness of staff to provide VS services after training,
- Commitment of facility management to implement the VS program,
- Availability of operating room space for VS, and
- Potential VS caseload (presumably two referrals per month per WFMC).

Three of the four doctors interviewed in the VS sites used to be part of the Population Commission (POPCOM) network and were already known to provide VS services in their communities. They joined the project for both the potential new clientele offered by the referral mechanism, as well as for the AVSC International technical assistance. In the smaller facilities, the equipment and training offered by the project seemed to be more appreciated than in the larger facilities.

None of the VS sites visited had yet received the promised equipment. One NGO explained that the tranching of funds from AVSC International was a constraint to turning over equipment to the VS sites. In turn, AVSC International explained that most of the NGOs received their initial release of funds (one-third of the total subagreement) in December 1997 and January 1998, and that the NGOs spent substantial time canvassing for equipment to be purchased. The release of subsequent funds depends on the successful accomplishment of program activities as specified in the subagreement and on the submission of quarterly financial reports. This process can be expedited by submitting a special financial report requesting an earlier release of funds.

Before the project, the VS sites relied on their own patients, walk-ins, and referrals from barangay health stations, and private midwives. No one had yet received referrals from the AVSC International partnership, although a General Santos-based midwife had already developed a list of 30 BTL patients and was just waiting for an available doctor. Most of the VS sites were providing services before signing agreements with AVSC International, and they are prepared to continue as soon as midwives make referrals.

Most of the BTLs done at these sites were postpartum. Charges varied depending on whether the BTL was an interval or postpartum procedure; providers also offered group discounts because of the savings incurred in medicines for five or more procedures done at the same time. Some expressed concern about the standard fees that they are required to charge under the subagreement, stating that they had only agreed to the standard fees because it had been set by another VS site; AVSC International reported that prices for services were reached after consultations among the NGOs, private VS service site staff, WFMC midwives, and volunteer health workers. These fees were P850 for a vasectomy and P1,500 for a BTL, broken down into P500 for the surgeon, P100 for the operating room assistant, P100 for the operating room fee, P100 for the NGO fee, and P500 for medicines. PHILHEALTH members can be reimbursed for a part of these fees. One doctor interviewed would have preferred a BTL fee of P2,000; his usual fee is P3,000. Prices can be renegotiated if needed to be consistent with changes in the cost of VS service provision.

Although the VS sites seemed to have been selected by the NGOs on the basis of their convenient location in relation to the franchised clinics, no clear criterion was given regarding their distance from public facilities offering similar services on the assumption that consumers will self-select (and providers will refer consumers) based on their ability to pay. Although this is the ideal, some patients who are able to pay may still seek the cost savings of using the public provider. But not all public facilities are voluntary sterilization, and public providers may refer to private VS sites, also affecting decisions about distance.

Consideration must be given to the distance of private clinics from public facilities from the market perspective, as well as from the access-to-services perspective. AVSC International is working with both public and private providers to improve the quality of care in delivering VS. If improvements to both public and private sites are taking place in the same area, private clinics may have difficulty differentiating themselves for consumers. Without significant differentiation, the private clinics may have difficulty attracting clientele, a situation that will adversely affect financial viability.

During field visits made during this assessment, private clinics expressed their intention to raise prices once their initial contract period is over. If clear market segments exist for public and private clinics, then there will be no problem about the proximity of these clinics, because the market will automatically segment. But, if the same market segment that is comfortable using the public sector services is served by both sites, then the market for the private clinic will be affected.

The distance of private clinics from public facilities also becomes important if one considers access to sterilization services on a national basis. The infrastructure for such a delivery system is already imbalanced; why aggravate the situation by putting clinics close to each other rather than dispersing them to broaden reach and increase accessibility?

### **5.3 Conclusions**

Because the project started in November 1997, it is premature to evaluate the effectiveness of the project design. However, the success of the project will greatly depend on good working relationships among the project's key players: AVSC International, JSI/RTI, the NGOs and their franchised clinics, and the private practitioners. For some of these key players, such as JSI/RTI and the NGOs or the NGOs or their franchised clinics, partnerships already exist. Some difficulties may arise if roles and responsibilities are not clarified among all partners and accepted early in the project, and if no effort is made to assess how this new partnership is congruent with existing ones.

The following issues may also emerge in project implementation. First, in areas where VS sites are close to public facilities that are also being strengthened by AVSC under its public sector project, the two facilities may turn out to compete with each other unless their respective services and prices are well-differentiated. Second, any disagreement regarding fees should immediately be addressed to avoid problems of providers opting out of the project at the midpoint. Third, the reporting and monitoring system has to be assessed, with regard to the midwife in the franchised clinic, to ensure that she is not overburdened with reporting and monitoring visits for her various projects. For the VS program, midwives complete referral forms and Informed Consent forms; AVSC monitoring visits, to provide follow-through support on FP counseling, are scheduled quarterly, to coincide with the NGO staff visit.

### **5.4 Recommendations**

22. Agreements and subagreements must clearly define roles, responsibilities, and accountabilities of the key players in the project, especially for the important evaluation indicators. Process activities should be held (workshops, meetings, formation of task forces, and working committees) if the working relationships on which the project is premised require clarification or negotiation.
23. The screening of the locations for VS referral sites should not only consider their proximity to the midwife clinics to be served, but also their proximity to public facilities that may compete for the same clients.
24. The project should help the VS sites develop services that can be differentiated by their target clientele from the free services available at public facilities. Characteristics of such services could include shorter waiting times and more frequent scheduling of VS services. Such a differentiation may help increase the family planning market segment of low-

income, female, permanent-method users who go to public hospitals and clinics for VS services. These users are estimated to be 8.2 percent of the market share, or about 411,000 women in 1997.<sup>15</sup>

25. To avoid possible dissatisfaction with the standard fees, a more rigorous costing method should be used to come up with the schedule of fees; some flexibility in fee-setting, within limits, should also be allowed to accommodate variations in catchment areas, market incomes, and facility standards. In addition, the project should facilitate the VS site's access to VS reimbursements available under the PHILHEALTH benefit package.
26. Record keeping by the midwife at the franchised clinic should be kept simple and manageable. NGOs should be held responsible for most record keeping.

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<sup>15</sup>The POLICY Project. "Family Planning Use in the Philippines: Market Segmentation Study." Manila, The Philippines. 1998. Table 9.



## **CHAPTER 6. PHILIPPINE CENTER FOR POPULATION AND DEVELOPMENT**

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### **6.1 Project Background**

Initial USAID funding for the Responsible Parenthood-Maternal and Child Health Project (RP-MCH) of the PCPD began in 1985. The program has since undergone four funding periods or cycles: Cycle 1, which lasted for 18 months; Cycle 2, which lasted for 2.5 years; and Cycle 3, which lasted for three years.

The grant for the current Cycle 4 was signed on February 1, 1995, and is intended to continue through December 31, 1999, at a total estimated cost of \$2,257,337. According to the revised project description dated July 1, 1996, the project will institutionalize the provision of RP-MCH services in industrial and agro-industrial settings in response to the health and welfare needs of its workers, through the "replication of the program in the industrial sector piloted by PCPD in 1985 and refined in 1987 and 1990."

### **6.2 Findings**

#### **6.2.1 Project Objectives and Design**

Project Cycle 4 has eight objectives:

1. Respond to the FP-MCH needs of employees in 135 (75 new and 60 from Cycles 1, 2, and 3) participating companies through the provision of IEC, training, service delivery, and technical assistance.
2. Institutionalize the provision of RP-MCH services in 75 new companies nationwide. To the extent possible, implementation in each of the new companies will be three years.
3. Develop and test a scheme for using company clinics to serve the FP-MCH needs of residents in underserved areas near five or six factories or plantations.

4. Develop and pilot a scheme for using industrial clinics, franchise clinics, and FP/NGO clinics to serve the FP-MCH needs of workers of companies without clinics.
5. Develop and pilot a scheme for using Health Maintenance Organizations (HMO) to serve the FP-MCH needs of workers of their affiliate companies.
6. Develop an RP-MCH advocacy program for organized groups of workers and professionals in support of company-based RP-MCH programs.
7. Strengthen the links among past participating companies and develop them as a resource for RP-MCH program.
8. Generate 72,886 CYPs by 1999 from those acceptors served by the company clinics and through effective referrals to other government offices (GO) and NGO clinics.

To meet these objectives, the project has undertaken five activities:

1. Technical assistance by PCPD for the companies in setting up and managing their in-plant RP-MCH program. This technical assistance is in the form of training for the company's RP-MCH team, liaison and assistant liaison officers, clinic staff, and volunteer-motivators; service delivery through links with GO and NGO entities; IEC materials and events; and supervision and monitoring of the company programs.
2. Institutionalization of the RP-MCH program in the company through negotiations with the company for its counterpart resources; a participative planning process; continuing orientation for top- and mid-level managers, union officers, and leaders; intercompany planning workshops and area coordination meetings; and coordination with the DOH and the DOLE.
3. Development and implementation of a scheme for using industrial clinics for companies without their own clinics.
4. Development and implementation of a scheme for using company clinics for RP-MCH services for families in underserved communities near the company.



5. Development and implementation of a scheme for using HMO clinics or hospitals to provide FP services to the workers of their affiliate companies.

For the latter three activities, a similar procedure will be used consisting of negotiating with the clinics, developing an appropriate program, signing the MOA, implementing the scheme on a pilot basis, and assessing and possibly refining the scheme.

The project design has additional features. It sets down criteria to be observed in selecting participating companies. It has a research component that includes a prequalifying survey to establish the status of CPR in potential companies; a baseline survey on demographics and FP-MCH knowledge, attitudes, and practices; a company census; an end-of-program survey; and a survey on price sensitivity to contraceptives. Project implementation includes the installing an information and reporting system that will generate monthly reports that can be used to assess the program and contribute to decision making. The program will also be assessed through focus group discussions within the company. For interested companies, cost-benefit studies will be undertaken.

The grant document explicitly stated that "priority will be given to companies located in the first 19 Local Government Units (LGUs) to be assisted under the LGU performance-based component of the USAID bilateral project (IFPMHP)." Although the original grant required no definite benchmarks of PCPD as to the numbers of people served or the number who adopt and continue to practice FP, two succeeding documents specified benchmarks. In a November 1995 planning document, PCPD projected a total of 40,000 FP users by the year 2000. Later, in the July 1996 revised project description, benchmarks were given in terms of the number of participating companies, both new and old—that is, coming from the first three cycles—and in terms of CYPs.

**Table 6**

**PCPD: RP-MCH Project Benchmarks**

Project Year	CYPs(Cycle 4)	CYPs (all Cycles)	Companies
1995	523	11,745	56 old, 9 new
1996	2,217	12,536	60 old, 53 new
1997	4,973	15,108	60 old, 75 new
1998	6,468	16,440	60 old, 75 new
1999	7,215	17,057	60 old, 75 new

Source: PCPD

Throughout the 12-year life of the project, changes have been made in its initial design. Whereas Cycles 1 and 2 concentrated on introducing service delivery, Cycle 3 started looking at sustainability aspects for the four program components: service delivery, IEC, training, and active volunteer motivators. Cycle 4's design stressed sustainability as well, calling the process "institutionalization." For the project, sustainability meant not only the financial support forthcoming from the company, but also the organizational structure and skills level developed in the company that would ensure the continuation of the RP-MCH program beyond the life of the project. Cycle 4 objectives, specifically objectives 3 to 5, also introduced innovations in the project design in terms of alternative service delivery partners that could potentially expand industry-based private sector participation in family planning.

### 6.2.2 Project Implementation

As of March 1998, the following table represents selected indicators of Cycle 4 implementation when applicable to the end-of-project benchmarks:

**Table 7**

**PCPD: RP-MCH Project Implementation Indicators and Benchmarks**

<b>Indicators</b>	<b>Achievements</b>	<b>End-of-Project Benchmarks</b>
Old Companies:	51*	60
New Companies:	41	75
Workforce:	121,328 (excluding latest three companies)	
MCRA:	32,000-41,000 (excluding latest three companies)	
CPR:	47.5% including NFP	
CYPs:	30,700 (78% achievement of December 1997 benchmark)	72,886

Source: PCPD

\* Of 60 of 112 "old" companies that signed MOAs, 51 are actually reporting to PCPD; nine have dropped out of the program (eight due to company closing, one due to changed management).

PCPD carefully selects companies to participate in the program. Each company must pass a rigid set of criteria that include the following:

- A large workforce—initially set at 500 full-time employees who are predominantly married women—where less than 30 percent of the reproductive age employees are FP users;
- The company must have been in existence for at least five years if the workforce is made up mostly of single people;
- A company clinic with staff in place; and
- A willingness to continue supporting the program beyond the project end.

To develop a list of candidate companies, various master lists are used as references: listings of the Department of Trade and Industry (DTI), DOLE, POPCOM, export processing zones, industrial estate authorities, industry associations such as the Textile Manufacturers of the Philippines, and organized groups such as the Personnel Management Association of the Philippines (PMAP).

Letters of invitation are sent to selected companies. These letters are usually addressed to the human resources manager and endorsed by DOLE. PCPD also makes presentations in DOLE multisectoral meetings to identify potential companies for the program. The period from when the letter of invitation is sent until a company signs a MOA is one year on average. Company recruitment statistics as of March 1998 show that of 813 screened companies, only 230 or 28 percent qualified. Of the qualifying companies, 41 or 18 percent eventually signed an MOU with PCPD. The last 8 companies for Cycle 4 signed up in the first quarter of 1998. A monitoring report prepared by PCPD on company recruitment presents various reasons why a company in the long list fails to qualify: (1) refusal to provide financial counterpart, (2) religious beliefs, or (3) a DOLE program already in place. Since 1985, the industries from which the program draws most of its company participants are electronics, textiles and apparel, food and beverages, and agriculture and agri-based products.

Once an MOA is signed, PCPD installs the RP-MCH program in the company by creating the RP-MCH Committee, headed by a liaison officer, assistant liaison officer, clinic staff, and kaugnays, with the human resources manager as adviser. Training is provided, with IEC activities and materials, marketing events, and special recognition awards. PCPD also assists the company clinic and personnel in becoming accredited by the DOH as an FP provider so it can access free contraceptives. Technical assistance is provided, and a reporting and monitoring system is set up for the program. By the third year, given that advocacy with management has been successful, the

RP-MCH program should be integrated into regular company activities. To implement the project, PCPD has the following full-time project personnel: a project director, three project coordinators, and five project officers. Each project officer takes charge of 10 to 12 companies that he or she visits once every two weeks.

In the companies visited, the program was spearheaded by the RP-MCH Committee whose head can be the medical director, the clinic nurse, or any other employee. Although it is the committee head who communicates with management for the program, the members of the committee or the kaugnays are responsible for promoting the program among their peers. The kaugnays are identified by the company and are then screened by PCPD before they undergo training. The kaugnays receive no remuneration for their services, but they supposedly value their training and enjoy a certain level of prestige among their coworkers. The number of hours they work depends on the management support given to the program. The companies visited had clear ideas about how they wanted their programs to be maintained once PCPD pulled out; in one or two companies, budget support had already been allotted for the program.

Reporting and monitoring are done at the clinic by the clinic nurse, under the supervision of the PCPD project officer. However, the reports included not only clinic-sourced contraceptives, but also contraceptives sourced outside the company clinic. In most clinics, clinic staff were responsible for giving out contraceptives; however, in one of the companies visited, the kaugnays were allowed to distribute them as well. All the clinics covered by PCPD submit reports to PCPD. PCPD collates the reports for all the programs (including CYP) to submit to the DOH and USAID.

Some clinic nurses perform IUD insertions. In the companies visited, contraceptives were obtained from the public health facility, the DOLE regional office, or the FPOP. The quarterly reports prepared by PCPD presented IEC materials developed and used by the program, but these materials were not seen in the clinics visited.

### 6.2.3 Institutional Sustainability

During the last year of Cycle 3, the issue of sustainability became a matter of concern. By Cycle 4, companies were asked to provide a financial counterpart for the program and to indicate if they would continue supporting the program beyond the life of the project. Although the financial support was an important measure of sustainability, the project also interpreted sustainability in the context of creating a structure and building skills within the organization for the program. Thus, the project undertook development of manuals, creation of the RP-MCH committee, continuous training, and networking of committees of different participating companies.

In the companies and factories visited, presentations were usually made at the RP-MCH committee level, with the committee head presenting the status of the program. The quarterly reports for the project also documented the training conducted at different levels and the networking meetings across participating companies.

Several other opportunities for program sustainability exist, but these have not been well investigated by PCPD and may in fact prove to be weak options. Nevertheless, possible links should be explored during the final phase of Cycle 4 implementation. Although 15 to 20 old companies initiated sustainability by linking the program to the Family Welfare Program, all the old companies did not take this course of action. This might be one way to take advantage of DOLE's mandate to implement Article 134 of the Philippine Labor Code, which states that establishments required by law to maintain a clinic or infirmary (those with 200 or more employees) shall provide free family planning services to their employees. These services shall include but not be limited to the application or use of contraceptive pills and intrauterine devices. Based on visits to two DOLE Family Welfare Program clinics, the program can also benefit from technical assistance from the project on reporting and monitoring.

The project might also work with the DOH, whose measure of success for expanding the role of the private sector in family planning in its FP Strategy for 1996 to 2000 is the installation of RP-MCH programs in industry-based clinics. It might provide some guidance to DOLE and the DOH on whether and how to implement another article in the Labor Code that states that DOLE, with other government agencies, should develop and prescribe bonus schemes to encourage FP among female workers in any establishment or enterprise.

PCPD might also consider links with organizations such as the Trade Union Congress of the Philippines (TUCP). TUCP, the biggest confederation of labor unions in the country, represents 1.4 million workers belonging to 50 affiliated federations, more than half of all organized workers. TUCP has projects to establish or strengthen FP service delivery outlets, IEC, and motivation. Such projects include training for clinic personnel and local union leaders, FP awareness seminars, and integration and expansion of the FP/FW provisions in collective bargaining agreements.

#### 6.2.4 The Role of the Kaugnay in Program Sustainability

The active and effective performance of the kaugnays is essential to the long-term success of the factory-based RP/MCH programs as they are now implemented. PCPD program managers are convinced that the prestige of the kaugnays' role constitutes sufficient motivation for them. These psychological benefits are important, but they may not be sufficient to sustain the kaugnays' interest in and enthusiasm for tasks.

Several means have been identified to generate small financial rewards for kaugnays. The first option is an "in-house" scheme that could be piloted in a limited number of companies. Although many of the participating companies would not support any such additional costs for their programs, those in which top managers are highly supportive of the RP/MCH program might accept the modest cost of a kaugnay-paid referral effort. Alternatively, company-wide prevalence benchmarks could be set, with bonuses to be paid to all kaugnays when these milestones are reached.

For RP-MCH programs located in the vicinity of WFMC facilities, an option for linking kaugnays to the midwives could be explored. Selected kaugnays might be able to serve as unofficial "volunteers" for the midwife, referring workers' spouses to the WFMC for their FP/MCH service needs. When either workers or spouses motivated by the kaugnay receive services from the midwife, the kaugnay would receive a small referral bonus. This option has several advantages: it provides a financially sustainable motivation for the kaugnay, it makes effective use of the initial investment in kaugnay training, and it increases the midwife's volume of business.

#### 6.2.5 Financial Sustainability

PCPD has found that the commitment of a company's top management is essential to successfully initiating and sustaining the RP-MCH program over time. During Cycle 4, PCPD identified several mechanisms to ensure that management demonstrates its active interest and commitment to the program.

- Companies sign a MOA stipulating that they are willing to support the program during the three-year contract and to continue the support after the PCPD contract is complete.
- The agreement includes a cash payment, a "subscription" fee of P48,000 paid over three years, and a minimum in-kind contribution of P379,000 per year.
- Top management is included in the orientation seminar.
- Selected upper and middle management staff from human resources and medical departments constitute an oversight team that drafts the initial implementation plan. This participatory planning process is repeated annually and is presented to company managers for their approval.
- Selected companies may elect to measure the benefits and savings that result from their RP-MCH programs by participating in a cost-benefit analysis.

These mechanisms are designed to verify a company's initial commitment to the program and to sustain the program over time. The assessment team saw evidence that these activities are being implemented. The strategy appears to be working fairly well, because no Cycle 4 companies have withdrawn from the program. In addition, 60 of the "graduated" companies continue to maintain their contact and reporting to the PCPD program. Another indication of management's "buy-in" to this process is their willingness to pay the "subscription" fee. Ninety percent of Cycle 4 companies have made at least one of these annual payments. However, a number of companies owe a balance on these fees as of December 1997. The evaluators could not determine if this subscription fee is the most realistic proxy measure of a company's financial commitment to the program, but it is a readily available indicator.

PCPD has done well to ensure middle and upper management's awareness of and commitment to the basic RP/MCH program. At the company level, the PCPD sustainability measures are well thought out and applied. These measures foster management support and create programmatic and financial commitment to the work-based programs, at their current modest size and cost.

The more serious obstacle to the long-term sustainability of the company-based strategy concerns the macroenvironment in which this PCPD program operates—economic factors operating at both the national and international levels. Current trends of economic globalization result in mobile capital and labor markets that lead to high turnover among companies operating in any given country. PCPD sees this manifestation when, trying to recruit companies, it runs into the very short-term outlook of newer companies, particularly in the export processing zones. The companies often are short-term investors that tend to use subcontracted labor, and thus are not interested in investing in their workers. Even for companies with a longer history or a longer-term view, their compliance with Philippine labor law and regulations is not easily enforceable, and they may not have sufficient motivation to treat employees as valued human resources worthy of investment.

PCPD has found that there is a subgroup of companies (including some large multinationals) that will make a more substantial investment in their employees. In a future program, such companies could be recruited through a more targeted selection process.

### 6.2.6 Strengths and Weaknesses of the Project

In 1990, a report evaluating Cycle 1 of the RP-MCH project noted its major strengths and weaknesses. Among its strengths were its appropriate product positioning with clinical FP methods packaged and presented to address and satisfy the needs of target users (both employees and dependents); a change strategy that effectively used in-plant volunteers and trial adoption; and a communication and distribution network that linked project officers, liaison officers, in-plant volunteers, clinicians, and the labor union. Its main weakness was its inability to sustain company management's interest and support.

In 1994, similar findings were noted in another evaluation that concluded that PCPD had achieved program objectives in 85 percent of its participating companies, and that FP service delivery continued in old companies even when PCPD pulled out. At that point, PCPD could credit itself with the development of a complete, well-thought-out package covering necessary procedures, systems, and operations for its RP-MCH program. However, the program's success still depended on management support that at times was not forthcoming.

The concern for the seeming lack of management support during company recruitment and project implementation continues. Efforts have been made to address this lack of support, including, upon request, a cost-benefit analysis for the program using company-specific data. Nevertheless, many companies remain unconvinced. In addition, management is still reluctant to hold program activities during office hours, and to allow people to train.

### 6.3 Conclusions

The initial confusion regarding the benchmarks set forth for the project, from FP acceptors to number of old and new companies assumed to generate a corresponding number of CYPs, no longer exists. At present, the CYP benchmarks are clearly indicated and adequately reflected in PCPD's reporting and monitoring system. Given its present activities, the project is expected to meet 75 to 85 percent of its CYP benchmark, but it is not expected to reach that percentage of the benchmark for participating companies. It is not clear whether the three innovation objectives will be met such that on the basis of their results, new models for RP-MCH programs for industry-based clinics can be developed. For example, only three of the Cycle 4 companies have developed programs with HMOs.

PCPD has developed one model of an industry RP-MCH program that works well in certain environments. In companies where it has successfully been installed, the program continues even when the company turns "old." In other words, PCPD is able to set up a structure and a system before it pulls out of a company that ensures the institutional sustainability of the program. PCPD



has also succeeded in creating networks of RP-MCH committees of various companies. This mechanism can also work as a support structure for institutional sustainability.

However, in modifying the same basic model over 10 years, PCPD may have overlooked other ways of bringing the program to companies. Management support, both in initial acceptance of the program and in continuing program activities following the resignation of involved managers, has remained a problem through the long life of the project. No defining strategy has been developed to address this problem.

Similarly, new partners and new entry modes have not been pursued as vigorously or as creatively as may be warranted by a program that can invoke support from government agencies such as the DOH, DOLE, and PHILHEALTH; market partnerships with dynamic private sector companies and NGOs in the health care industry; and obtain advocacy and funding, from labor unions through collective bargaining agreements. These partnerships do not only offer ways of reinforcing the programs' work; over the long run, these are the partners that will ensure that the RP-MCH programs are lodged in institutions that can nurture them, if the project ends.

One model that might be considered for this program entails identifying an agency to serve as a coordinator, creating alliances among a diverse set of partners. The industrial sector is not monolithic, judging from PCPD's success in specific subsectors. Redesigning an industry-based project, although involving some exploratory work initially, would likely be worth the effort because it could introduce and maintain reproductive health and family planning to large groups, and because the economic outlook for the country is promising.

In this model, the coordinating agency would have the task of identifying the various players in the RH sector and having them work together so that individual players' goals or mandates are met; the aim is to drive the project by these goals rather than by those of the coordinating agency. Regulation by DOLE; advocacy from unions or NGOs; technical assistance from POPCOM, the DOH, or the private sector; funding from PHILHEALTH; networks from HMOs; and entry passes from industries or LGUs will all tie together in program implementation. The alliance would take different modes depending on the regional strengths and political will of government offices, unions' mission statements, and socio- and ecodemographics of company labor forces. The project would be process oriented and, therefore, time intensive. However, if it is successful, each company's FP efforts would be lodged in institutions that will work for its continued sustainability.

Finally, it must be recognized that PCPD has accumulated over a decade of experience in implementing work-based programs from which other countries can benefit. An in-depth analysis and documentation of different aspects of the RP-MCH program would make a valuable contribution to the field. Following are some potential elements of such an analysis:

- Attempt to verify project service statistics, resolving inconsistencies noted.
- Gather information on participating companies' real expenditures, for both RP/MCH programs and overall employee health services.
- Analyze the impact on program effectiveness of the present strategy of serving only married couples of reproductive age (MCRA), which cuts by two-thirds the number of workers really reached by this program.
- Identify companies willing and able to purchase commercial contraceptives. Help companies calculate how much it will cost to buy commercial contraceptives, and whether several companies can make bulk purchases for a more cost-effective procurement.
- Analyze the potential impact on CPR if workers paid for contraceptives at the work-based clinic, following the results of the study, "The Survey of Pill Acceptors in PCPD's Company-Based RP-MCH Program," by Dr. Eduardo Roberto. Investigate potential cost-sharing schemes with companies paying a portion of contraceptive costs. More information on worker income levels is needed for this analysis.
- Conduct a desk review of work-based reproductive health programs in other countries, including data on cost per CYP.

#### **6.4 Recommendations**

27. Design an IEC program for unmarried people in Cycle 4 companies. Program implementation must abide by company-specific policies that may limit availability of contraceptives and services to unmarried workers. PCPD reportedly undertakes IEC efforts for unmarried workers, but the assessment team believes more can be done to reach this population to prepare them for decisions they will make regarding reproductive health and family planning.
28. Before the project ends in December 1999, the following documentation should be completed:

- An analysis of project strengths and weaknesses, including lessons learned;
  - A report on the work done to meet the three "innovation" objectives;
  - A manual containing all procedures, systems, and structures related to the company-based institutional sustainability of the program;
  - A manual containing all procedures, systems, and structures related to the networking of participating companies in RP-MCH program-related activities;
  - An industry-disaggregated performance analysis and benchmarking of participating companies.
29. Efforts to increase the family planning contribution of the industry-based private sector should continue. Based on the results of the documentation of Cycle 4, more findings and conclusions can be drawn about the types of companies and industries that the RP-MCH program is most suited for. For other companies and industries, some considerations for a redesigned project include the following:
- Going beyond the basic RP-MCH model that has been used for over 10 years to consider other implementing partners, entry strategies, and program implementation modes, as well as special requirements of target industries and target market segments.
  - Packaging and marketing the RP-MCH program as a business case proposition to get management support (promotional package with testimonials from respected business leaders, with professional, sophisticated cost analyses and productivity indices). Industry-specific business cases can be used as marketing tools and as monitoring frameworks for regular reports to top management.
  - Strengthening existing alliances and developing new links with organizations with a legal mandate for FP (DOH and DOLE), organizations interested in a shared market (HMOs, and health insurance companies, including PHILHEALTH), and mission-driven groups such as unions and NGOs. Develop strategies to use these alliances to ensure the sustainability of the program.
30. Any future project should be worked out in close cooperation with pertinent offices of the Department of Labor and Employment with the long-range view of lodging the project

within an institution whose mandate ensures its continuing implementation beyond USAID assistance.

The results of the evaluation team's field visits to the DOLE offices were not particularly encouraging in terms of ongoing cooperation, possibly because ongoing cooperation was not clearly stated as an objective in the current project. The project to be designed can have as a deliverable a partnership in place between the DOLE and the implementing organization, building on DOLE's present work, involving an exchange of resources and technical assistance, and supported by a clear memorandum of agreement.

## CHAPTER 7. PROGRAM ENVIRONMENT

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### 7.1 Policy Context

Support for reproductive health and family planning, in general, and the role of the private sector in providing services and supplies, in particular, is clearly stated in the GOP/DOH policy documents. The long-term National Health Plan (1995 to 2020) identifies the private sector, including commercial and business organizations and noncommercial organizations, and the NGO sector as two essential elements of the health service sector. The Philippine Family Planning Strategy for 1996 to 2000 includes expanding the role of the private sector as one objective. While acknowledging that the role of the private sector is currently small, the strategy notes the importance of the private sector in increasing availability and accessibility of supplies and services, in improving sustainability, and in freeing public sector resources to better serve poor and hard-to-reach populations.

In her 1997 "State of the Nation's Health Address," Secretary Carmencita Noriega-Reodica underscored the need to focus efforts on a few strategic health initiatives that would give the greatest leverage and impact. She advocated a "focus on what government can do well and best and what the private sector can, so we can complement each other and relieve financial pressure on the public health care delivery system." The DOH Family Planning Maternal and Child Health and Nutrition 1996 Status Report lists activities intended to improve the performance of the private sector during 1997, citing the principal components of IR 3: expanding midwife clinic franchises through NGO support, expanding coverage of industries with FP programs, and developing and consolidating the commercial market for FP products.

Although this level of support is evident within the DOH, political support for family planning has been sorely lacking. Many leaders at both national and LGU levels do not have the willingness or interest to show a clear commitment to the program, doing little to counter rumors and misconceptions concerning contraceptive use. At the same time, a number of laws and operational policies impede the full development and expanded capacity of the private sector.

The POLICY Project of TFGI has formed a technical working group composed of POPCOM, the DOH, USAID and other organizations. This technical working group has identified seven policy reforms to facilitate expansion of private sector delivery of family planning services and supplies:

- Obtain exemption from the pharmacy law to enable private physicians and midwives to dispense contraceptives,

- Establish eligibility criteria for industry-based clinics to receive free contraceptives from the DOH,
- Establish eligibility criteria for NGOs to receive free contraceptives from the DOH,
- Accredite selected private training programs to offer FP to private physicians and midwives for a fee,
- Remove regulations requiring surgeons to receive additional FP training courses prior to becoming accredited to do sterilization procedures,
- Reduce the import tariff on contraceptives from 10 percent to 3 percent,
- Ease regulations concerning advertising contraceptives.

The POLICY Project has as one of its benchmarks under IR 3, the achievement of at least two policy reforms by the end of 1998, and it has targeted the first five reforms as immediate priorities. The POLICY Project has begun working with the DOH to develop strategies appropriate for each action.

At present, the pharmacy law is not strictly enforced. The POLICY Project should clarify this law to determine whether midwives operating private franchises and some industry midwives offering a full range of contraceptive services and supplies are, in fact, in compliance with Philippine law. POPCOM and TFGI plan to clarify the position of the enforcement agency, the Bureau of Food and Drugs (BFAD), and then prepare a proposal seeking exemptions for administering IUDs and injectables. Simultaneously, they will start to work on revising allowances for dispensing other contraceptives.

The DOH has asked that the POLICY Project develop eligibility criteria for the distribution of free contraceptives to nonpublic sector service providers. Historically, the DOH has provided free commodities to all service providers on request. This supply has led to distortion of the market, with a large share of middle- and upper-income users accessing free commodities, thus reducing the demand for commercial contraceptive products and placing the financial burden for commodity importation and distribution on the public sector.

A 1997 market segmentation study by the POLICY Project found that 40 percent of middle- and high-income users continue to use the public sector. Shifting these users to private sector sources such as pharmacies, midwives, physicians, and private hospitals will presumably free public sector resources for low-income and difficult-to-reach populations. Additionally, most of the couples using NGO and industry sources are receiving free commodities provided by the DOH. Although

several models of means testing of health care clients and fee for service are being piloted on a small scale at different Philippine locations, it is unlikely that a decision to implement such a program nationwide will be made in the near future. It is more likely that the DOH will develop and slowly phase in an institutional means test to reduce the reliance of industry programs and some NGOs on public sector commodities. Indeed, this phase in has already begun. It is not clear how far the DOH can go in mandating policies for LGUs. For example, it appears that LGUs can initiate their own programs, including cost-recovery schemes, without endorsement or approval from the DOH. On the other hand, should the DOH issue circulars endorsing cost-recovery schemes, it is not clear whether the LGUs would have to follow DOH policies. As discussed, the NGOs and industry-based projects included in IFPMHP are in the process of shifting to the social market as their sole source of supply.

Until recently, customs duties and taxes on the USAID-donated commodities were paid through a noncash, paper transfer from the DOH budget. New customs regulations were announced in March 1998, mandating that the DOH must pay cash for import duties and taxes on contraceptives before clearing them through customs. This payment is 23 percent of the value of the commodities. Duties and taxes on commodities already in port are over P9 million, an amount not included in the already-approved 1998 budget for the DOH Family Planning Service (FPS). The DOH/FPS is attempting to free funds to pay for this shipment while awaiting the results of appeals made to the Office of the President and the Secretary of Finance to exempt future donated commodities from duties. The DOH/FPS is hoping that a reply will come before the delivery of a second contraceptives shipment already in transit. They have requested that USAID delay shipment of subsequent orders until a solution is reached. The POLICY Project has been working closely with USAID and the DOH to clear the contraceptives currently on the pier, as well as to develop medium- and long-term solutions to this issue of taxation of donated commodities.

Finally, not enough public or private sector doctors have been trained in family planning, but at the same time public sector training programs are unable to fill their courses. Currently, no mechanism is in place to allow private doctors to pay to participate in courses offered by the public sector. Also, none of the 27 colleges of nursing and midwifery receiving technical and financial support from the Johns Hopkins Program in Reproductive Health (JHPIEGO) have been accredited as a training institution for FP/RH. The POLICY Project is examining the training requirements to see if the Training Accreditation Board can be reconstituted and revitalized to process accreditation applications and to ease current barriers to training private providers.

The POLICY Project also has several research activities underway or planned for 1998 in support of IR 3 activities. In addition to the two studies that the POLICY Project has completed, it is finalizing a study on the contraceptive market structure, focusing on pricing policies and procedures. The Policy Project will soon undertake a consumer intercept study to examine why people use the public sector for FP while they use the private sector for other health care needs, and a legal and regulatory study to identify policy constraints inhibiting private sector expansion. Together, these studies form a complementary and balanced package of research that should

prove extremely valuable for the public and private sectors in developing realistic market targets and strategies. A concern, however, is that the POLICY Project has been laboriously slow implementing studies and producing final reports. Serious efforts must be made to hold consultants to contracted deadlines for report submission and to conduct speedy internal review and finalization of publications.

## **7.2 Influence of the Private Sector Climate**

According to the World Bank, 39 percent of Philippine families had household incomes below the poverty line in 1991. Of these families, 39 percent were urban residents and 61 percent were rural, implying that 61 percent of urban and 39 percent of rural households were above the poverty line with varying amounts of disposable income. Furthermore, the shortfall between the expenditures of poor households and the poverty line was only 17 percent in 1991. Urban poor are closer to the poverty line than rural residents and are more likely to move out of poverty with economic growth. Thus, there remains a reasonably large segment of the population able to pay some share of health care costs.

For the moment, the Philippines has escaped the severe economic turmoil occurring in other countries in East Asia. Recent estimates place the Philippines project's 1998 growth at 3 percent, down from the 6 to 7 percent that occurred before the regional downturn, and compared with the zero or negative growth in Indonesia, Thailand, and South Korea. Nevertheless, retrenchments are starting to occur, and the building boom is slowing. Furthermore, rainfall has decreased during the past year, and agricultural production is suffering. It remains to be seen how these forces will impact national economic growth during the short- and medium-term.

A number of policy reforms exist that would facilitate the development of the private sector market, including issues of taxation, training, and advertising, but two reforms stand as notable obstacles affecting a significant share of the private sector. First is the previously discussed DOH policy of distributing free contraceptives to accredited NGOs and industry clinics. The DOH is well aware of the impact this distribution is having on their own resources and of its distorting effect on private sector capacity. It appears that soon steps will be taken to address this problem.

The DOH appears to be moving to make NGOs and industry-based clinics obtain contraceptives from alternative sources, such as the commercial or social markets. PCPD has begun shifting industries from DOH sources, and recently enrolled companies are not given a choice of sources; they must purchase supplies through SOMARC distributors.<sup>16</sup> However, this implicit policy is not

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<sup>16</sup>This move implies adding an additional layer of distribution and its attendant cost to the SOMARC system.



uniformly implemented; companies participating in DOLE's Family Welfare Program continue to obtain supplies either through DOLE or through the Contraceptive Distribution Logistics and Management Information System (CDLMIS).

In 1999, the DOH will include a line item for 10 percent of contraceptive costs in its budget request as a test of Congressional support. Contraceptive costs are approximately P150 to P200 million per year, while the total budget for the family planning service in 1998 was only P54 million (covering personnel, training, IEC, and other technical support). Although this represents an increase of 50 percent over the 1997 budget, growth remains insufficient to fully cover commodity costs.

A second obstacle is the provision contained within Republic Act No. 5921, referred to as the pharmacy law<sup>17</sup>, regulating the practice of pharmacy and restricting the dispensing of ethical products to pharmacies. The BFAD has not strictly enforced the law with regard to distribution, but pharmaceutical companies have instituted controls for their representative and detail staff so that contraceptives are not sold to unauthorized service providers. These controls may have particular implications for the expansion of the midwife franchises under TANGO II.

### **7.3 Measurement and Validity of IR 3 Indicator**

The SOW instructed the team to assess the validity of the IR 3 benchmark indicator, that the private sector share of family planning services will increase from 27 percent in 1993 to 34 percent in 2000. In particular, the team was asked to consider the assumptions used to establish the benchmark, the relevance and progress of current project inputs, the overall private sector climate in the Philippines, and the monitoring mechanisms (CYP) currently being used.

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<sup>17</sup>Republic Act No. 5921, "An Act Regulating the Practice of Pharmacy and Setting Standards of Pharmaceutical Education in the Philippines and for other Purposes."

### 7.3.1 Benchmark Assumptions

The Program Assistance Approval Document (PAAD) for the IFPMHP, designed in 1993 for program start-up in 1994, had ambitious goals for the growth of the private sector share of family planning services and supplies. The 1993 Philippines National Demographic Survey (NDS) showed that 71 percent of contraceptive users obtained services from the public sector, while 27 percent met their needs through private providers. The PAAD proposed that by the end of IFPMHP, the proportion of users at government clinics would drop to 40 percent. It also projected a new distribution of users in the private sector: 25 percent served by nonprofit NGO outlets, 25 percent served by social marketing, and 10 percent using private doctors and other sources. At the same time, the PAAD projected an annual growth of 1.5 to 2.0 percent in the use of modern contraceptives, implying a rise from about 25 percent in 1993 to between 34 and 37 percent (35.7 percent is mentioned in the Results Framework) in 1999.

In hindsight, these goals, particularly regarding expansion of the private sector market share, were not attainable in the short term. Although growth in each sector was feasible, it was expected to take place within the context of a major change for the national family planning program, as authority for monitoring and coordination shifted from POPCOM to the DOH and as frontline responsibilities were devolved to LGUs. Furthermore, the overall program had been moribund during the Aquino administration and was only recently regaining political support as a result of the 1992 election of President Fidel Ramos. The expected growth in the private sector implies a linear shift that increases each year of program activity. Such a shift is highly unlikely during such a period of large-scale expansion to previously nonparticipating organizations. If the program does not start out with rapid growth, compensatory larger gains must be accrued during later years.

In late 1995, results from the first rider to the annual labor survey of the National Statistics Office (NSO) showed, rather than growth, a drop of nearly eight percentage points in the share of contraceptive users using private sector sources. The DOH and USAID could not easily determine whether this shift represented a growth in the absolute numbers of public sector users, thereby reducing the proportion using the private sector, or whether the baseline data were flawed. Within this context and considering experiences in other countries, new assumptions for private sector growth were negotiated, reducing overall growth during the program period to one percent annually.

USAID and the DOH estimated that 35.7 percent modern method contraceptive prevalence is equivalent to 3.94 million CYPs. A goal of 2.60 million CYPs was set for the public sector and 1.34 million for the private sector to be achieved by 2000. Shifts in the proportion of users accessing different segments of the private sector were assumed, with private hospitals, clinics, and NGOs growing from 16.4 percent in 1993 to 20 percent by 2000, and pharmacies and stores growing from 7.5 percent to 10 percent. The remaining 4 percent of the market share would be taken up by private doctors, midwives, and industry-based clinics.

The assessment team did not have access to the assumptions concerning method mix underlying the CYP calculation and thus could not comment on its appropriateness. Given the vitality of the private sector in the Philippines, the level of income of residents, and the widespread availability of a variety of private sector health services, the projected growth of its market share seems reasonable. Not yet apparent during the development of the IR 3 benchmarks were the obstacles to program implementation that became evident during 1996 and 1997: weak NGO capacity, stunted social market growth, slow inroads to the industrial sector, and small proportions of private doctors and midwives trained to provide family planning services.

Fieldwork for the 1998 round of the National Demographic Survey was underway as this assessment was taking place. Data collected for the survey will provide a new picture of the distribution of private sector sources for contraceptive users and will indicate whether perceptible growth is taking place in the sector.

### 7.3.2 Relevance and Progress of Project Inputs to Achieving Indicator

The benchmark private sector indicator of 34 percent is a national goal. USAID is virtually the only supporter of private sector FP and RH activities, but with limited geographic scope, it is providing only a fraction of the possible coverage.<sup>18</sup> Of the 1.34 million CYPs needed to achieve the 34 percent private sector share by 2000, USAID assumed that just under half (16 percent, or approximately 650,000 CYPs) of the market would be covered by the combined effort of JSI/RTI (9 percent), CARE (0.04 percent), PCPD (0.6 percent), and SOMARC (6.4 percent estimate).

According to worksheets prepared during the redesign of IFPMHP in 1996, the number of CYPs projected to be provided by IFPMHP private sector subprojects in 1997 totaled approximately 454,575. Table 8 shows new benchmark CYPs negotiated with each project, and the actual CYPs achieved during 1997. The new benchmarks represent only 64 percent of the estimated amount needed to achieve the original IFPMHP benchmarks. Actual achievement is just over one-fourth of these lower benchmarks.

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<sup>18</sup>UNFPA included NGOs in its Fourth Country Program of Assistance (1994-1998), but USAID and UNFPA pursued different strategies in engaging NGO participation in their respective country programs. While USAID emphasized NGO sustainability and cost recovery among the clients served, UNFPA instead promoted delivery of services in hard-to-reach or underserved areas with no or minimal assistance, and in areas where specific high-risk groups are concentrated.

**Table 8**

**Benchmark and Actual CYPs Achieved by Subproject: 1997**

	<b>Benchmark CYP</b>	<b>Actual CYP</b>	<b>% of Benchmark</b>
TANGO II	60,976	24,650	40
CARE	14,721	9,249*	63
PCPD	15,108	13,824	92
SOMARC	177,440	34,725	20
TOTAL	290,459	82,448	28

*Source:* Subproject agreements and reporting systems.

\* Figure is one half the reported CYPs for the period July 1996 to June 1997 (4000) plus actual CYPs for July 1997 to December 1997 (5249).

PCPD and CARE, the projects having had the fewest major modifications during implementation, show the best performance relative to their comparatively low benchmarks. TANGO II, only one year into a substantial redesign, has not yet reached optimal performance levels. The SOMARC project, after nearly six years of operation in the Philippines, is seriously lagging behind its reduced benchmarks.

IFPMHP subprojects are clearly not reaching benchmark CYP output. Nearly all of the subprojects have revised CYP estimates more than once, always downward. Even assuming modest growth as the TANGO II and SOMARC activities stabilize, the project cannot achieve the benchmark CYPs by the end of the project period. USAID should revise its benchmark in light of the actual performance of the subprojects, coupled with data obtained from the 1998 NDS.

### 7.3.3 Current Monitoring Mechanisms

All of the subprojects have successfully applied the CYP methodology as a means to monitor their performance, and there do not appear to be any problems in their application of the conversion factors to commodities distributed. However, the team repeatedly noted flawed data collection systems that may have a cumulative effect on the overall quality and accuracy of the CYP reports.

There is little or no follow-up on PCPD industry sites or NGO midwife franchises of clients that drop out of the program. Few providers could interpret monthly swings in contraceptive users (often 25 percent or more), nor could they understand these as an indicator of incomplete protection against unwanted pregnancy. In one case, the team was told by a DOLE-supported company being recruited by PCPD, "it is their option" for women not to return for monthly supplies. Repeatedly, the team stressed the need to observe consistent and growing numbers of users of temporary methods, particularly the pill and injectable contraceptives.

In some cases, the team noted implausibly high numbers of continuing users over time with little evidence of the change expected, even on the basis of international standards of contraceptive failure rates or first-year discontinuation rates documented by the 1993 NDS (35 percent for all methods). One company measured contraceptive use once a year in an annual employee survey and reported the same figures every quarter for the rest of the year.

Another company, touted as a DOLE success story for achieving 100 percent CPR among its married employees, cited 1996 data as evidence of continued good performance. The figures included nearly 45 percent of respondents using the calendar method of NFP; it appears that respondents who did not mention using a modern method were automatically put in this category. When the summary statistics were compared with monthly service statistics, major inconsistencies were observed. For example, the number of pill users dropped from 113 to 7. When queried, the staff nurse replied that many women obtained their services from a different source, such as the local barangay health station. Although these data are not directly relevant to IFPMHP performance because they are not included under the USAID-assisted PCPD project, they are mentioned here as an indicator of the poor comprehension of service statistics among both service providers and monitoring personnel.

The question of supply source arose more than once among PCPD companies or former companies, as well as among other service providers. To document total contraceptive use among company employees, statistics record all users regardless of source. However, given the weaknesses inherent in monitoring noncompany users or spouses of company employees, this likely overstates the population that uses contraceptives. This miscalculation in turn has several effects, including incomplete and inaccurate targeting of couples and individuals at risk and overstating current users in estimating costs of the program, which are used in negotiations with management. In at least one case, a company gives pill users two cycles every month so the user

will have a reserve supply. CYPs are calculated on the 46 cycles distributed, overstating protection that is actually provided to only 23 users. These weaknesses were discussed several times during the assessment with PCPD and TANGO II staff, and they indicated efforts would be made to improve the data interpretation skills of counterparts.

Although CYP provides an easy-to-use standard by which to measure project performance, its use in the Philippines appears to have diverted attention from the individual users IFPMHP is designed to serve. Little effort is made to monitor continuity of contraceptive use or the appropriateness of methods supplied. USAID and its service delivery partners should reemphasize use and interpretation of measures of continuing users and new acceptors for monitoring (not performance) purposes.

#### 7.3.4 Project Costs per Contraceptive Year of Protection

Each subproject has experienced implementation problems and a consequent low level of performance. Table 9 summarizes expenditure (including overhead and operational costs for Philippine and U.S.-based offices) and output data for the four primary subprojects that compose the IFPMHP.<sup>19</sup> The most striking element of the table is the very high cost per CYP seen in all four programs in 1997 and projected over their full project durations. In 1997, costs ranged from approximately \$20 to \$40 per CYP. For the expected cost per CYP over the life of the project, the range is even greater, from \$8 to \$38. By the end of 1999, these four projects will have spent a total of \$13.9 million with a projected output of less than 800,000 CYPs. Overall, this implies a combined private sector cost per CYP of nearly \$18.

Detailed analysis of these results is problematic. There is no reason to believe that there are significant problems with the project-level financial information; however, the basic CYP-related data inputs to this table have raised skepticism among assessment team members. As mentioned, site visits to all the subprojects revealed inadequate and inconsistent monitoring reports, analysis of service statistics, and commodity and stock management. This creates concern regarding the accuracy of the CYP outputs of the table.

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<sup>19</sup> The data are drawn from detailed annual expenditure and CYP data for each subproject. The most recent contract with AVSC has not been included because (1) it has just begun operations, and (2) its VSS outputs are to be attributed to the TANGO project. Therefore, the AVSC program does not have a cost per CYP measure.

**Table 9****USAID Private Sector Program Summary Financial Table (\$ USD)**

<b>Project Duration</b>	<b>Actual Expenditure</b>	<b>Actual CYP</b>	<b>Actual Cost/CYP</b>	<b>Actual + Projected LOP Expenditure</b>	<b>Actual + Projected LOP CYP</b>	<b>Actual + Projected Cost/CYP</b>
SOMARC (1994-1998)	827,809	34,725	23.84	7,891,017	209,634	37.64
PCPD (1995-1999)	259,203	13,824	18.75	1,388,646	56,244	24.69
CARE (7/96-6/98)	333,498*	7,995*	41.71	623,872	16,985	36.73
TANGO (1997-1999)	911,532	24,650	36.98	3,954,247	498,672	7.93
<b>TOTAL</b>	<b>2,332,042</b>	<b>81,194</b>	<b>28.72</b>	<b>13,857,782</b>	<b>788,785</b>	<b>17.57</b>

Source: Subproject worksheets, Appendix I

\* CARE expenditure and CYP data refer to the period July 1996 to June 1997.

Other constraints are relevant to attempts to compare results across the diverse program strategies. Such a comparative analysis faces the following difficulties:

- Each subproject covers a slightly different time period, so each subproject is at a varying level of programmatic maturity. TANGO II is the most recently redesigned activity; therefore, the bulk of its life-of-project expenditure and outputs are projections. As such, they may be overly optimistic.
- Some of the sub-projects have multiple program outputs, yet because of time and data constraints, this cost-effectiveness comparison focuses only on cost per CYP. TANGO II is the best example of that; its expected outputs and benchmarks include reproductive health and MCH services. In addition, it is as much a small enterprise development project as a health project.
- The CARE program for Sustainable Community-Based Family Planning differs from the other programs in location of its targeted clients and in the purposeful choice of its non-FP NGO partners; it too has significant institution-building components, in addition to the measured family planning-related outputs.

The PCSMP project implemented by SOMARC is the longest running of the four programs. As such, one might expect it to be a more mature program and thus a better performer than the other projects. In some other countries, mature social marketing programs deliver CYPs at a cost of approximately \$10 or less. In the Philippines, the program's most effective cost performance was the \$24 per CYP in fiscal year 1997. From 1994 through project completion in 1998, cost per CYP ranged from \$24 to \$61 and averaged over \$35 over the life of the project. SOMARC's portion of total USAID/Manila IR 3 project expenditures is 57 percent; it has contributed 27 percent of the IR 3 CYPs.

The factory-based program appears relatively effective; consuming 10 percent of IR 3 resources, it produced 7 percent of CYPs. In 1997, the program had the lowest cost per CYP within the IR 3 package. However, if the CYPs generated by PCPD's Cycle 4 companies (those newly recruited under the current USAID grant) in 1997 are isolated from total CYPs generated from combined graduated and Cycle 4 sites, cost per CYP jumps to more than \$80. Strictly speaking, PCPD has the right to count both graduated and new companies' CYPs. Because they provide some limited maintenance services to these old companies, they are considered to be continuing participants in the program. This distinction suggests that the summarized results of Table 9 may obscure more than they reveal.

The CARE project's two years of operation was the shortest of any in this analysis. Its performance does not appear to be very strong, but this may be explained by the multiplicity of its objectives; the difficulty and expense of attempting to identify and transform non-FP NGOs into health-service-delivering entities; and the generally rural, poorer, and harder-to-reach nature of their targeted clients. Appendix I shows that the project's cost per CYP appears to have declined by 23 percent from the first to second year at the same time that the CYPs generated increased by 12 percent.

Despite a relatively high start-up cost per CYP in its launch year, evaluators believe that the TANGO II model is a promising one. The projected life-of-project cost per CYP is favorable at \$8 per CYP. This number will probably not be as low at the end of the project period, because the projected CYPs do not take into account the strong possibility that 25 percent or more of the WFMC clinics will lag in performance, if not fail and be deselected. If evaluators are correct regarding this potential new business failure rate, the end-of-project cost per CYP may be closer to \$10.



## 7.4 Future Role of Private Sector and Follow-on Private Sector Strategies

Follow-on strategies for the specific project elements were discussed in Chapters 2 through 6. In this section, we address the potential for growth in the private sector for the various project types.

To all appearances, the private sector's potential to deliver family planning commodities and supplies and other RH services remains largely untapped. TANGO II's midwife franchise system can increase significantly and it should be encouraged to do so. Growth should be monitored, however, to maintain minimum quality standards. A set of inspection criteria should be developed and a routine system instituted to ensure that all participating midwives adhere to a set of common practices and services, delivered with appropriate care. Once midwives graduate from direct NGO support, they must agree to regular annual or biannual inspections, perhaps coupled with an association registration, to verify their continued qualification as a WFMC.

The industrial sector also presents a large potential market for contraceptive users. What is lacking in the current program is attention to unmarried workers. Although there may be cultural inhibitions to providing FP services to women before marriage, NDS data show that 30 percent of women aged 20 to 24 were sexually active by age 20, usually within the context of marriage. Opportunities are being missed to inform, educate, and motivate young women to choose contraceptives early in their childbearing years to plan and space their pregnancies. On-site seminars are usually open to all workers, but little extra effort is made to encourage unmarried women to attend.

In addition, industrial programs must give more emphasis to family planning. For most sites visited by the assessment team, FP and RH are included as one component of the company's family welfare program. As such, it is typically given concentrated attention only one month a year as part of an annual agenda that includes topics such as dental care, eye care, exercise, sport, and cardiovascular disease. Company staff must recognize that RH and FP are daily needs for women and warrant more consistent attention throughout the year.

Of the IR 3 program components, SOMARC presents the most puzzling dilemma. After nearly six years of development, little public demand for socially marketed contraceptives exists. That may change if a longer-term, revised marketing strategy is put in place that involves greater commitments from manufacturers. Such commitment should be coupled with a more consumer-oriented approach to establish clear brand recognition through price differentiation, to motivate new users, and to draw existing users away from public sector sources. Unless revised strategies are put in place, it cannot be recommended that the project be extended beyond September 1998.

## 7.5 Recommendations

31. Given that IFPMHP subprojects are not reaching benchmark CYP output and will not do so by the end of the project, USAID should revise its benchmark in light of the actual subproject performance and data obtained from the 1998 NDS.
32. USAID and its service delivery partners should reemphasize use and interpretation of measures of continuing users and new acceptors for monitoring (not performance) purposes, to ensure appropriate counselling and client follow-up, thereby reducing program drop-outs and method failure.
33. Growth of the midwife franchise system should be monitored to ensure that standards of quality are maintained. A routine inspection system should be developed—perhaps implemented by a professional association—and participating midwives should agree to regular audits to verify their continued qualification as a WFMC.
34. Industry-based programs should exert greater effort to reach young, unmarried women. An IEC program targeting the needs of young women should be developed and implemented in partner companies with large unmarried workforces. Negotiations should be undertaken with companies to secure specific times, for example during shift changes, when such programs can be presented.
35. Industrial programs must further emphasize the family planning content of the RP-MCH program. Company staff should recognize that RH and FP warrant more consistent attention because women want and need to learn more about these issues.
36. Renegotiation of the SOMARC contract or development of a new procurement with a different contractor must include a long-term marketing strategy that requires greater commitment and participation from manufacturers coupled with a more consumer-oriented approach.

## **APPENDICES**

## APPENDIX A

### SCOPE OF WORK

#### MID-TERM ASSESSMENT - INTERMEDIATE RESULT NO 3 STRATEGIC OBJECTIVE NO 3 USAID/PHILIPPINES

##### I INTRODUCTION

The goal of USAID/Philippines assistance is to support the effort of the Government of the Philippines (GOP) to achieve the status of a newly industrialized democratic country by the year 2000. Towards this end, USAID/Philippines is supporting six major Strategic Objectives (SO) and two Special Objectives (SpO), as follows:

- SO 1 Broad-based Economic Growth in Mindanao
- SO 2 Improved National Systems in Trade and Investment
- SO 3 Reduced Fertility Rate and Improved Maternal & Child Health (MCH)
- SO 4 Enhanced Management of Renewable Natural Resources
- SO 5 Reduced Emission of Greenhouse Gases
- SO 6 Broadened Participation in the Formulation and Implementation of Public Policies in Selected Areas
- SpO Rapid Increase in HIV/AIDS Prevented
- SpO Assistance to Amerasians in the Philippines

USAID/Philippines is also on the leading edge of USAID worldwide reengineering efforts, having served as a successful experimental laboratory for the new results-oriented program approach and management. The Mission has shifted from a project orientation and has developed a country strategy based on SOs with clearly defined Intermediate Results (IRs), benchmarks and indicators that lead to the achievement of the overall Mission Goal to enable the Philippines to achieve the status of a newly industrialized democratic country by the year 2000.

##### II ASSESSMENT BACKGROUND

This assessment will focus on SO 3 and in particular its IR 3 (Increased private sector provision of contraceptives and family planning/MCH services). The goal of SO 3 is Reduced Fertility Rate and Improved Maternal and Child Health. To attain this goal, the following ambitious but attainable indicators have been established jointly by USAID/Philippines and GOP Department of Health (DOH) to be achieved by the year 2000:

- 1 Total Fertility Rate will drop from 4.1 in 1991 to 3.1
- 2 Infant Mortality Rate will fall from 57 per 1,000 live births in 1990 to 41.2
- 3 Maternal Mortality Ratio will fall from 209/100,000 live births in 1990 to 190
- 4 Contraceptive Prevalence Rate (CPR) for all methods will increase from 40.0 percent in 1993 to 50.5 percent
- 5 CPR for modern methods will increase from 25.2 percent in 1993 to 35.7 percent, and
- 6 Percent of births in high risk groups will fall from 62.4 percent to 56 percent

Three IRs have been designed and developed jointly by USAID and DOH to achieve these SO results by February 28, 2000. They are:

- IR 1 Increased public sector provision of family planning/MCH services,
- IR 2 National systems strengthened to promote and support the family planning/MCH program, and
- IR 3 Increased private sector provision of family planning/MCH services

The primary USAID-funded program for the attainment of these SO/IR objectives and results is a \$153 million (\$65 million bilateral, \$62 million Global Bureau, and \$26 million GOP contribution), six-year, Integrated Family-Planning Maternal Health Program (IFPMHP), which was initiated in 1994 prior to USAID reengineering efforts and the design and development of the SO and its IRs. However, a new Results Framework, as mandated by USAID/W reengineering guidelines, was prepared in 1996, which superseded the IFPMHP Program Assistance and Approval Document (PAAD) and which sets forth how SO 3 will contribute to sustainable development in the Philippines, how each of the IRs will contribute to achievement of the SO results, and how the IRs themselves will be achieved. It also presents the measures and targets that will be used at the SO level, IR-level, and activity level to manage the program in such a way as to maximize the chances of success and to determine whether the expected results have been achieved. A one-page spreadsheet summarizing the detailed Results Framework is attached to this Scope as an Annex.

The performance-based approach, developed jointly by USAID and DOH, under SO 3 is based on the successful experience with a similar performance-based approach under the previous USAID-funded program in the Philippines, the Child Survival Program. Under the SO 3 performance-based approach, DOH, Commission on Population (POPCOM), National Statistical Office (NSO) and the collaborating agencies must achieve certain benchmarks for IRs 1 and 2 (the public sector components of the program) each year in order for the GOP to receive an annual tranche of funds from USAID. This tranche is then available for grants to Local Government Units (LGUs) that have achieved the benchmarks and for DOH activities in family planning and MCH. Over the life of the program, \$29.2 million are budgeted for tranche disbursements. Tranche funds are not conditional on achievement of benchmarks under IR 3, the private sector component of the program.

A mid-term review of SO 3 and its IRs is being undertaken by USAID to determine if the SO is on target with regard to its stated goals for the year 2000 and to determine if any mid-course corrections or changes in program strategies or implementation approaches are warranted. This review is also intended to provide insights into future needs and potential strategies, including recommendations as to whether any of the present strategies are worthy of emulation or should be changed or dropped in our next strategic planning period 2000 - 2005.

Because of the magnitude and complexity of the SO3 and the IRs, three separate assessments are planned, one for each IR. This scope of work relates to the assessment of IR 3.

As articulated in the PAAD, IR 3 expands assistance for a) strengthening NGO capability for FP/MCH service delivery, b) expanding in-plant, industry-based FP/MCH programs, and c) developing private sector channels for provision of FP/MCH services and commodities through social marketing. Financial sustainability is a major objective of IFPMHP's assistance to non-governmental organizations (NGOs) and the expansion of commercial and private sector provision of FP/MCH services and commodities. It is hoped that expanding NGO and commercial channels of FP/MCH services will eventually shift individuals who can pay for all or a major part of service costs from free or highly subsidized government services to these non-government channels. Consequently, limited government resources can be better targeted towards individuals who are truly unable to pay for FP/MCH services. Through this process, IFPMHP's assistance is expected to contribute to greater efficiency in government expenditures for FP/MCH services.

From 1994 - 2000, currently approved funds for IR 3 activities are \$12.9 million under bilateral and \$11.6 million from the Global Bureau for a total of \$24.5 million.

### III PURPOSE OF ASSESSMENT OF IR 3

IR 3 calls for increased private sector provision of contraceptives and FP/MCH services. Specifically, it aims to increase the share of FP services provided by the private sector from 27% in 1993 to 34% in 2000. Activities and corresponding benchmarks for IR 3 are:

1. Contraceptive social marketing (CSM) program expanded  
Benchmarks
  - 1.1) CSM implemented in 33 urban areas by December 1999,
  - 1.2) Annual CYPs provided by current CSM project expanded from 28,837 in 1993 to at least 283,076 in 1998.
2. The provision of FP services in private/NGO hospitals and clinics expanded

## Benchmarks

- 2 1) 135 industry-based clinics have Responsible Parenthood-MCH programs by December 1999
- 2 2) Between January 1997 and December 1999 USAID-assisted NGO-affiliated services (PCPD, JSI CARE AVSC) will provide at least 601 171 CYPs (cumulative), including CYPs for completed referrals
- 3 The role of the private sector on the PFPP enhanced  
Relevant Benchmarks
  - 3 1) Studies conducted on factors that affect private sector participation,
  - 3 2) At least two policy reforms identified in the studies are adopted by December 1998

To accomplish the above benchmarks, the following activities are currently in-place

### **1 The Contraceptive Social Marketing Program**

The Philippine Contraceptive Social Marketing Project (PCSMP), begun in 1992, is part of the worldwide Social Marketing for Change Project (SOMARC) implemented by the Futures Group International with funding from the U S Agency for International Development (USAID)

The purpose of the project is to improve and increase access and supply of safe, effective and affordable contraceptive products and services through private sector commercial networks to middle and lower income consumers Being marketed under the Couple's Choice Program of the PCSMP at present are three oral contraceptives, and one injectable contraceptive The CuT380A IUD is programmed for inclusion in the Couple's Choice Program product line before the end of 1997

Due to completion of the USAID/W SOMARC contract, the PCSMP was originally set to end in September 1996 However two project extensions (initially from October 1996 to September 1997 and afterwards, from October 1997 to September 1998) have been made to date

### **2 Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations (TANGO II)**

Implemented by the John Snow Inc Research and Training Institute (JSI/RTI) TANGO II started in February 1995 The goal of the project was to assist Philippine non-government organizations (NGOs) working on FP programs to strengthen their

management capacity and prospects for financial sustainability as they expanded their family planning and maternal health (FP/MCH) service delivery systems

Following a project assessment undertaken in March and April 1996, the project was redesigned to better contribute to the Mission's strategic objective of reduced fertility rate and improved maternal and child health. The current project aims to increase the availability of FP services in the private sector by significantly expanding the number of midwife-owned clinics that provide family planning and basic maternal and child health (MCH) services

From 1997 to 1999, funding support and technical assistance will be provided to carefully selected Philippine NGOs for the establishment of some 330 midwife-owned clinics nationwide. A significant feature of the current project design is a performance-based payment mechanism for NGOs

### **3 Responsible Parenthood-Maternal and Child Health Program for the Industrial Sector**

The goal of this project is to institutionalize the provision of RP/MCH services in selected industrial and agro-industrial companies in response to the health and welfare needs of its workers

By the end of 1999, the Philippine Center for Population and Development (PCPD), a Philippine NGO, has planned to provide technical assistance to some 135 companies with at least 500 workers in setting-up a company-based Responsible Parenthood and Maternal and Child Health (RP/MCH) Program. Technical assistance from PCPD includes training, basic clinic equipment for provision of FP/MCH services, information/education/communication and motivation materials (IEC/M) and supervision and monitoring of company programs

### **4 CARE Philippines' NGO-Support Project Phase II Sustainable Community-Based Family Planning**

The current USAID-supported FP project of CARE Philippines is the second phase of a project which started in 1992 and ended in 1996. The extension project covers a two-year period from July 1996 to June 1998

Under Phase II, CARE Philippines is working with nine NGOs involved in the provision of expanded FP information and voluntary services in some 208 Philippine villages. The thrusts under the current project are to develop sustainable community-based schemes to ensure continuity of services at the village-level and to empower the community's capacity to demand quality services

### **5 Strengthening Voluntary Sterilization Services in the Private Sector**



Started only in July 1997, this activity, done in conjunction with the JSI/RTI project described above, is being implemented by the Association for Voluntary and Safe Contraception (AVSC). It aims to strengthen and make sustainable the provision of voluntary sterilization (VS) services in the private sector.

AVSC is establishing a VS services referral system between the selected NGO midwife-owned clinics under the JSI/RTI project and selected private, LGU and DOH VS service sites and providers. With AVSC assistance, the VS services capability of selected private VS service sites and providers will be upgraded and a quality assurance system for VS services in the private VS service sites will be established and maintained.

## 6 Policy Research Studies

Under the Policy Project, several policy research activities intended to enhance the role of the private sector in the Philippine Family Planning Program are on-going and/or planned for completion by March 1998. These include the market segmentation study, the market structure study and the consumer intercept research.

For purposes of this mid-term evaluation, policy research activities would not be included in the assessment of projects. Rather, the findings of the research activities shall be used as inputs in the analyses of IR 3 activities and in the formulation of recommendations, where relevant.

Given all of the above, the specific objectives of the IR 3 mid-term evaluation are as follows:

- 1 To assess the progress in the achievement of the objectives of each activity and evaluate the relative effectiveness of each in terms of actual and potential contribution to IR 3, vis-a-vis, costs involved,
- 2 To review the progress in the implementation of on-going IR 3 projects, with a critical look at the strengths and weaknesses in the project design, the effectiveness of marketing and sustainability strategies, and the efficiency in the project management and implementation process.
- 3 To assess GOP/DOH/LGU awareness, appreciation and support at management and implementation levels of the thrusts and directions of IR 3 and their role in furthering IR 3 activities.
- 4 To assess the validity of IR 3 benchmark indicator, "private sector contribution increases from 27% to 34% between 1993 - 2000" based on assumptions used in establishing the same, on the relevance and progress of current project inputs, the over-all private sector climate in the Philippines,

and monitoring mechanism currently being used

- 5 To formulate recommendations relative to revisions in the level and monitoring mechanism of IR 3 benchmark if necessary modifications in the design and implementation of IR 3 projects strengthening linkages between and among project activities to maximize contribution to IR 3 and enhancing GOP/DOH/LGU support and involvement in the implementation of projects for the private sector, and
- 6 Assess potential future role of the private commercial and NGO sectors in FP/MCH and identify additional strategies to encourage private sector participation and involvement in FP/MCH
- 7 Assuming diminished USAID human and financial resources in the next strategic planning period (post year 2000), make recommendations for follow-on private sector strategies based on IFPMHP IR 3 experience to date

#### IV SCOPE OF THE REVIEW

The evaluation will cover the period from the signing of the original project agreement currently in effect for each activity, until the time of the review. Exceptions to this are the scope for the JSI/RTI project which should focus on the new performance-based service delivery scheme commenced in January 1997, and the FP project of CARE, the extension phase of which started in July 1996. The evaluation will cover all aspects of the various IR activities funded by USAID.

#### V ISSUES/QUESTIONS TO BE ADDRESSED PER ACTIVITY

##### A The Philippine Contraceptive Social Marketing Program (PCSMP)

- 1 How successful is the current PCSMP in terms of achieving its benchmarks and in contributing to overall IR 3 performance? Considering the amount of program resources being provided to the project, is PCSMP generating reasonable level of results compared to other IR 3 activities?
- 2 To what extent has the PCSMP been successful in encouraging private commercial sector participation and involvement in FP? To what extent is PCSMP meeting current contraceptive demands?
- 3 What are the strengths and weaknesses in the current PCSMP design? Is PCSMP as presently designed likely to succeed in the country given the current environment both in the public and private sector FP program? Why

is this so?

- 4 Are the current marketing and promotions activities being implemented under the PCSMP effective? If no why not? Are these strategies sustainable? What steps are being pursued by the project to sustain the same? What are the results of project efforts along this line to date if any?
- 5 Should the PCSMP approach be continued in the Philippines after September 1998, the end of the current SOMARC contract? What critical changes in the project design, the implementation process and project management need to be introduced, if any and why?
- 6 What are the elements/factors that are affecting the effective implementation of the contraceptive social marketing project in the Philippines? What existing policies need to be revised/repealed and what new policies should be put in-place in support of the contraceptive social marketing project?

## **2 Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations (TANGO II) Project**

- 1 How successful is the current TANGO II FP/MCH service delivery scheme in terms of achieving activity benchmarks and in contributing to overall IR 3 performance? Considering the amount of program resources being provided to the project, is TANGO II generating reasonable level of results compared to other IR 3 activities?
- 2 What are the strengths and weaknesses in the current TANGO II project design, in the project implementation process, and along project management? What critical changes in these components, if any, are needed to further strengthen/improve project effectiveness and efficiency?
- 3 What are the marketing and promotion activities being implemented at the clinic, NGO and JSI/RTI level? Which of these are effective? Which are not effective and why? Are these activities sustainable? Is there a mechanism in-place through which midwives and NGOs are able to share lessons and experiences from initiatives implemented along marketing and promotion? What do you recommend to strengthen clinic marketing and promotion activities at the clinic, NGO and JSI/RTI level in the short-run and in the long-term giving emphasis on strategies/activities that could be implemented in a sustainable fashion?

- 4 What are the innovative income-generating strategies/activities being implemented at the midwife and NGO levels? Which of these strategies/activities are successful? How could these strategies/activities be replicated by other midwives/NGOs? What do you recommend to improve the sustainability of the midwife clinics? of the NGOs?
- 5 What are the strengths and weaknesses of the performance-based payment mechanism under the project? What are the implications and consequences of adopting the scheme?
- 6 Has there been a significant change in the perspective and attitudes of NGOs and midwives involved in this project in terms of operating more as a private entity rather than as an extension of the public sector? Has this change, if ever, affected the management of their clinics that are not under the current JSI/RTI project? How?
- 7 Will it be viable to continue expanding this scheme to other areas of the country in the future? Why?
- 8 Should DOH continue to provide free contraceptives to NGOs clinics? What are the positive and negative implications of continuing this practice?
- 9 What is the current thinking of donors, DOH, and LGU on the role of NGOs in the FP program and on NGO sustainability? What policy reforms are needed to create a more favorable climate for the development and sustainability of NGOs engaged in the delivery of FP/MCH services?

**3 Responsible Parenthood-Maternal and Child Health (RP-MCH) Program for the Industrial Sector**

- 1 How successful is the current RP-MCH project in terms of achieving activity benchmarks and in contributing to overall IR3 performance? Considering the amount of program resources being provided to the project, is the RP-MCH project generating reasonable level of results compared to other IR3 activities? What are the reasons why the project to date is not able to achieve its benchmarks?
- 2 To what extent is the RP-MCH program meeting the needs for FP in the organized sector?
- 3 What are the strengths and weaknesses of the current RP-MCH project design in the project implementation process and project management? What critical changes in these components if any are needed to further strengthen/improve project effectiveness and efficiency?

- 4 What are the FP promotion activities being implemented at the company level under the RP-MCH project? Which of these are effective? Which are not effective and why? Are these activities sustainable? What do you recommend in terms of strengthening FP program promotion activities? Are there attempts to learn from each other between and among companies participating in the project in terms of effective program promotions strategies? What would be a good mechanism/ system for this purpose?
- 5 What are the strategies in-place to sustain the RP-MCH project at the company-level? Which of these strategies/activities are effective and why? How could these strategies/activities be successfully replicated by other company clinics? What do you recommend to improve the sustainability of the company clinics, the volunteer worker motivators, and the company RP-MCH management team?
- 6 Is the current non-FP approach of the project effective? Is the perception of project staff that managers are less likely to accept a program that puts emphasis on FP valid? Does this perception affect the effectiveness of project staff in the implementation of the project?
- 7 Given the current environment in the industrial sector, is this kind of scheme viable in the long-term (after PCPD phase-out)? Why? What is the experience on this of the companies covered in earlier project cycles under the same PCPD initiative?
- 8 Is a private non-profit foundation like PCPD the best organization to implement this kind of project? Why or why not? If not, what are the viable alternatives to PCPD?
- 9 Should DOH continue to provide free contraceptives to company clinics? What are the implications, if any, of terminating this practice at this point? Are companies willing to shoulder the price of contraceptives for their workers? Are workers willing and able to shoulder the costs of the contraceptives that they need?

**4 CARE Philippines' NGO-Support Project Phase II Sustainable Community-Based Family Planning**

- 1 How successful is the current CARE community-based FP project in terms of achieving activity benchmarks and in contributing to overall IR 3 performance? To what extent has the project been successful in promoting the thrusts of IR 3? Considering the amount of program resources being provided to the project, is the project generating reasonable level of results compared to other IR 3 activities? If relevant what are the major reasons

why the project is not able to meet its benchmarks?

- 2 What are the strengths and weaknesses of the current CARE community-based FP project design in the project implementation process, and along project management? What critical changes in these components, if any are needed to further strengthen/improve project effectiveness and efficiency?
- 3 What are the FP IEC/promotion activities being undertaken at the community level under the project? Which of these are effective? Which are not effective and why? Are these activities sustainable? What do you recommend in terms of strengthening FP IEC and program promotions activities?
- 4 What are the sustainability strategies, if any that have been instituted at the community level under the CARE FP project? Which of these strategies are effective, not effective and why? What do you recommend to improve the sustainability of the project at the community level?
- 5 What are the strengths and weaknesses of partnering with non-traditional FP NGOs (originally engaged in and pursuing non-FP programs/activities)?
- 6 Should this approach of using non-traditional FP NGOs be continued in the Philippines in the next planning period?

## 5 Strengthening Voluntary Sterilization Services in the Private Sector

- 1 How successful is the current VS services for the private sector project in terms of achieving activity benchmarks and in contributing to overall IR 3 performance? Considering the amount of program resources being provided to the project is the project generating reasonable level of results compared to other IR 3 activities?
- 2 What are the strengths and weaknesses of the current private sector VS services project design in its project implementation process and along project management? What critical changes in these components if any are needed to further strengthen/improve project effectiveness and efficiency?
- 3 What are the VS promotion activities being implemented at the midwife clinic NGO and private facility level? Which of these are effective and which are not effective and why? Are these activities sustainable? What do you recommend in terms of strengthening VS services marketing and promotions

activities?

- 4 What are the innovative sustainability strategies/activities being implemented at the midwife, NGO and private facility level relative to provision of VS services in the private sector? What do you recommend to improve the sustainability of VS services in the private sector?
- 5 Is this project, as presently designed viable in the long term, given the current environment in the delivery of VS services in the Philippines? Why?
- 6 Is the current socio-economic environment in the country conducive to a further expansion of the private sector VS services considering the places currently covered, the comparative VS performance in these areas and the cost of VS services?
- 7 What policies must be adopted, both in the public and private sectors, in support of expanding and improving private sector VS services in the country?

## VI METHODOLOGY

The evaluation will rely on non-quantitative methods and will consist primarily of the following data-gathering techniques: review of project documents and reports, interviews with key individuals involved in policy-making, program implementation and management, and field trips to project sites. No survey is expected to be undertaken for the evaluation, instead, secondary data sources will be analyzed.

Project documents to be reviewed include the following:

- 1) the Revised PFPP Strategy 1996-2000,
- 2) the paper of B. Ravenholt on, "Potential for Increased Involvement of the Commercial in FP Service Delivery in the Philippines,"
- 3) the Reports on the TANGO III 1996 and 1997 Project Review,
- 4) the Modified TANGO II Project Proposal,
- 5) the original and modified PCPD project proposals on the RP-MCH Program for the Industrial Sector
- 6) the Strategic Plan for the Philippine SOMARC Project
- 7) the project proposal on CARE Philippines: NGO Support Project on FP (Phase II),
- 8) the project proposal of AVSC on Strengthening VS Services in the Private Sector
- 9) the reports of relevant research studies undertaken under

- the Policy Project (market segmentation market structure, consumer intercept etc )
- 10) the 1993 DHS the 1995 1996 and 1997 FP survey reports
  - 11) the SO 3 framework and IR 3 activity benchmarks
  - 12) the OPHN Briefing Book
  - 13) CA workplans,
  - 14) monitoring reports, and
  - 15) other relevant documents

The key individuals to be interviewed include relevant USAID staff in Manila and in Washington, D C , officials from the DOH, POPCOM, selected LGUs and representatives from the donor community, CA representatives, NGO partners private/commercial sector representatives, and selected program implementors

Site visits will be determined by the team, in collaboration with USAID, government counterparts and CA representatives

## VII TEAM COMPOSITION

The evaluation will require a team of four technical experts

- 1 FP/MCH Project Evaluation/Policy Specialist This person should have extensive experience in evaluating both public and private sector international FP/MCH programs He or she will serve as the team leader and will be responsible for putting together the evaluation report At the same time, this person must also be experienced and have extensive exposure in the formulation, analysis and evaluation of public and private sector family planning policies, as he/she will be responsible for looking into the policy-related components of IR 3 activities (Expatriate)
- 2 FP Marketing/IEC Specialist This person should have extensive experience in the design, implementation and evaluation of family planning and health communication programs, including contraceptive marketing He/she will be responsible for evaluating the marketing/IEC-related components of IR 3 activities (Expatriate or CCN)
- 3 Project Management Analyst (Private Commercial/Private Provider) This person will be responsible for evaluating the design, project implementation and management of IR 3 activities involving private commercial/private providers He/She should have extensive experience in designing implementation and management of private sector FP/MCH programs (CCN)



- 4 Project Management Analyst (NGO/PVO) This person will be responsible for evaluating the design, project implementation and management of IR 3 activities involving NGOs/PVOs. He/She should have extensive experience in designing, implementation and management of NGO/PVO FP/MCH programs (Expatriate or CCN)
- 5 Economist This person should have background in health/family planning economics, with extensive experience in cost-effectiveness analyses of private sector FP/MCH programs. He/She will be responsible for looking into the sustainability-related components of IR 3 activities (Expatriate or CCN)

The evaluation, including the printing of the report and submission to the Mission, is expected to be completed in three months, with not more than 27 days spent in-country by each team member. This includes briefings and debriefings that the Team will provide for USAID and DOH. The team leader will be allowed to spend five working days in the U.S. to contact U.S.-based program participants (both USAID/Washington and CA representatives) to validate and/or clarify data collected in-country and to finalize the report. Data-gathering and all of the report writing up to the semi-final draft should be completed in-country.

In-country work of the team will start on March 2 and end on April 1, 1998. A six-day work week is authorized with no premium pay.

## VIII REPORTING REQUIREMENTS

The final report will be prepared by the Team Leader in the U.S. after receipt of USAID and DOH comments.

The evaluation report with tables and annexes should not exceed 50 pages. The report format will be as follows:

- 1 Executive Summary (to follow Project Evaluation Summary [PES] format) stating findings, conclusions and recommendations, not exceeding 3 pages.
- 2 Table of Contents
- 3 Body of the Report which includes brief program description, the environment in which the project operated, a statement of the methodology used, major findings, conclusions and recommendations, and
- 4 Annexes, to include the evaluation scope or work, list of persons consulted, background supplemental materials useful for a fuller understanding of the report, an annotated bibliography of significant documents used or consulted, and a list of

## acronyms

The timetable for reporting should be as follows

- |   |   |                             |
|---|---|-----------------------------|
| 1 | Team debriefing with copies of semi-final report  | Two days prior to departure |
| 2 | Review of report by Mission and DOH/Mission sends comments back directly to Team Leader   | Two weeks                   |
| 3 | Team Leader revises report and submits to BHM   | Two weeks                   |
| 4 | Editing of report by BHM and semi final draft returned to Mission for substantive reviews (BHM can continue editorial/formating work while substantive review is ongoing) | Two weeks                   |
| 5 | Mission reviews report and returns it with clearance or additional comments to BHM  | Two weeks                   |
| 6 | BHM prepares polished final report including comments if any from No 5 printing of report and submission to Mission in 25 copies  | Two weeks                   |

## VIII LOGISTICS

BHM/Futures is responsible for arranging travel office space secretarial/logistical support and communications. In addition the Team Leader is responsible for draft and final report development and reproduction as well as other eligible expenses associated with the completion of the midterm evaluation.

## IX TERMS OF PAYMENT

Payment for professional services shall be based on actual workdays performed not to

exceed the ceiling price as stated in the delivery order budget. Payment of Other Direct Costs up to the ceiling specified in the delivery order will be on an actual cost reimbursement basis subject to presentation of adequate supporting documentation.

To obtain payment, the contractor shall submit directly to the Office of Financial Management, USAID/Philippines Standard Form (SF) 1034 in original and three copies together with the contractor's regular invoice citing the authority of this payment. Two (2) sets of SF 1034 are attached for Contractor's use.

## **APPENDIX B**

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## **APPENDIX C**

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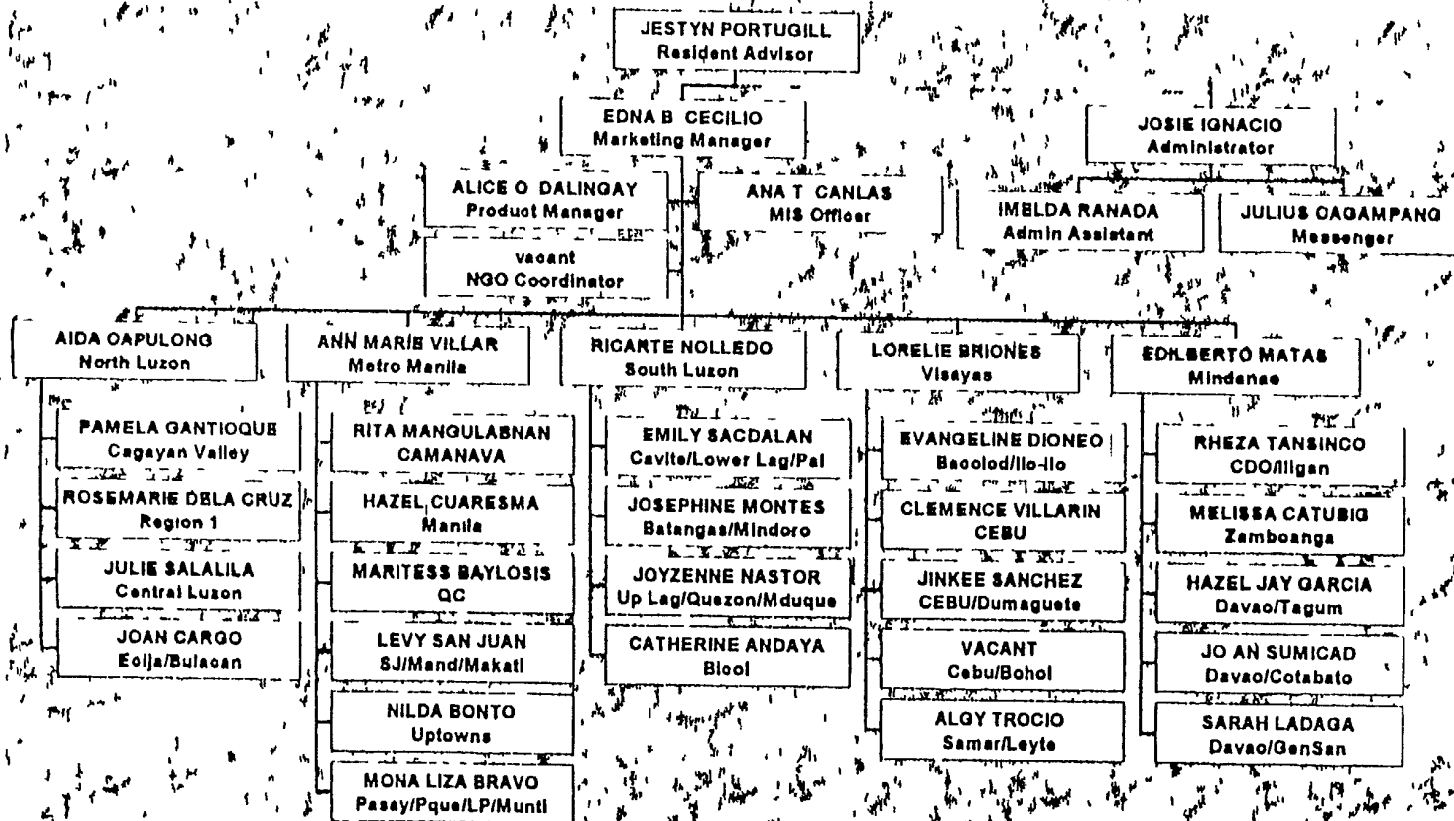
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## **APPENDIX D**

### **SOMARC/Couples Choice Organigram**

# The Futures Group International

## SOMARC



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## **APPENDIX E**

### **IMS Contraceptive Sales Report**



IMS SALES REPORT

	1994	1995	CHANGE	1996	CHANGE	1997	CHANGE
PRODUCTS	cycles	cycles		cycles		cycles	
<b>MONOPHASICS</b>							
>50 mcg							
Femeral (Wyeth)	503,000	464,000	-8%	438,000	-6%	410,000	-6%
Nordiol (Wyeth)	160,000	165,000	3%	149,000	-10%	154,000	3%
Ologyn (Gideon Richter)		100		200	100%	1,500	650%
<50 mcg							
Nordette (Wyeth)	211,000	268,000	27%	266,000	-1%	326,000	23%
Marvelon (Organon)	45,000	85,000	89%	44,000	-48%	104,000	136%
Micropil (Pascual)	104,400	104,400	0%	116,400	11%	147,600	27%
Microgynon (Schering)	21,900	24,400	11%	18,700	-23%	35,800	91%
Rigevidon (Gideon Richter)		100		200	100%	1,800	800%
<b>TRIPHASICS</b>							
Logynon (Schering)	197,800	241,000	22%	212,600	-12%	242,000	14%
Trimodiol (Wyeth)	193,000	216,000	12%	219,000	1%	225,000	3%
Gynera (Schering)						3,900	
<b>PROGESTIN ONLY<sup>1</sup></b>							
Excluton				12,159		55,200	354%
<b>Sub total</b>	<b>1,436,100</b>	<b>1,568,000</b>	<b>9%</b>	<b>1,476,259</b>	<b>-6%</b>	<b>1,706,800</b>	<b>16%</b>
<b>INJECTABLES</b>							
Nonsteral	6,300	6,000	-5%	4,577	-24%	6,500	42%
Depo Provera	16,400	15,800	-4%	16,250	3%	28,600	76%
Megestron		3,000		1,734	-42%	4,300	148%
<b>Sub-total</b>	<b>22,700</b>	<b>24,800</b>	<b>9%</b>	<b>22,561</b>	<b>-9%</b>	<b>39,400</b>	<b>75%</b>
<b>TOTAL</b>	<b>1,458,800</b>	<b>1,592,800</b>	<b>9%</b>	<b>1,498,820</b>	<b>-6%</b>	<b>1,746,200</b>	<b>17%</b>

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## APPENDIX F

### Analysis of SOMARC Sales in 1997

#### Drugstore Sales Compared with Other Outlets

The majority of Couples Choice products were sold through drugstores. The following table compares sales through drugstores with sales to NGOs, midwives, and dispensing private practitioners in 1997 by CYP.

**Table A-1**

**PCSMP Sales by Outlet Type**

	Drugstore Sales	Other Outlets	% Drugstore
OCPs	23,625	2,936	89%
Injectables	6,286	177	97%

The relatively low level of non-drugstore sales demonstrates the poor results to date of efforts to develop direct sales through these other mechanisms.

#### Performance Compared to Total Hormonal Sales to Drugstores

Sales of ethical pharmaceuticals to the commercial drugstores are tracked by Information Medical Statistics (IMS), Switzerland. It is estimated that these studies cover 77 percent of all sales of ethical pharmaceuticals in the Philippines with the remaining 23 percent of sales to private hospitals (9%), public hospitals (4%), and dispensing physicians (10%). Analysis shows total OCP sales to drugstores in 1997 at 1,706,800 cycles with Couples Choice brands accounting for 363,600 cycles or 21 percent of the market. Total injectable sales were 39,400 with Depo-Provera accounting for 28,600 vials or 73 percent of the market.

Couples Choice OCP brands increased sales by 29 percent in 1997 over 1996. The overall OCP commercial market increased sales by 16 percent over the same period. In the case of injectables the total market increased by 75 percent and sales of Depo-Provera by 76 percent (even though a stock out occurred at the end of 1997).

Couples Choice OCP brands therefore gained a share of the total market in 1997 and retained their share of the injectables market.

## APPENDIX G

### Analysis of Contraceptive Manufacturers' Sales Targets

Manufacturers and distributors of Couples Choice products find it difficult to predict sales. Couples Choice OCPs have experienced growth rates averaging 15 percent per year from 1994 to 1997, and this is set as a low estimate for future sales. The Rigevidon distributor expected 1998 sales of 40,000 cycles from a low of 8,953 cycles in 1997; the Upjohn representative believed Depo-Provera should perform well in 1998 as sales had been slowed by a temporary stock out.

Wyeth and Schering are not convinced the sales targets set for their products by SOMARC for 1998 are realistic. Wyeth believes that a 47 percent SOMARC target is optimistic and prefers a target of 15 to 25 percent. SOMARC predicts growth of 161 percent for Schering, whereas they set an internal target of 6 percent. SOMARC's Upjohn target is 136 percent, and while they were uncertain of sales achievement in 1998, experience would suggest 25 percent as a realistic target for Depo-Provera.

Taking inputs from manufacturers' representatives and distributors and revising SOMARC's IUD estimates, the following table shows a more realistic "worst case" appraisal of potential future sales. These sales are tempered by the lack of a consistent track record in sales growth; an uncertain economic situation; continued uncertainties of full commitment from manufacturers and distributors; continued supply of free DOH contraceptives; and uncertainties of political and social support for family planning in general, as well as uncertainties in predicting IUD sales. Even these modest projections may be difficult to achieve, but if the constraints change, the program could out perform the projections.

**Table A-2****Projected Couples Choice CYP Increases: 1998 to 2000**

	<b>Actual 1997 CYP</b>	<b>Percent Increase to 1998</b>	<b>Projected 1998 CYP</b>	<b>Percent Increase to 1999</b>	<b>Projected 1999 CYP</b>	<b>Percent Increase to 2000</b>	<b>Projected 2000 CYP</b>
Nordette	365,871	15	420,752	15	483,865	15	556,445
Microgynon	33,959	20	40,751	20	48,901	20	58,681
Rigevidon	8,953	347	40,000	30	52,000	30	67,600
Total	408,783	23	501,503	17	584,766	17	682,726
OCP CYP	26,561		32,586		37,996		44,362
Depo-Prov.	29,405	25	36,756	25	49,945	25	62,431
Inject. CYP	6,463		8,078		10,098		13,721
IUD			2,000	300	5,000	25	6,000
IUD CYP			7,120		17,800		21,360
Total CYP	33,024	30	47,784	38	65,894	21	7,944

**APPENDIX H**

**TANGO II Selection Criteria for NGOs, Midwives, and Sites**

## MODIFIED TANGO II PROJECT

**IDENTIFY CLINIC LOCATIONS  
SELECT AND RECRUIT MIDWIVES**

**FIRST  
SECOND**

### PROTOCOL FOR SELECTION OF CLINIC LOCATION (refer to locality)

- 1 Gather Data
  - demographic - total population, # of barangays
  - Contraceptive Prevalence Rate (CPR)
  - economic indicators/status - labor profile, economic activities, income level of municipality /brgy, household incomes
  - health facilities/FP service centers (*GO, NGO or private*) in the area
  - LGU position on FP
- 2 Analyze Data in Relation to Criteria for Clinic Site Selection
- 3 Conduct Rapid Market Appraisal to Determine Demand and Cost Estimates for FP/MCH Services
- 4 Contact and Coordinate with LGUs, PHOs, CHOs, POPCOM and Other Related Agencies and Discuss Project Objectives
  - Ensure support from above agencies
- 5 Short List Clinic Locations
  - NGO to visit short-listed clinic locations
- 6 Submit List of Clinic Locations to JSI/RTI
  - JSI/RTI, together with the NGO, to validate clinic locations
- 7 Finalize Clinic Locations as a Result of Validation
- 8 Select Midwives and Clinic Sites Based on Selection Criteria and Protocols
- 9 Match Selected Midwives with Clinic Sites to Selected Clinic Locations
- 10 Submit List of Selected Midwives and Clinic Sites to JSI/RTI

- 11 NGO and JSI/RTI to Do Final Validation of Clinic Sites

### PROTOCOL FOR MIDWIFE SELECTION AND RECRUITMENT

- 1 Sourcing and Identification
  - Contact and talk to IMAP/attend IMAP conference
  - Visit and consult PHO/CHO
  - Arrange with radio stations for announcements (*community billboards, news items, PSA*)
  - Coordinate with Midwifery schools for post announcements
  - Ask referrals from other midwives
  - Distribute survey questionnaires
  - Meet with community leaders
  - Talk to representatives of/research at Local Civil Registrar's Office and other agencies
- 2 First Screening
  - Interview midwives (*present program overview, responsibilities, counterpart, etc*)
  - Ask midwives to submit documents (*bio-data, PRT/license*)
  - Review documents
  - Prepare short list of midwives
- 3 Second Screening
  - Undertake community validation (*family, site validation, linkage with community, work ethics*)
  - Require medical certification
  - Identify priority grouping (*1st and 2nd Priority Groups*)
- 4 Selection/Recruitment
  - Confirm final acceptance by midwife
  - Prepare final list
  - Provide program orientation (*responsibilities, accountabilities, exposure trip to an existing/operating clinic*)

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# MODIFIED TANGO II PROJECT

## SELECTION CRITERIA

### MIDWIVES

#### MUST

- ⇒ Registered Midwife  
25 - 40 years old  
outgoing personality and attitude  
believes in the FP program and willing to  
provide FP services
- ⇒ Practicing Midwife  
performing a minimum of 3-5 deliveries per  
month  
at least 3-5 years experience
- ⇒ Resident of the Community  
good relations with community, including  
local health units
- ⇒ With Positive Support from Family  
husband's support if married, parents'  
support if single
- ⇒ Willing to Put Up Counterpart  
if home-based, with available space for  
clinic  
if commercial location, willing to shoulder  
initial expenses such as advance rentals  
willing to spend for renovations of facility, if  
necessary, as required by managing NGO
- ⇒ Entrepreneur  
with good business sense  
willing to adopt new ideas
- ⇒ With Good Communication Skills  
ability to interact with people  
with appropriate skills in transferring  
correct information to others
- ⇒ Willing and Committed to Comply  
with Program Requirements  
attendance in all training courses  
reporting and recording responsibilities  
service performance

#### OPTIONAL

- ⇒ Membership in IMAP or any other  
accredited midwives' association

### CLINIC SITES

- ⇒ Accessible to Public Transport and  
Walk-in Clients
  - along primary road, or in commercial  
areas
  - presence of private medical  
practitioners (*indicator of people  
patronizing private medical practice*)
- ⇒ Distance from Nearest Government  
Health Facility & Other FP Centers No  
Less Than 3 Kms
  - capacity of nearest FP service provider
  - number of active FP facilities (*GO,  
NGO or private*) in the area
- ⇒ Densely Populated with Presence of C  
& D Families Willing to Pay for FP  
Services
  - \* *C & D - Lower and Middle Class  
earning a total monthly household income  
of P3,000 - P8,000 (D) and P8,000-  
P30,000 (C)*
- ⇒ Geographic Concentration of Clinics  
must be Cost-efficient and Cost-  
effective for Management Purposes
  - not so dispersed from one another to  
allow efficient monitoring
- ⇒ Not Vulnerable to Floods/Fire
- ⇒ Expansion Potential in Terms of  
Population Coverage





## ① Careful selection of partners

➤ The NGO should.

- have an entrepreneurial orientation,
- have previous experience in family planning and/or maternal health service delivery,
- have the basic organizational capacity to administer a clinic franchise-type program using midwives;
- be willing to concentrate operations in selected geographic areas.

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**APPENDIX I**

**Subproject Cost per CYP Worksheet**

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**SOMARC  
COST PER CYP (1994 - 1998)  
(US\$)**

FY 1994			FY 1995			FY 1996		
Actual Expend	Actual CYP	Actual Cost/CYP	Actual Expend	Actual CYP	Actual Cost/CYP	Actual Expend	Actual CYP	Actual Cost/CYP
1 247 246	37 085	\$ 33 63	1 158 829	42 683	\$ 27 15	763 703	31 183	\$ 24 49
FY 1997			FY 1998 *			TOTAL Life of Project (LOP)		
Actual Expend	Actual CYP	Actual Cost/CYP	Actual + Prj Expend	Actual + Prj CYP	Actual + Prj Cost/CYP	LOP Expend	LOP CYP	LOP Cost/CYP
827 809	34 725	\$ 23 84	3 893 430	63 958	\$ 60 87	7 891 017	209 634	\$ 37 64

Oct - December 97 is actual and Jan Sept 98 is projected  
Source Budget and other materials handed out by Somarc at 3/11/98 briefing session

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**T A N G O II**  
**C O S T P E R C Y P (1997 - 1999)**  
**(US\$)**

	19 9 7			19 9 8		
	Actual Expend	Actual CYP	Actual Cost/CYP	Proj Expend	Proj CYP	Proj Cost/CYP
NGO Direct	494,131	24,650	\$ 20 05	832,177	174,846	\$ 4 76
JSI/Tango/Manila	354,227	24,650	\$ 14 37	610,330	174,846	\$ 3 49
JSI/USA	63,173	24,650	\$ 2 56	106,025	174,846	\$ 0 61
<b>TOTAL</b>	<b>911,532</b>	<b>24,650</b>	<b>\$ 36 98</b>	<b>1,548,532</b>	<b>174,846</b>	<b>\$ 8 86</b>

	19 9 9			Total Life of Project (LOP)		
	Proj Expend	Proj CYP	Proj Cost/CYP	LOP Expend	LOP CYP	LOP Cost/CYP
NGO Direct	881 957	299 176	\$ 2 95	2,208,265	498,672	\$ 4 43
JSI/Tango/Manila	510,615	299,176	\$ 1 71	1,475,173	498,672	\$ 2 96
JSI/USA	101,611	299,176	\$ 0 34	270,809	498,672	\$ 0 54
<b>TOTAL</b>	<b>1,494,183</b>	<b>299,176</b>	<b>\$ 4 99</b>	<b>3,954,247</b>	<b>498,672</b>	<b>\$ 7 93</b>

Source Briefing Materials and fax communications

**CARE  
COST PER CYP (7/1996 - 6/1998)  
(US\$)**

	7/96-6/97			7/97-6/98			TOTAL		
	Actual Expend	Actual CYP	Actual Cost/CYP	Actual + Proj Expend	Actual + Proj CYP	Actual + Proj Cost/CYP	Total Life of Project (LOP) Expend CYP Cost/CYP		
Grantees	140 263	7995	\$ 17 54	128 413	8 990	\$ 14 28	268 676	16 985	\$ 15 82
CARE/Philippines	165 425	7995	\$ 20 69	134 484	8 990	\$ 14 96	299 909	16 985	\$ 17 66
CARE/USA	27 810	7995	\$ 3 48	27 477	8 990	\$ 3 06	55 287	16 985	\$ 3 26
<b>TOTAL</b>	<b>333 498</b>	<b>7995</b>	<b>\$ 41 71</b>	<b>290 374</b>	<b>8,990</b>	<b>\$ 32 30</b>	<b>623 872</b>	<b>16 985</b>	<b>\$ 36 73</b>

Notes CYP figures include referrals  
Exchange rate for 96/97 is 27 9  
Exchange rate for 97/98 is 34 8  
Source CARE Presentation materials plus faxed communication 3/26/98

**PCPD  
COST PER CYP (1995 - 1999)  
(US\$)**

	1995			1996			1997		
	Actual Expend	Actual CYP	Actual Cost/CYP	Actual Expend	Actual CYP	Actual Cost/CYP	Actual Expend	Actual CYP	Actual Cost/CYP
Direct Project Expenses	28 479	8 023	\$ 3 55	81 689	8 853	\$ 9 23	80 458	13 824	\$ 5 82
Overhead Expenses	204 407	8 023	\$ 25 48	189 073	8 853	\$ 21 36	178 744	13 824	\$ 12.93
<b>Total Expenses</b>	<b>232 886</b>	<b>8 023</b>	<b>\$ 29 03</b>	<b>270,762</b>	<b>8 853</b>	<b>\$ 30 58</b>	<b>259 203</b>	<b>13,824</b>	<b>\$ 18 75</b>
	1998			1999			Total Life of Project (LOP)		
	Projected Expend	Projected CYP	Projected Cost/CYP	Projected Expend	Projected CYP	Projected Cost/CYP	LOP Expend	LOP CYP	LOP Cost/CYP
Direct Project Expenses	131 111	12 772	\$ 10.27	88 370	12 772	\$ 6 92	410 108	56 244	\$ 7 29
Overhead Expenses	185 142	12 772	\$ 14 50	221 172	12 772	\$ 17 32	978 538	56 244	\$ 17 40
<b>Total Expenses</b>	<b>316,253</b>	<b>12 772</b>	<b>\$ 24 76</b>	<b>309 542</b>	<b>12 772</b>	<b>\$ 24 24</b>	<b>1 388 646</b>	<b>56 244</b>	<b>\$ 24 69</b>

Source PCPD presentation materials and handouts from 3/10/98 briefing

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