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PRIVATE SECTOR MOBILIZATION FOR FAMILY PLANNING (PRISM) PROJECT ASSESSMENT

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This publication was produced for review by the United States Agency for International Development. It was prepared by Nancy Pielemeier, Abt Associates Inc.; Bettina Brunner, Consultant, Abt Associates Inc.; Delila Lojo, Consultant, Abt Associates Inc.; and Deanne Williams, Consultant, Abt Associates Inc., for the Private Sector Partnerships-*One* project.

PSP-*One*
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Submitted to: Susan Wright, CTO
Bureau of Global Health
Global Health/Population and Reproductive Health/Service Delivery Improvement
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abt Associates Inc.■ 4800 Montgomery Lane, Suite 600 ■
Bethesda, Maryland 20814 ■ Tel: 301/913-0500.■ Fax: 301/652-3916
■ www.PSP-One.com ■ www.abtassoc.com

In collaboration with:
Banyan Global ■ Data Management Systems ■ Dillon Allman and Partners
Family Health International ■ Forum One Communications
■ IntraHealth International ■ O'Hanlon Consulting ■ Population Services International ■ The London School of Hygiene and Tropical Medicine
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DISCLAIMER

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

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ACRONYMS

A4Y	Advocates for Youth
ARMM	Autonomous Region in Muslim Mindanao
BCC	Behavior change communication
BEST	Business Enhancement Support and Training
BFAD	Bureau of Food and Drug Administration
BTL	Bilateral tubal ligation
BYWY	Bureau of Women and Young Workers
CADPI	Central Azucarera de Don Pedro, Inc.
CCI	Clean Cities International
CEO	Chief executive officer
COC	Combined oral contraceptive
CPR	Contraceptive prevalence rate
CSR	Contraceptive self reliance
DKT	Dharmendra Khumar Tyagi
DOH	Department of Health
DOTS	Directly observed treatment short-course
DSAP	Drug Store Association of the Philippines
EBM	Evidence-based medicine
FAB	Fertility awareness based
FI	FOURmula One
FP	Family planning
GR	Growth Rate
HCP	Health care professionals
IEC	Information, education, and communication
IMS	International Medical Statistics
IUD	Intrauterine devices
KfW	Kreditanstalt Für Wiederaufbau
LEAD	Local Enhancement and Development for Health
LGU	Local government unit
M&E	Monitoring and evaluation
MCH	Maternal and child health
NATTCO	National Confederation of Cooperatives
NCR	National capitol region
NGO	Nongovernmental organizations
NSV	Nonscalpel vasectomy
OC	Oral contraceptive
OPHN	Office of Population, Health and Nutrition
ORBIT	Organization and Business Information Tool
PBSP	Philippine Business for Social Progress
PCCI	Philippine Chamber of Commerce and Industry
PHIC	Philippine Health Insurance Corporation
PMAP	Personnel Management Association of the Philippines
PMP	Project Monitoring Plan
PNDF	Philippine National Drug Formulary
PNGOC	Philippines NGO Council on Population, Health and Welfare, Inc.

POP	Progestin-only pill
PRISM	Private Sector Mobilization for Family Planning
PSP-*One*	Private Sector Partnerships-*One*
RFA	Request for assistance
SIA	Strategic intervention areas
SME	Small and medium enterprise
TB	Tuberculosis
USAID	United States Agency for International Development
WPFI	Well Family Clinics Partnership Foundation

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EXECUTIVE SUMMARY

The United States Agency for International Development (USAID)/Manila's Private Sector Mobilization for Family Planning (PRISM) project (recently renamed Private Sector Mobilization for Family Health) was designed to harness private sector motivations and capabilities to increase the share of the total need for family planning (FP) the private sector addresses and to reduce the unmet need for FP among women of reproductive age. The project aims to increase the contraceptive prevalence rate (CPR) for modern methods obtained in the private sector from 11.3 percent in 2004 to 20.5 percent in 2009 and to increase overall CPR from 35.1 percent in 2004 to 42 percent in 2009. The project includes three components: the workplace component, which is designed to increase support for FP within the formal employment sector; the pharmaceutical market development component, which seeks to establish a viable mass market for a variety of contraceptive brands in the commercial sector; and the private practice expansion component which aims to increase the business value of FP in private provider practices (with a focus on private practice midwives).

At the end of the five-year project's second year, USAID/Manila asked the Private Sector Partnerships-*One* project to assess the appropriateness of PRISM's strategy and to assess opportunities and constraints of the program's strategy and performance. In addition the assessment examined the possibilities for increasing the project's emphasis in certain strategic directions, including placing greater attention on reaching the poor, incorporating small and medium enterprises (SMEs), and broadening the project's focus.

The PRISM project is an ambitious program, incorporating multiple complex components. Project staff members are committed and many are experienced in FP program and policy development and implementation. The project has interacted with numerous partners, public and private, which see PRISM as timely and important for achieving contraceptive self-reliance, as well as reaching program objectives. The project has achieved several of its initial objectives in Component 1, the workplace program. The project also has had early successes in introducing new contraceptive brands through grants to pharmaceutical companies, the objective of Component 2. Furthermore there has been progress in identifying and working with partners to address policy issues. Because of a number of issues, however, including changes in strategy, the project has not made the desired progress in Component 3.

As the major USAID project focused on private sector family planning, as well as the largest donor-funded private sector initiative, the project is subject to many expectations. Some of these expectations have changed over time, such as USAID's increased emphasis on reaching the poor, working with SMEs, achieving accreditation of birthing homes (also called lying-ins), and broadening the FP focus to include maternal and child health (MCH). At a minimum these changes require adjusting indicators and reporting requirements—in some cases, however, project strategies will have to be altered. USAID and the PRISM implementation team must clarify their objectives and ensure the coherence of the broadened focus with overall strategies. And they must agree about these shifts in focus and the resulting targets and monitoring frameworks.

The project's early emphasis on attracting partners by encouraging broad involvement through grant applications resulted in high expectations among collaborators. All of these expectations cannot be met; therefore careful relationship management is required, beginning with a renewed emphasis on

communication with partners to inform them of decisions about grant proposals, as well as to convey the reasons for rejection. In addition, because of high levels of spending (partly resulting from the project's focus on rapid mobilization and broad-scale involvement of partners in the first two years), the project now faces budget constraints that require downsizing at a time when it needs to deliver significant achievements. This downsizing has coincided with major changes in project leadership. It is important, therefore, that the project team prioritize building and rebuilding partner relationships, even as the project manages other challenges.

OVERALL RECOMMENDATIONS

PRISM-USAID Discussions

USAID and the PRISM implementation team should clarify their objectives and ensure the coherence of the broadened emphases with overall strategies, as well as agree about shifts in focus and the resulting monitoring frameworks. USAID and the project implementation team also should look at the targets for each component and re-examine their relevance in light of the importance of achieving the project's goals.

Project Management

Employing a midwife (or at least a person who is familiar with midwifery and whom the midwives know and trust) on staff, or a team of consultants, to increase the ability to incorporate the midwives' perspectives in implementing Component 3 and to improve communication with the midwife association partners, would benefit PRISM. The project also should obtain input from staff or consultants with private sector experience, both to create a marketing-oriented mindset in implementing Component 2 and to increase the project's ability to think like the private sector in implementing Component 1. Project management should encourage increased synergies between components by creating inter-component working groups or by designating staff to focus on increasing synergies between components. Given the project's need to manage relationships, especially in view of the recent downsizing, PRISM should consider designating an officer or team to focus on field communications and outreach, external relations, and partner relationship-building. The PRISM team should re-evaluate the utility of the ORBIT (Organization and Business Information Tool) monitoring and evaluation system versus simplifying approaches to data collection and tracking, such as purchasing and analyzing data on sales and contraceptive prevalence to track progress toward achieving the project's objectives. The project should use grants to increase synergy among project components; for example, using grants to stimulate the establishment of contraceptive and MCH commodity sales outlets to direct the supply of products (Component 2) to the users generated at workplace programs (Component 1) and through private midwife practices (Component 3).

PRISM-Partner Relations

The project team should prioritize building and rebuilding partner relationships. The public-private, private-public referral system PRISM and Local Enhancement and Development for Health (LEAD) designed cannot be implemented effectively until donated or government-procured contraceptives become scarce. PRISM, therefore, should focus on two aspects of referrals: referral from workplace programs to public and private providers and referrals from private midwives to higher-level providers and facilities. Institutionalization can be increased in the following ways: Component 1—obtain greater commitments from grant partners for continuing and replicating workplace FP programs after the project ends, Component 2—provide additional support to faltering grantees, Component 3—strengthen partner's capacities through follow up and technical assistance.

Broadened Project Emphases

PRISM should document how the project directly reaches the poor, as well as conducting a study to estimate the project's indirect effect on the poor. The PRISM project has proposed appropriate maternal health interventions, selecting actions that will impact both maternal and child health. USAID and project management should agree on a limited set of expectations for achieving MCH goals in the project's remaining three years.

Component 1 Recommendations

PRISM has executed a complicated workplace health activity that has benefited thousands of workers. Closer collaboration is needed with Components 2 and 3, however, particularly regarding contraceptive supplies in company clinics. To maximize the impact of Component 1, the assessment team recommends PRISM reduce its company target from 1,000 companies to 750. Furthermore, by using a standard company size measure of 500 employees, the project can better capture the complexity involved in large workplace FP programs. For future grant awards, the assessment team suggests PRISM focus on providing small add-on grants to existing partners, as training grantees is time intensive.

For the themes of SMEs, pro-poor, and MCH, the assessment team recommends PRISM document the extent to which it is involved in these themes and consider adding these elements only to grants that have not been awarded. Setting MCH indicator numbers is a high priority if the project hopes to measure its impact in this area. MCH indicators that are suitable for collecting at the worksite include prenatal care, supervised delivery by a skilled birth attendant, and breast-feeding counseling.

PRISM's training materials need to be shortened and have more of a business focus, especially the Cost Benefit Module, Negotiation Skills, and the Behavior Change Communication Planning Matrix. Finally, an increased focus on sustainability should be incorporated into grant agreements and in dialogue with grantees and companies.

Component 2 Recommendations

PRISM should adopt a market-driven mindset by focusing on sales data, including developing national and regional forecasts in sales and shares, regularly checking on its forecasts' accuracy, and immediately addressing issues it encounters; monitoring new FP acceptors from efforts in Components 1 and 3, as well as monitoring the contraceptive prevalence rate and private sector use, using annual survey data; and using a functional database of potential sources of new acceptors that includes lying-ins, midwives providing delivery services in homes, and general practitioners. The project also should monitor grantee performance and provide support to ensure annual targets are achieved, conduct monthly business review meetings with grantees during the first quarter of the grant period and every other month in subsequent quarters, and forecast the number of acceptors per month for each area and product and incorporate this information into efforts in Components 1 and 3.

In terms of market-development strategies, PRISM should fast-track product launches to reverse decline in the market segment by launching new brands, including *LoGentrol* and another contraceptive, such as *Micropil*, through PRISM grants. The project should adopt a special strategy for *LoGentrol* in the commercial market, including a referral system for *LoGentrol* users, given its wide use in the Philippines. With the phaseout of this free contraceptive, a special strategy linked with the local government unit (LGU) is needed to ensure that *LoGentrol* users are identified, segmented, and referred to the private sector. This work needs to be done in conjunction with an aggressive communications strategy. In

addition PRISM should develop a USAID and PRISM strategy for Dharmendra Khumar Tyagi's (DKT, a social marketing firm) products.

In relation to partner communication and outreach, PRISM should build, rebuild, and strengthen relationships within PRISM and with other partners and stakeholders, such as pharmaceutical companies, national and local drugstore associations, and midwifery groups. The project should reach out to more women and more health care professionals (HCPs), addressing myths and misconceptions. With the expansion into MCH there is an even greater need for a well-crafted communications strategy that addresses all stakeholders, including HCPs, LGUs, workplaces, and users. Finally the project should celebrate successes and efforts towards teambuilding. There are numerous success stories that it can share to recognize performers and support others in reaching greater heights.

Component 3 Recommendations

PRISM should strengthen business-enhancement activities for midwives. To maximize the value of business enhancement for midwives, training and forums on this topic should include leaders in midwifery organizations. Also the project should develop a plan to teach and model successful midwife-vendor relationships. Data collection should be simplified (for example, commodity use might be considered a proxy for trends in HCP activity) and should be relevant for the project's goals, with few open-ended questions that might require interpretation.

PRISM must clarify the plan for training additional midwives and providing additional Business Enhancement Support and Training (BEST) for midwives in light of the new strategy for Component 3. The follow-up plan for BEST graduates also should reflect the shifts in the component's strategy. PRISM should support organizational development for each of the national-level midwifery organizations.

The new strategy and goal of establishing 500 accredited or "accreditable" birthing homes must be well defined, including establishing the baseline and determining if this number includes only newly accredited homes. Finally, the project should find new ways to help midwives become accredited, including means of overcoming resistance to accreditation. PRISM should continue to work with all stakeholders on passing legislation to strengthen midwifery practice and to develop and implement policies supporting midwives.

1. INTRODUCTION

The United States Agency for International Development (USAID)/Manila's Private Sector Mobilization for Family Planning (PRISM) project (recently renamed Private Sector Mobilization for Family Health) was designed to harness private sector motivations and capabilities to increase the share of the total need for family planning (FP) the private sector addresses and to reduce the unmet need for FP among women of reproductive age. The project aims to increase the contraceptive prevalence rate (CPR) for modern methods obtained in the private sector from 11.3 percent in 2004 to 20.5 percent in 2009 and to increase overall CPR from 35.1 percent in 2004 to 42 percent in 2009. The project includes three components: the workplace component, which is designed to increase support for FP within the formal employment sector; the pharmaceutical market development component, which seeks to establish a viable mass market for a variety of contraceptive brands in the commercial sector; and the private practice expansion component which aims to increase the business value of FP in private provider practices (with a focus on private practice midwives).

At the end of the five-year project's second year, USAID/Manila asked the Private Sector Partnerships-*One* (PSP-*One*) project to assess the appropriateness of PRISM's strategy and to assess opportunities and constraints of the program's strategy and performance. In addition the assessment examined the possibilities for increasing the project's emphasis in certain strategic directions, including placing greater attention on reaching the poor, incorporating small and medium enterprises (SMEs), and broadening the project's focus to include maternal and child health (MCH).

Annex 1 contains the assessment's scope of work. Bettina Brunner, corporate social responsibility specialist; Delila Lojo, pharmaceutical marketing specialist; Deanne Williams, private sector midwifery specialist; and Nancy Pielemeier, public health and management specialist and team leader; performed the assessment in September and October 2006. The team reviewed program documents, including annual and quarterly reports, training manuals, monitoring and evaluation (M&E) forms and data, PRISM strategy papers, reports from program partners, and other documents that are in this report's bibliography.

The consultants also conducted an in-country visit from September 23 to October 7, which included trips to regional project sites in Luzon, Visayas, and Mindanao, and interviews with USAID and project personnel (20 meetings), public-sector counterparts (14 meetings), project partners (34 meetings), and other informed observers (11 meetings) as detailed in the team's schedule, included as Annex 2. The team benefited from interactions with numerous groups and individuals, such as attending the Midwife Entre-PINAY Forum sponsored by PRISM and the Banking on Health project in Davao, where team members heard the keynote speakers, visited the vendors, and interacted with several of the more than 200 midwives who attended this event. In Visayas interviewers included a nurse who was attending a peer-educator training session who testified that as a result of the PRISM project, her employer was expanding the FP content in its health clinic. In the province of Pangasinan in Luzon, team members met with many informants, including the provincial population officer and the governor, who provided valuable insight about the program's strategy, implementation opportunities, and challenges. Interviews with numerous corporate partners also provided the team with data, observations, and suggestions.

This report is organized by component and overarching issues, in response to the specific concerns identified in the assessment scope of work (Annex 1). Although each team member focused on one

project component or on overarching issues, the team met regularly to consolidate program-wide observations, which are discussed in the following section that addresses overall themes.

2. PROGRAMWIDE OBSERVATIONS

The PRISM project is an ambitious program, incorporating multiple complex components. Project staff members are committed and many are experienced in FP program and policy development and implementation. The project has interacted with numerous partners, public and private, which see PRISM as timely and important for achieving contraceptive self-reliance, as well as reaching program objectives. The project has achieved several of its initial objectives in Component 1, the workplace program. The project also has had early successes in introducing new contraceptive brands through grants to pharmaceutical companies, the objective of Component 2. Furthermore there has been progress in identifying and working with partners to address policy issues. Because of a number of issues, however, including changes in strategy, the project has not made the desired progress in Component 3.

As the major USAID project focused on private sector family planning, as well as the largest donor-funded private sector initiative, the project is subject to many expectations. Some of these expectations have changed over time, such as USAID's increased emphasis on reaching the poor, working with SMEs, achieving accreditation of birthing homes (also called lying-ins), and expanding the FP focus to include maternal and child health (MCH). At a minimum these changes require adjusting indicators and reporting requirements–in some cases, however, project strategies will have to be altered. USAID and the PRISM implementation team must clarify their objectives and ensure the coherence of the broadened focus with overall strategies. And they must agree about these shifts in focus and the resulting targets and monitoring frameworks.

The project's early emphasis on attracting partners by encouraging broad involvement through grant applications resulted in high expectations among collaborators. All of these expectations cannot be met; therefore careful relationship management is required, beginning with a renewed emphasis on communication with partners to inform them of decisions about grant proposals, as well as to convey the reasons for rejection. In addition, because of high levels of spending (partly resulting from the project's focus on rapid mobilization and broad-scale involvement of partners in the first two years), the project now faces budget constraints that require downsizing at a time when it needs to deliver significant achievements. This downsizing has coincided with major changes in project leadership. It is important, therefore, that the project team prioritize building and rebuilding partner relationships, even as the project manages other challenges.

The implementation team focuses on project targets that appear to be set largely by the project team (see Annex 3.) The assessment team was unable to pinpoint the origin of these targets, some of which have changed over time, particularly those associated with Component 3. USAID and the project implementation team should review each component's targets and re-examine their relevance in light of the importance of achieving the project's goals. For example, implementing workplace programs in 1,000 companies may be less relevant than focusing on the quality of programs implemented in 750 companies. Similarly, in defining the goals for the new strategy for Component 3, attention should be paid to tradeoffs between quantity and quality, as well as to the importance of establishing a baseline of accredited birthing homes and realistic estimates of homes that can achieve accreditation (or become "accreditable") within the project's remaining three years.

Another issue all of the assessment team members identified is the project's focus on the Organization and Business Information Tool (ORBIT) web-based M&E system. This system, which was developed to track targets and outcomes established in the Project Monitoring Plan (PMP), is complex and requires constant modifications as project strategies and targets change. This system, however, is not linked to tracking of project inputs and outputs, which require separate monitoring systems. Significant time, attention, and funds are devoted to monitoring, even though few of the data have been analyzed and applied in the project's implementation. The PRISM team should re-evaluate the ORBIT M&E system's utility, focusing on simplifying approaches to data collection and tracking, such as purchasing and analyzing data on sales and contraceptive prevalence to track progress toward achievement of overarching project objectives.

Because of the project's strategy of focusing on the three components and the resulting management structure put in place to reflect the tripartite program, PRISM has given little attention to inter-component synergies. The synergy between components which could be most directly addressed by the project is the creation of sales outlets for low-cost commodities (stimulated by Component 2) in the workplace and provider sites at which Components I and 3 create demand. As there are several organizations already establishing kiosks or boutiques for the sale of low-cost FP and MCH commodities, the project's grant program could connect these efforts with the project's efforts to enhance program outcomes, as discussed in the Grants section (section 6.7).

Lastly, there is a need for demand creation among all components through information, education, and communication (IEC) and behavior change communication (BCC) activities, possibly through USAID's new BCC project. PRISM may learn from other projects, such as the recently concluded Philippines TB Initiatives in the Private Sector (PhilTIPS) project, which had a comprehensive approach using IEC and effectively employed partnerships.

3. COMPONENT 1: WORKPLACE HEALTH PROGRAMS

3.1 COMPONENT STRATEGY

PRISM's goal in the workplace health component is to increase the formal employment sector's involvement in and support of promoting and providing FP and MCH among its employees. With a theme of "through, don't do," PRISM identifies organizations (such as chambers of commerce, nongovernmental organizations (NGOs) and unions) to be grantees and then trains them to help companies implement workplace FP programs. The procedure is outlined in Annex 4 to provide an understanding of this multi-step process.

PRISM's strategy is on target with regard to grantees, company size, and location. PRISM has chosen excellent organizations, such as Philippine Business for Social Progress (PBSP), the country's premier social-responsibility NGO, and Philippine Chamber of Commerce and Industry (PCCI), the most influential business organization. PRISM's spotlight on large companies in major industrial zones has the greatest ability to influence USAID's Strategic Objective 3, "Desired family size and improved health sustainability achieved." Targeting the industrial zones has allowed PRISM to work in all major industrial categories, including electronics, garments, food processing, and light manufacturing. While most companies in the program have between 200 and 1,000 employees, many can be categorized as SMEs, with less than 200 employees.

Task	Activities
Task A: Increase public discussion by business leaders about FP issues	CEO Roundtables, Human Resource Director Fora, PCCI's Family Excellence Awards
Task B: Increase support by firms for FP at the workplace	113 companies have FP programs, with 587 more companies expected to add them.
Task C: Increase support by labor unions for FP at the workplace	Two labor unions are prospective grantees.
Task D: Develop cost-effective and sustainable FP models for the workplace	Workplace FP modules are being finalized.

Looking at the tasks outlined in the original PRISM contract under Component 1, the table shows that PRISM has made progress in all task areas, including increasing business leaders' public discussions about FP issues, increasing firms' support for FP at the workplace, increasing labor unions' support for FP at the workplace, and developing cost-effective models. PRISM's executive roundtables and sponsorship of PCCI's Family Excellence Awards have heightened the visibility of FP in the business community.

While there is a need to review and revise project targets in general, as discussed in the previous program-wide observations section, the assessment team was asked to evaluate the extent to which each component is performing on the delivery of its objectives. Component 1's indicators are shown in the following table.

PERFORMANCE INDICATORS FOR THE WORKPLACE FP PROGRAM COMPONENT

Performance Indicators		Actual	Cumulative Annual Targets				
		2006	2005	2006	2007	2008	2009
1.1	Number of national associations and partner institutions with the capacity to implement workplace FP programs	8	1	3	6	9	12
1.2	Target companies and cooperatives implementing PRISM-supported FP programs	75	2	202	502	802	1,000
1.3	Target companies and cooperatives implementing PRISM-supported MCH programs	NA		0	TBD	TBD	TBD
1.4	Proportion of employees in target companies and cooperatives reporting use (or partner's use) of a modern FP method	NA		TBD	TBD	TBD	TBD
1.5	Proportion of expectant mothers and mothers with newly born babies who have used company-supplied MCH services	NA		TBD	TBD	TBD	TBD

3.1.1 STRATEGY 1.1

Number of national associations and partner institutions with the capacity to implement workplace FP programs

Observations

There are eight partner organizations with signed subcontracts or grants. Twenty-nine grants are in process, bringing the total to 37. This number exceeds the project's target of 12. PRISM has added a large capacity-building activity to Component 1 that the contract does not require, nor is it measured.

Recommendations

If the project limited grants to its target requirement and leveraged its impact with additional grants to existing NGO and business association grantees, PRISM could reach previously identified companies and workers, particularly as one of its themes is to "pick the low-hanging fruit" and focus on building sustainable capacity among fewer intermediaries.

3.1.2 STRATEGY 1.2

Target companies and cooperatives implementing PRISM-supported FP programs

Observations

There are 113 project companies. If recently signed and prospective grantee companies are added, the total is 587. This number is below the 1,000-company goal for target 1.2. Given the implementation timetable for the project's first two years, it is unlikely that PRISM will have the resources to train all prospective grantees to implement workplace programs in the remaining years of the project.

Recommendations

When a workplace program is considered implemented must be clarified. PRISM appears to count companies when the partner grant is signed, but on average companies require one year to implement the workplace FP program (as described in Annex 4). PRISM may want to split target 1.2 into two separate indicators: the number of companies with signed grants and the number of companies that have functioning FP workplace programs.

PRISM also should re-examine the use of the number of companies as an indicator as company size varies. For example, the Mahintana Foundation's FP workplace project is planned for 13,000 workers and community members; it will require extensive coordination and planning, but will only count as one company. Instead, if PRISM uses an average number of employees per company as an indicator, such that each 500 employees counts as an additional company, it could better balance company size and program complexity.

As noted elsewhere, the project has focused on creating monitoring systems and collecting data, but few of these data have been analyzed and used to inform implementation. In addition, new indicators have been added and others removed, such as the number of unions that have implemented FP policies.[1] The MCH indicators have not been assigned target numbers, including the feasibility of determining the proportion of pregnant women and mothers with newborns who report using project-supported MCH services. Unless these measures are quantified in the next few months before additional grants are signed, it is unlikely PRISM will be able to track these indicators.

3.2 OBSERVATIONS

A recurring theme regarding PRISM's performance that emerged during interviews with grantees, subcontractors, and companies was a lack of communication and consultation. Lines of communication were not kept open and there were delays in the approval of training and grant documents. For PBSP this holdup led to the duplication of efforts, such as when it developed a cost-benefit tool because of PRISM's delay in providing this tool to partner organizations. As another example of poor communication, PCCI and the Bureau of Women and Young Workers (BWYW) had not been provided with the FP workplace training materials to help companies wishing to initiate workplace health programs. PRISM has had no direct contact with the BWYW for some time and the BWYW had not received the directory of pharmaceutical companies with a list of FP service providers.

In terms of project synergy, PRISM was structured to allow companies participating in the workplace health program in Component 1 to reach pharmaceutical resources in Component 2 for workplace clinics, while clinic midwives could be trained via Component 3. The collaboration among components is less than optimal because of the complexity of PRISM's mandate and the silo nature of the three components. Two companies participating in Component 1 the assessment team visited had no knowledge of the pharmaceutical directory published under Component 2. And they had no idea how to procure contraceptives for their clinics. As free contraceptives are phased out in the Philippines, this issue will become critical.

3.2.1 MEASUREMENT AND EVALUATION

While it took time for PRISM to develop monitoring and training materials, it now has a host of such tools, including the FP Index, the FP Assessment Tool, ORBIT, and several training modules geared for

[1] USAID and PRISM decided that lobbying unions to include FP language in collective bargaining agreements was ineffective. PRISM, however, has changed its strategy and plans to award grants to two unions to manage workplace FP programs.

company management and employees, including the Cost Benefit Module, Negotiations Skills Module, and the BCC Planning Matrix. It appears that USAID/Manila has not seen all of these training materials. The Managing Family Planning Programs in the Workplace manual under final revision is an excellent training tool, but the other training modules are too academic and detailed. PRISM must think more like a business and distill key points into shorter training sessions.

An essential issue missing from the training materials is when companies should provide FP counseling. While Central Azucarera de Don Pedro, Inc. (CAPDI), for example, provides FP counseling during prenatal checkups, two company nurses said they do not provide FP counseling to employees unless they request it or after the birth of their fifth child. PRISM needs to ensure that training materials transmit the message that clinic visitors should be counseled on FP to increase the number of acceptors.

While grantees receive training on the Tiahrt Amendment, informed choice and voluntary consent need to be more emphasized in all training materials for companies. This focus is critical because PRISM does not work directly with companies and grantees may not realize this issue's importance.

As part of the process for implementing the workplace program, the project collects information from the companies' employees. No company data had been finalized, although some grantees have implemented their worksite FP programs and finished their grant. At the Cavité Program Assessment Conference in September 2006 (which assembled participating companies, the Cavité Chamber, and PRISM representatives), several companies described "difficulties in gathering data/information from the employees, seems they are hesitant to open up about their private concerns." Data collected should reflect these concerns.

PRISM also must look into the viability of the FP Index as a tool to measure company improvement. PBSP, the only partner/subcontractor thus far to have used the FP Index at the end of an intervention, found that the tool does not accurately measure progress. PBSP indicated that in one instance, a company scored worse on the Index after implementing the FP program and that some companies felt threatened by the Index as a tool to measure change.

The delay in developing the M&E module for grantees and companies has resulted in a knowledge gap about monitoring requirements. Grantees did not understand that monitoring would continue beyond the contract's one-year timeframe and several reporting elements were not written into grant agreements. For example, the Cavité Chamber, Lopez Group, and PBSP considered the baseline survey and one-year follow-up to conclude reporting requirements under their PRISM contracts. In addition, the original grant agreement for Cagayan de Oro did not include baseline-data gathering, installation of an M&E system, and peer-educator training in its budget, necessitating an amendment.

It is unclear whether PRISM is using or passing along all of the marketing information it has collected. PBSP's original survey of 1,040 companies yielded 275 companies that were interested in a workplace FP program. PBSP has worked with eight companies to fulfill its contract, but the remaining 267 companies are also prospective program participants. Similarly, in the Pangasinan area, a survey indicated 47 companies were interested in an FP program. It is not clear how many of those companies have been contacted. It is critical to utilize the data collected and to keep in contact with prospective partners.

3.2.2 GRANTS PROCESS

Grants help PRISM gain access to business organizations and NGOs to implement the workplace program, with the idea that these grantees would continue the program once PRISM ends. PRISM spent its first two years developing the grant instruments and M&E materials, so funding amounts and contractual obligations for the first few grantees varied. The following table shows that the grant

payment per company varied between $842 (to Cavité Chamber) and $8,399 (to Lopez Group). (Advocates for Youth (A4Y)'s grant is higher than other recent grantees because it is responsible for data centers that have employees working three shifts.)

SIGNED PRISM GRANTEES BY GRANT AMOUNT, COMPANY SIZE, AND FUNDING PER COMPANY THROUGH OCTOBER 2006

Grantee	Grant (PhP)	Companies	Funding/Firm (PhP)	$
Lopez Foundation	2,099,786	5	419,957	8,399
Oro Chamber	3,079,838	25	123,194	2,464
Cavité Chamber	1,893,650	45	42,081	842
Coastal Conservation and Education Foundation, Inc.	2,981,725	30	99,391	1,988
TriDev Development Specialists, Inc.	2,055,060	8	256,883	5,138
A4Y	4,402,540	10	440,254	8,805
Total	16,512,599	123	1,381,760	4,606 (avg.)

The exchange rate is 50 PhP to $1.

The following table shows the anticipated grantees in 2007, their grant totals, the number of companies each serve, and the average grant payment per company. The anticipated grant disbursement by company is between $1,027 and $5,368. The assessment team was unable to conduct a complete grants assessment; further study of the variation in grant awards is needed.

ANTICIPATED PRISM GRANT AWARDS THROUGH 2007

No.	Grantee	Funds (PhP)	Firms	Funding/Firm (PhP)	Funding/Firm ($)
1.	Davao Chamber	1,600,000	10	160,000	3,200
2.	Makati Business Club	3,800,000	74	51,351	1,027
3.	General Santos Clean Cities International (CCI)	1,800,000	15	120,000	2,400
4.	Philippine Federation of Credit Co-operatives	1,639,550	15	109,303	2,186
5.	Kasilak Development Foundation Inc.	2,000,000	15	133,333	2,667
6.	PhilExport Socks	2,200,000	15	146,667	2,933
7.	OPTIONS	4,081,725	40	102,043	2,041
8.	Mandaue CCI	3,600,000	40	90,000	1,800
9.	Participatory Research Organization of Communities and Education towards Struggle for Self Reliance	1,500,000	15	100,000	2,000
10.	Bohol Association of NGOs	3,000,000	25	120,000	2,400
11.	Philippine Partnership for the Development of Human Resources in Rural Areas	2,200,000	20	110,000	2,200
12.	Alfonso Yuchengco Foundation, Inc.	6,515,060	38	171,449	3,429

No.	Grantee	Funds (PhP)	Firms	Funding/Firm (PhP)	Funding/Firm ($)
13.	Employers Confederation of the Philippines	8,052,540	30	268,418	5,368
14.	Personnel Management Association of the Philippines (PMAP), Pampanga	5,000,000	39	128,205	2,564
15.	Forum	4,456,000	40	111,400	2,228
16.	FriendlyCare	2,444,444	15	162,963	3,259
17.	Batangas Chamber	1,500,000	10	150,000	3,000
18.	PMAP Pangasinan	2,000,000	10	200,000	4,000
19.	PhilExport	2,000,000	10	200,000	4,000
20.	PCCI	3,000,000	50	60,000	1,200
21.	Bulacan CCI	2,200,000	16	137,500	2,750
22.	PMAP Subic	2,700,000	20	135,000	2,700
23.	HRMAC	2,500,000	21	119,048	2,381
	Totals	69,789,319	583	119,707	2,394

The exchange rate is 50 PhP to $1.

PRISM's mandate is "work through, don't do," meaning grant partners work with companies. These companies have little knowledge of PRISM and thus feel little contractual responsibility to the project. PRISM can get more impact by writing sustainability language into the grants and working more with grantees to carry on the program after the contract ends. Furthermore, the grant agreement must define company-reporting requirements. The recommendations section provides possible wording for these issues in the grant agreement.

Another grant issue that PRISM needs to address is company targets. Grantees are held to numerical targets although companies drop out or circumstances change through no fault of the grantee. The Cavité Chamber had six companies drop out of the program because of financial difficulties after they had signed letters of commitment and initiated training. Cavité Chamber was required to solicit the participation of other companies to fulfill the terms of the contract and conduct six trainings instead of the three in the PRISM contract. Lopez Group has met the PRISM target for the number of participants trained, but not for the number of trainings, so it has not received funding for that deliverable. A more flexible, common-sense approach to grant targets is needed that considers objectives as well as realities.

Another issue that was mentioned during interviews was that the grantees felt the payment system was onerous. PRISM established grants so that organizations receive payment upon completing deliverables. While this rule ensures that work is performed, chambers and other grantees have limited funds and have found it difficult to cover costs prior to payment. A system whereby grantees are advanced a sum might make more sense.

3.2.3 APPROACHES IN INTEGRATING SMES

SMEs usually are defined as companies with less than 200 employees.[2] According to the Philippine Department of Trade and Industry, in 2004 SMEs comprised about 99.6 percent of all registered firms nationwide, employed 70 percent of the labor force, and contributed 32 percent to the Gross National Product.[3] Ninety-two percent of all SMEs in the Philippines, however, are micro industries with less than 10 employees, as the following table illustrates.

PHILIPPINE COMPANY SIZE BY CATEGORY, 2004[4]

Company Category	Size	Number of Firms	Percent of Total
Large	More than 200	2,958	0.4
Medium	100–199	2,923	0.4
Small	10–99	61,762	7.6
Micro	1–9	743,949	91.6

A PRISM focus on microenterprises would be a fundamental departure from its goals and would require a re-examination of indicators and procedures. The assessment team does not recommend such a change. Furthermore, two chambers indicated that microenterprises were not interested in the workplace FP programs, as they are more concerned with immediate business issues.

PRISM's goal to increase the CPR for modern methods obtained in the private sector is best conducted through activities with companies that have a large pool of workers and can implement a FP program efficiently and expediently. The assessment team recommends PRISM determine which current and prospective partners are SMEs, rather than initiating extensive new SME activities outside of the grant program. In Cavité alone, the assessment team found that PRISM already works with many SMEs through current grantees, including Kings Rubber Intl. (76), Sanwa Electric Phils (115), Shi Tai Mfg. (105), and Phil Advanced Processing Tech (147). As new grants are awarded, dozens of SMEs will be served.

There are few FP workplace models focused exclusively on SMEs as by definition workplace FP interventions can run the gamut from dissemination of IEC materials to service provision in on-site clinics. In 2005 the PBSP conducted 16 case studies of FP worksite programs among large companies and found the following range of options.[5]

[2] The term SME is open to interpretation. In the United States there is no standard definition for SME, although 200 employees is the general cut-off. The European Union calls SMEs companies with 250 or fewer employees (European Union's website), while Canada considers companies with fewer than 500 employees as SME (About.com).

[3] Department of Trade and Industry, Government of the Philippines' website.

[4] Department of Trade and Industry, Government of the Philippines, 2004.

[5] Philippine Business for Social Progress (PBSP) 2005.

Elements	Range of Options				
Policy	Collective bargaining agreement	General health policies	Integrated in current workplace health policies	Stand alone workplace family planning policy	
Structure (internal)	Human Resources Dept./Personnel Department	Occupational health and safety and company clinic	Family welfare committee	Labor union	Combination
Structure (external)	Public	Private	HMO	NGO	Combination
Service delivery—education	Dissemination of IEC materials	Various and sporadic IEC activities	Peer education by employee volunteers	Referral (public, private, and NGO)	Combination
Service delivery — counseling and dispensing	In house by medical staff	In house by trained motivators	Public referral	Private referral	Combination
Financing	100 percent by employees	Shared	100 percent by company		

These options are also valid for SMEs. As with any FP intervention, buy-in and commitment from SME company leadership is critical for successful programs. For the PRISM project, SMEs could be encouraged to promote FP via peer counselors and link with other Philippine government and USAID programs for service delivery. PCCI, which has implemented the Family Welfare Award, is eager to become more involved in FP. PCCI could use a limited version of PRISM's worksite program that reflects the lack of infrastructure and resources found in SMEs and also deliver presentations to its local chapters.

One model that PRISM could adapt for SMEs involves linking companies to drugstores via in-store promotional activities, similar to the Boticas Torres de Limatambo program in Peru.[6] Pathfinder International negotiated contracts linking employers with drugstores in Peru to ensure workers' FP needs were met via family planning day promotions and discounted contraceptives. PRISM could work with drugstores to train employees and offer promotional family planning days and also negotiate discounts with pharmaceutical companies on FP products through Component 2. In the Philippines drug store chains, which control over 70 percent of the drugstore market, may be amenable to such a partnership. In particular Mercury Drug Superstores and the Botika ng Bayan franchise program[7] (discussed in Component 2) may be prospective candidates.

With regard to the concept of a common service facility, typically SMEs and microenterprises are not clustered together, but are spread over large areas, often with backyard operations. Mobile health units would be needed to serve these SMEs. Given that the Rotary Club has sponsored a health clinic, it (or another business association) may be amenable to sponsoring such a mobile health unit for SMEs.

Finally, Lopez Group is interested in adapting the workplace FP program to the SME context. By providing a small grant to jump-start such a program, PRISM could stimulate the development of a valuable model for SME implementation of the workplace FP program while responding to USAID's interest in SMEs.

3.2.4 APPROACHES IN INTEGRATING MCH INTO THE OVERALL PRISM STRATEGY

Chambers of commerce and companies interviewed were unaware the focus of PRISM had broadened

[6] The CATALYST Consortium 2005.

[7] Pacific Bridge Medical, Asian Medical Newsletter.

from FP to MCH and were unclear what this new focus would mean for their programs. There was a consensus, however, that MCH would be easier to sell to company management and employees than FP alone, although one company did not feel ready to move from FP to MCH. The project's suggested definition of MCH, which focuses on maternal interventions including tetanus toxoid vaccination, at least four prenatal visits, referrals for warning signs of complicated pregnancies, and midwife-assisted birthing plans, is appropriate. Expanding from FP to maternal health activities will require revising all training materials, grant agreements, and company memorandums of understanding, as well as retraining grantees, the family planning monitoring teams, and clinic staff. To avoid confusion the shift to maternal health activities only should be conducted with prospective grantees that do not have signed agreements.

The extent of MCH activities already offered at company workplaces has not been documented. At one end of the spectrum, CADPI provides extensive MCH services at the workplace, while others, such as smaller companies in Cavité, have no health staff onsite. A first step should be to determine the extent to which MCH activities are being conducted at the worksite. A second step would be to survey participating companies to determine their interest in adding MCH components.

3.2.5 STRATEGIES TO INCREASE PRO-POOR IMPACT WHERE FEASIBLE

As with the SME theme, it is likely that Component 1 already reaches the working poor. The term "poor," however, must be defined. The BWYW computes the regional minimum wage ($6.26 to $7.00 per day for the national capitol region (NCR) in 2006), and the regional living family wage ($15.20 per day for the NCR) as well as poverty levels by region.[8] International organizations use other measures such as the $2 per day indicator used by the Millennium Development Goals. Seasonal, contract, and unskilled workers in client companies may meet these definitions of poor, as well as community members where companies are located. The FP Needs Assessment already asks company's employees their occupation (manager, supervisor, or rank and file), employment status (regular or contract), and estimated gross monthly family income (such as less than 6,000 PhP or 9,000 to 12,000 PhP). PRISM could analyze this data to gain insight into the poverty status of employees in the project without any additional outlay of funds.

During interviews several companies indicated they conduct the FP program in surrounding barangays, which is a pro-poor activity. In Cavité, Epson is rolling out the FP program to the surrounding barangay. CADPI has extended its tuberculosis (TB) program to nine barangays and plans to roll out the FP program to the surrounding community in the near future. Likewise, the Mahintana Foundation's FP program targets 13,000 employees and will be implemented in poor communities surrounding the plants to impact a total of 60,000 people. To demonstrate its ability to reach the poor, it would be useful for PRISM to collect and disseminate this information.

3.2.6 LEVERAGING PRIVATE INVESTMENTS

PRISM does not accurately capture a company's total investment in the workplace FP program, such as the worker's time for surveys and training and the loss in productivity. The Lopez Group indicated that employee's time alone represents an additional $10,000 in company contributions, without adding the loss in productivity. A standardized leveraging checklist is needed, such as the example provided in the Annex 5 that lists direct and indirect costs, employee time, and the loss of productivity because of

[8] Exchange rate of 50 PhP to 1 USD was used. Minimum and living wage statistics are available directly from the BWYW director. Poverty maps by regional are at from the National Statistical Coordination Board, Estimation of local poverty in the Philippines.

participation in the program. It is important to stress that all calculations of investment leveraged from companies are only estimates and that reporting requirements should not unduly burden the company.

3.2.7 SUSTAINABILITY

The visibility of workplace FP programs is rising among the business community. PCCI's Family Excellence Awards have received media attention and are an example of PRISM's successful advocacy in action. Shell Philippine's director has championed family welfare and his leadership is raising the awareness of this issue. PRISM should meet with Shell to determine advocacy messages and possible joint activities to increase sustainability of FP programs in the workplace. Another hopeful sign of sustainability is that PBSP, responsible for implementing the Millennium Development Goals in the Philippines, is interested in including FP as one of its main focus areas.

PRISM's theme of "through, don't do" has been well executed in the workplace FP component via subcontracts and grants. Grantees have undertaken complicated FP workplace activities, but it does not appear that these organizations receive sustainable value from conducting the workplace health activities, as grants completely support activities. To become sustainable, grantees will need to be able to price their services to companies and companies will need to price the FP products they offer in their clinics. Currently, grantees and companies have no incentive or guidance to do so.

At the Cavité Assessment Conference in September 2006, companies were placed into small groups and asked "What measures do you propose to sustain the program after the pull-out of the Cavité Chamber in this project?" Companies responded that to make the FP program sustainable, a company should

- allocate an annual budget for the FP program
- conduct an activity in connection with the program at least once a year, such as a refresher course/training or a family day
- institute cost sharing for the FP program between the employees and the employer
- include in the program other family-welfare activities such as livelihood program, spiritual and value formation, responsible parenthood, and MCH
- provide incentives for peer educators at the end of the year

Training materials should incorporate these recommendations.

There was consensus at the Cavité Conference that program sustainability depends on the dedication and interest of the clinic nurse and the chief executive officer (CEO). The high company-nurse turnover rate will affect the project's sustainability, making periodic retraining crucial. While larger-company CEOs were strong advocates of the FP program, other CEOs felt it was too costly to continue indefinitely and would require "constant monitoring and updating presented to the management via cost-benefit-analysis." Given the high nurse-turnover rate, the human resource manager should be cultivated as another workplace-based champion whom PRISM can target to capacitate.

Several companies have an integrated package of health services for employees that include HIV/AIDS treatment and prevention, the directly observed treatment short-course (DOTS) for TB, and FP. For example, CADPI is working through PBSP to create an integrated health program for workers and has secured donor funding to cover its costs. In cases such as this one, PRISM should integrate FP more closely to this model.

PRISM is well placed to evaluate which models hold the most promise for sustainable workplace programs. Lopez Group companies run the gamut from management paying for all FP products and services, to cost-sharing programs, to full employee payment. PRISM could analyze which companies have more FP acceptors and determine the elements of a successful FP program. Despite USAID workplace programs in the 1980s and 1990s, there is no credible body of information regarding the financial benefits of company participation in a workplace FP program or its impact on CPR. USAID could further the cause by conducting a cost-benefit analysis of a workplace health program that all USAID-sponsored workplace health activities could use (through PRISM, if funds are available for such a study, or through another mechanism).

3.3 RECOMMENDATIONS

- The provision of contraceptives at the workplace is becoming a pivotal issue for companies as the supply of free contraceptives is exhausted. It is crucial for Components 1 and 2 to work together to assist companies with this issue.

- As discussed in more detail in the following crosscutting themes section, PRISM may be able to facilitate the link between organizations that establish boutiques or kiosks to supply low-cost commodities in workplaces that do not have access to contraceptives and other reproductive health and MCH commodities. PRISM's role could be brokering arrangements between partner companies and these organizations. Or PRISM could take a more active role by providing grants to these groups.

- Given the frustration of grantees, the assessment team recommends that PRISM increase communications with grant partners via frequent face-to-face discussions and telephone calls.

- With regard to the training modules, the assessment team recommends PRISM

    - revamp the Cost Benefit Module[9] to a half-day session that makes the case for FP and MCH in the workplace and provides limited calculations of company benefit

    - trim the Negotiation Skills Module from a three-day course to a half-day session, remove the How to Negotiate primer, and concentrate on convincing companies' management about the benefits of workplace FP programs

    - remove the BCC Planning Matrix from training materials as the information is not user-friendly and it is unlikely that clinic staff would separate clients into four different FP target audiences

    - develop a *How to Price Your Services* guide for grantees and a *How to Price Your Family Planning Products* guide for company clinics and provide cost-recovery training to grantees to help them package workplace FP programs to companies

    - re-examine all training materials and remove information that is sensitive or will not be used

[9] To avoid confusion with another acronym, PRISM's Cost Benefit Module is called the Benefit-Cost Assessment.

    - review and increase the emphasis about the concepts of informed choice and voluntary consent in all training materials for companies

- PRISM should determine the extent to which MCH activities are being conducted at participating company worksites. A second step would be to survey participating companies to determine their interest in adding MCH components.

- A standardized leveraging checklist is needed for companies to tally the costs of workplace FP programs, such as the example provided in Annex 5, which lists direct and indirect costs, employee time, and the loss of productivity because of participation in the program.

- The companies most likely to conduct social projects are those that have created a corporate foundation. PRISM can lobby the League of Corporate Foundations to place FP higher on its agenda and conduct workplace FP programs without PRISM grants. PRISM also could build on the synergy of such foundations. For example, the Lopez Group's CSR arm, the Lopez Foundation, is putting together a proposal for an FP marketing program for television and radio that focuses on Mindanao. PRISM could serve as the partnership broker with Lopez and the new BCC or policy project.

- PRISM can make an important contribution to future worksite FP programs by conducting a cost-benefit analysis that shows the advantages to workers and employers of such activities.

- The Lopez Group is interested in adapting the workplace FP program to the SME context. By providing a small grant to jump-start such a program, PRISM could stimulate the development of a valuable model for SME implementation of the workplace FP program.

- PRISM could collect and disseminate information regarding Component 1's impact on the poor.

- A more flexible approach to meeting grant targets is needed. For example, if the grantee has not met the target for the number of trainings conducted, but the target for the number of persons trained has been met, then the grantee should be paid.

Simple language is needed in grant agreements and training materials that emphasizes the ongoing nature of the worksite program. For example, a sentence in the grants between grantees and companies could read, "The company will make every effort to continue the program beyond PRISM funding" and "the company is required to provide statistics to PRISM on the worksite FP program until the end of the PRISM project in 2009."

4. COMPONENT 2: MARKET DEVELOPMENT

4.1 COMPONENT STRATEGIES

Component 2 focuses on developing a viable and sustainable market for affordable modern contraceptives in the commercial sector and addressing the lack of suppliers for a commercial mass market for FP products. A key strategy is to provide grants to pharmaceutical companies that can introduce or re-launch commercially sustainable oral contraceptives (OCs), injectables, or intrauterine devices (IUDs). These products should be within the medium and low price range. The strategy also links the pharmaceutical companies involved with the workplace leaders (through Component 1) and the HCPs (through Component 3) to provide more options for FP products.

A review of the key component strategies, performance indicators, major observations, and recommendations follows.

4.1.1 STRATEGY 1

- Establish and expand viable markets for affordable brands of pills, injectables, and IUDs through the commercial sector
- Encourage the commercial sector to significantly increase the private sector's share of the overall contraceptive market

Performance Measures

Sales of contraceptives increased as follows:

	2005	2006
OCs (cycles)	11.4 million	12.8 million
Injectables (vials)	146,000	417,000
IUDs (units)	92,500	100,000

Observations

Sales of OCs in 2005 were 11.8 cycles, exceeding performance targets by 3.5 percent. For the first half of 2006, however, initial readings show a decline in the sales of OCs; this trend has to be reversed. Dharmendra Khumar Tyagi (DKT) brands (*Trust* and *Lady*) have the biggest market share, 96 percent. Sales of injectables in 2005 were 219,000 vials, exceeding performance targets by 50 percent. Sales of injectables in the first half of 2006 were also ahead of performance targets. Please refer to the following graphs for more information. (Sales figures for IUDs were not indicated in the reports the assessment team received.) Most of the sales data are available through International Medical Statistics (IMS Health). DKT data are not fully accessible. Many key stakeholders within PRISM do not know the updates on trends in sales and market shares.

Three pharmaceutical companies have been given grants for the launch and relaunch of two combined oral contraceptives (COCs), one progestin-only pill (POP), and one injectable. As of June 2006 the combined sales of grantees are below expectations. Deficits are mainly due to the low sales performance of *Seif* and *Daphne*. PRISM needs to monitor the grantee companies more closely and provide assistance to help ensure that the performance targets are met within the grant periods. There is also a need to fast-track the introduction of other commercial brands in the segment, including support for at least one brand of IUDs.

The project should consider optimizing the use of grant funds by allocating the amount of the grant based on the sales it can generate (in terms of products sold and distribution). It was noted that the first three grantees were given the same amount of money ($250,000) even though the expected sales were different (PhP 6.4 million to 57.9 million).

While the grants program is encouraging more brands to enter the market, the projected sales, nature of the contraceptive (such as COC, POP, injectable, or IUD), and the current size and potential size of the market's sub-segment should be considered when determining the grant amount Based on its current size and growth potential, PRISM should give the COCs more grant funds than injectables, POPs, or IUDs.

Recommendations

PRISM should provide additional support to grantees to enable them to reach performance targets by the end of the grant period. The project should conduct monthly business review meetings with grantees during the first quarter of the grant period and every other month in subsequent quarters. Finally, PRISM should develop a forecast of acceptors per month for each area and product and incorporate that information into the efforts of Components 1 and 3.

The launch of additional brands, including *LoGentrol*, a generic OC and one brand of IUD, should be fast-tracked. Furthermore, PRISM should develop a strategy for the commercial availability of *LoGentrol*, including a public/private referral system for *LoGentrol* users.

Regarding communications, the project should develop and implement an aggressive and sustained program that will reach all stakeholders. This endeavor can be accomplished in coordination with the grantee firms.

PRISM should develop and strengthen its relationship with DKT and try to increase the availability of complete sales data of DKT products. The project should adopt a conscious strategy for interaction with DKT, as discussed further in section 4.5.

For the allocation of grant funds PRISM should review the existing criteria and mechanisms. It should consider providing more grant funds for products that are projected to sell better and have a larger market share on a sustainable basis.

4.1.2 STRATEGY 2

Establish an enabling environment by addressing the barriers that impede or restrict market development.

Performance Measures

No performance measures were in the PMP, but benchmarks in the work plan include

- providing PRISM components and other partners with regular tracking on market data to include not only the commercial sector but the free markets as well
- the timely release of the sixth edition of the Philippine National Drug Formulary (PNDF), which includes 11 additional formulations
- fast-tracking of product registration with the Bureau of Food and Drug (BFAD) Administration through an express lane for registering contraceptives
- evidence-based medicine (EBM) training for the medical representatives of the grantee firms

Observations

Project staff and other partners are not updated regularly on market trends for commercial and free markets. Also updated market data is not optimized in sales forecasting and strategy development.

PRISM has worked successfully with the Department of Health (DOH) on the inclusion of 11 additional formulations in the sixth edition of the PNDF. While efforts to establish an express lane for contraceptives did not materialize, the BFAD directors agreed that the bureau has started to streamline the registration process for all products. That process now can be reduced to about three to six months. The EBM training module has been developed for implementation in the latter part of 2006.

Recommendations

To have a market-driven mindset, PRISM must ensure that staff members are informed of the latest market trends. It should support the development and regular review of sales forecasts and marketing strategies at national and local levels. Targets on FP acceptors should be established and monitored from efforts in Components 1 and 3.

The project should develop and use a database of potential sources of new acceptors including lying-ins, midwives who provide delivery services in homes, and general practitioners. PRISM also should implement a new EBM training module for medical representatives and reach out to more women and HCPs, with focus on addressing misconceptions about contraceptives.

4.1.3 STRATEGY 3

Create partnerships to expand and exploit the market

Performance Measures

No performance measures were in the PMP, but benchmarks in the work plan include

- holding a CEO summit among pharmaceutical partners
- organizing an international trade mission of contraceptive manufacturers to offer local companies more products to market

Observations

The CEO summit was conducted in December 2005 and a strategy-formulating committee, composed mainly of pharmaceutical partners' CEOs, was formed to prepare action points on the consensuses reached. There have been gaps in communications, however, and the strategy-formulating committee's activities need to be revived.

PRISM conducted a trade mission in March 2006. It assembled a new set of manufacturers from the developing world, and new marketers in the Philippines. There were initial interests expressed after the trade mission, including local marketers' interest in several brands of OCs, injectables, and IUDs. The communications, however, slowed after the trade mission and PRISM needs to help re-establish them.

PRSIM has developed links with local government units (LGUs), HCPs, and workplace institutions. Such linkages have been documented in the regular reports of PRISM regional directors for Manila/Luzon, Visayas, and Mindanao. The objectives and results from these linkages, however, need to be specified and monitored.

Recommendations

The project should build, rebuild, and strengthen working relationships within PRISM and with other partners and stakeholders. Steps include resuming communications with the strategy-formulating committee and with the companies that have expressed interest in new product launches during the trade mission.

PRISM should plan, conduct, and document its project managers' field visits to partners. The expected outcomes from linkages with LGUs, HCPs, and workplaces should be quantified in terms of sales and new FP acceptors. They should be monitored and documented regularly. And PRISM should share and celebrate its successes and efforts towards teambuilding.

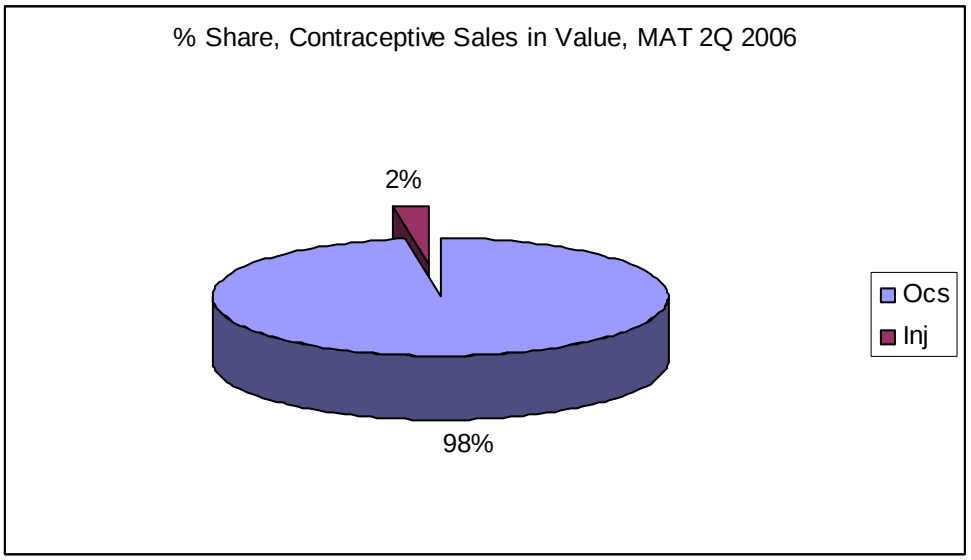
4.2 OVERVIEW OF THE CONTRACEPTIVES MARKET IN THE PHILIPPINES

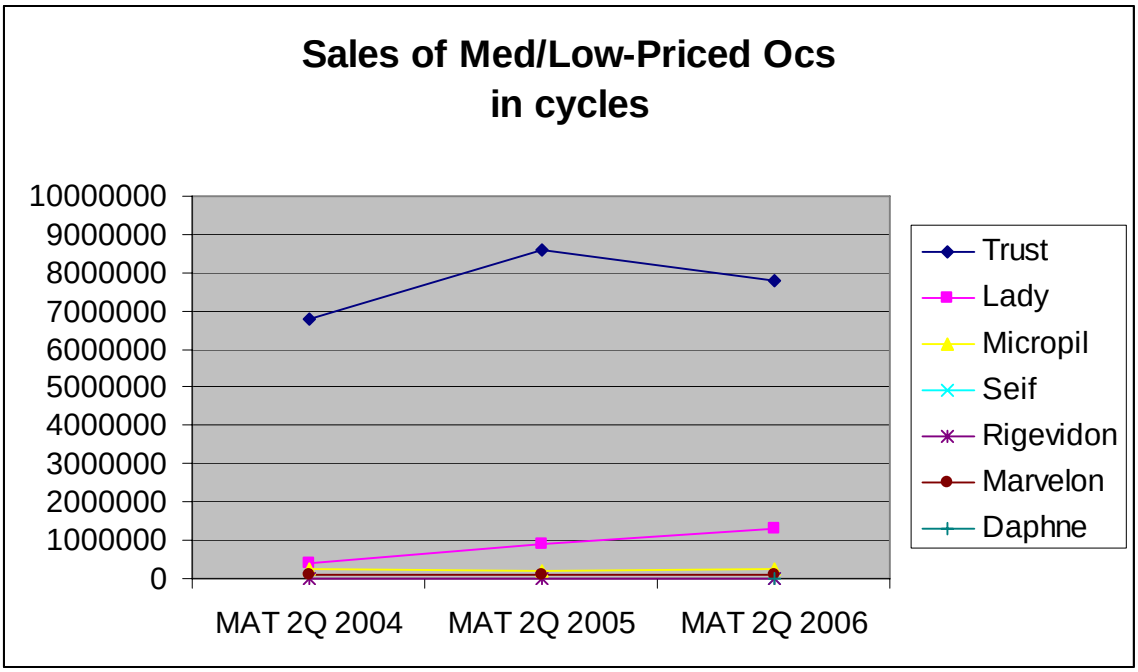
The commercial contraceptive market in the Philippines has grown 25 percent since 2004, with sales of PhP 800 million ($15.7 million).[10] OC pills dominate the market with a 97 percent market share, followed by injectables with 3 percent of the market. DKT brands, including *Trust Pill*, *Lady Pill*, *Depo-Trust Injectable*, and *Lyndavel Injectable*, dominate the commercial market with a combined volume share of 96 percent of the medium- and low-priced pills (having retail prices of PhP 100 and lower) and 100 percent of the medium- and low-priced injectables. DKT recently launched a generic OC aimed at the LGU market. Priced at PhP 19.50 per cycle, this pill is the lowest-priced one in the Philippines. DKT has established about 80 POP shops (down-scale distribution centers for FP products) in selected provinces, partly funded by the United Nations Population Fund.

In terms of OC market composition, medium- and low-priced OCs represent 82 percent of the total OC volume market; premium-priced brands constitute the remaining 18 percent of the market. Data from IMS indicate that the market segment for medium- and low-priced OCs grew 30 percent between 2004 and 2005, to 9,766,187 cycles. In 2006, however, the segment declined by 3 percent to 9,481,952 cycles. This negative growth rate is due to the decline in sales of the market leader, DKT's *TRUST* pill. While the volume sales of *TRUST* grew by 27 percent from 2004 to 2005, it declined by 9.1 percent from 2005 to 2006. Sales of medium- and low-priced injectables grew 688 percent, from 51,588 cycles in 2004 to 406,620 cycles in 2005, mainly due to the introduction of DKT's *Depo-Trust*. The segment grew an additional 21 percent in 2006, primarily due to *Depo-Trust* and the PRISM-supported *Lyndavel* of DKT and ECE Pharmaceuticals.

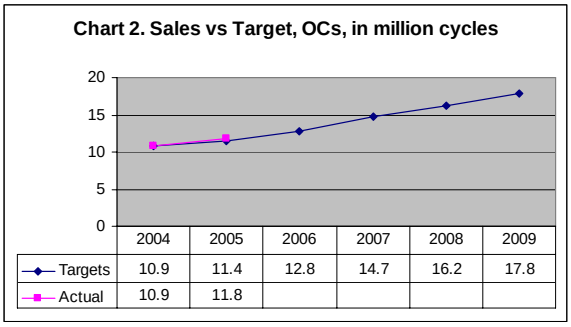
[10] The exchange rate is 51 PhP to $1.


Contraceptive Market, Philippines
in million pesos
1000.0
800.0
600.0
400.0
200.0
0.0
Inj
OCs
MAT 2Q 2004
MAT 2Q 2005
MAT 2Q 2006
Inj 7.2 15.8 19.7
OCs 633.3 736.3 780.9

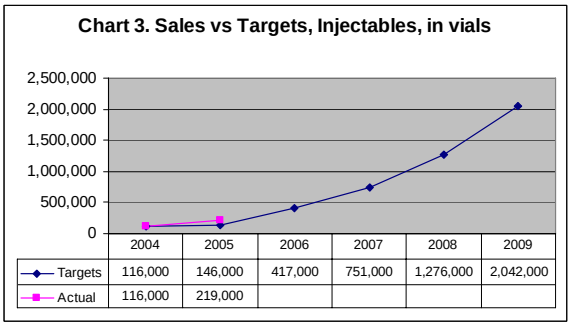

% Share, Contraceptive Sales in Value, MAT 2Q 2006
2%
98%
Ocs
Inj



4.3 CURRENT PERFORMANCE



Component 2's targets for OCs and injectables for 2005 were surpassed. The charts on the left show the baseline for 2004, targets for the five-year period (2005 to 2009), and achievements for 2005. The mid-year 2006 sales, however, show a decline for OCs, (this result is discussed in more detail later in the report).



Component 2's strategy is appropriate and the objectives of developing the contraceptives market to PRISM targets are challenging but realistic and achievable. The targets for the injectables may appear ambitious, but only because of a low base and low share in 2004. Sustainability of the brands beyond the grant period and the project life is also challenging but possible. With the needed mechanisms in place and with concerted efforts to move forward, the CPR goal can be achieved.

4.3.1 GRANTS

PRISM's marketing grants were designed to fuel the launch and initial year of marketing for medium- and low-priced brands and contribute to contraceptive self reliance (CSR). The DOH has acknowledged and recognized PRISM's efforts in providing contraceptive options for HCPs and women. The brands that grants support are priced within the reach of the target market, defined as women who can afford and

prefer medium- and low-priced contraceptives. During the past two years, PRISM worked on developing the market segment for medium- to low-priced products, which led to the launch or relaunch of four contraceptive products. The grants are expected to grow the market by 1.9 million cycles and PhP 86.4 million ($1.7 million). PRISM has supported three pharmaceutical companies through grants for four brands.

- Schering Philippines, for the launch of the *Seif* OC
- Organon Philippines, for the relaunch (at a reduced price) of the *Marvelon* OC
- ECE Philippines, for the launch of two brands of *DKT/Lyndavel* (an injectable) and *Daphne* (a POP)

In addition PRISM is finalizing its support for the launch of Wyeth's *LoGentrol* pill in the commercial sector. PRISM also has plans to launch a new IUD.

With these four product grantees (three OCs and one injectable), plus an additional two to three hormonal contraceptive brands, PRISM can fuel this market segment to grow at a faster pace and reach the target of growing the OC market by 62 percent and the injectables one by 1,663 percent by 2009. The assessment team proposes no additional support for injectables.

The newly launched and relaunched products have started to gain new users. The performance review of each grantee follows.

Marvelon

Marvelon's volume sales grew by 44.2 percent from 2005 to 2006, which is a major accomplishment considering that the segment as a whole posted a volume decline of 3 percent for that period. Organon attributes this success to the combination of focused strategies for the HCPs, a cost-effective interactive radio campaign, and links with other stakeholders. The following table indicates the major elements in Organon's marketing of *Marvelon*.

ELEMENTS OF ORGANON'S MARKETING STRATEGY FOR *MARVELON*	
Medical Marketing	Dedicated sales represenatives for *Marvelon* alone
	Detailing and sampling to midwives,general practitioners, obstetricians, and gynecologists
	Participation in medical conventions of HCPs
	Participation in PRISM events (for example, Business Enhancement Support and Training (BEST))
	Print advertising in medical publications
Consumer marketing	"Radyo Edukasyon" (Radio Education) radio program
	Sending text messages (using mobile phones) as participation in the radio program
	Link with the Satisfied Users and Acceptors Club
Others	Link with the Family Planning Organization of the Philippines by having *Marvelon* in its clinics
	Leveraging the company's budget for corporate social responsibility and corporate affairs to finance the radio program

Lyndavel

Lyndavel sales reflect an equivalent of 40,740 cycles as of June 2006, significantly ahead of PRISM's target of 8,064 cycles. By the end of September 2006, *Lyndavel* sales exceeded target sales for the entire year. This success is attributed mainly to the positive response and purchase by LGUs. *Lyndavel* is the lowest-priced injectable in the market, retailing at PhP 65 per vial.

SEIF

Seif, a Schering brand, has achieved only 0.5 percent of its target as of June 2006. As a result Schering has modified some of its strategies: it has reduced dependence on midwives and is now focusing more on physicians. *Seif*'s sales must increase dramatically to meet its year-end targets.

The sales targets for *Seif*, however, represent 76 percent of the combined volume sales targets of the grantees. Hence, poor sales of this brand have a significant effect on the combined performance of the grantees. There is a need to support and fast-track the sales and market-share development of the brand. Working with midwives is new for the company; in the past Schering mainly has marketed to physicians and health institutions in the premium segment. In addition the planned partnership between Schering and the National Confederation of Cooperatives (NATTCO) did not materialize because of a re-organization and change in NATTCO's leadership. NATTCO has a network of more than 1,200 member co-ops and over 1.2 million individuals as members. It is considered the strongest co-op network in the country. Through its health card program (NATTCO Health Solutions Inc.), Schering planned to cofinance the health card and achieve 70 percent of its *Seif* annual sales target through NATTCO. The planned memorandum of agreement did not materialize despite several attempts by Schering. Obviously, the failure for this relationship to materialize has impacted *Seif*'s sales. Schering has put alternative mechanisms into place, but the outcomes are not expected to be at the same level as those in the original NATTCO partnership.

Based on the assessment team's analysis, Schering does not have much experience working with midwives. Before *Seif*'s launch the company's portfolio was composed of products for the A and B socio-economic classes. Hence it has worked mostly with obstetricians and its experience is mainly with premium-priced products. In contrast the other companies in the target segments have been in partnerships with private and public midwives for years. Schering needs to build relationships with these groups to fast-track *Seif*'s growth in sales and market share.

Seif is a good product, has a brand name upon which a campaign can be based, and has strong market potential, but its marketing elements need to be revisited and supported by additional technical assistance. Suggestions for PRISM include

- meeting with Schering to identify and quantify performance gaps and develop a plan to immediately address the poor sales
- developing with Schering a strategy for midwives in terms of detailing, sampling plan, and other tactical activities; supporting additional links between Schering and midwife associations in coordination with Component 3
- creating a forecast of sales and acceptors for the balance of the grant period and monitoring the performance
- initiating a more focused product promotion and distribution plan that will help off-set the expected results from the partnership with NATTCO that did not materialize

Schering plans to launch other contraceptive brands in this segment, but the company's subsequent moves will depend *on Seif*'s performance. If *Seif* is not successful, Schering may shelf plans for further participation in the medium- and low-priced segment.

Daphne

This POP by ECE and DKT has achieved only 28.5 percent of its target sales as of June 2006. It continues to face competition from Organon's *Exluton* and has suffered from stockouts during the initial phase of its launch. Based on interviews with ECE, the initial stockouts of *Daphne* are due to start-up problems with the supply source. The situation has been addressed and the supply chain now works well. ECE is confident that the year-end sales target for the product will be attained.

4.3.2 COMBINED PERFORMANCE OF GRANTEES

As of June 2006 the combined performance of sales versus targets for the grantees was 44.2 percent in value and 21.9 percent in volume. The deficits are primarily due to the low sales of *Seif* and *Daphne*. The combined sales deficits for these two brands are PhP 19,305,241 or 610,622 cycles. If *Seif* achieved even half of its cumulative June targets, the corresponding sales of 300,000 cycles would easily off-set the decline in sales of *Trust*. The following table shows sales versus targets for grantees. Additional sales information is in Annex 5.

GRANTEE SALES VERSUS TARGETS AS OF JUNE 2006 (VOLUME, IN CYCLES)

	Actual sales (June 2006)	Target sales (June 2006)	Percent of June 2006 target accomplished	End-of-grant target	Percent of end-of-grant target accomplished	Date of end-of- grant period
Seif	2,975	600,000	0.5	1,500,000	0.2	July 2007
Marvelon	120,764	149,733	80.7	374,332	32	March 2007
Daphne	6,888	24,192	28.5	60,480	11	May 2007
Lyndavel	40,740	8,064	505.2	20,160	202	May 2007
TOTAL	171,367	781,989	21.9	1,954,972	0.9	

Sources: IMS and grant agreements

The IMS data on market trends and the sales performance of grantees needs to be available to all members of the PRISM team so it can be fully utilized to develop and modify strategies. To market effectively to HCPs, the universe of private lying-ins and birthing homes and the average caseload of each facility still needs to be compiled. PRISM needs to use the number and distribution of such facilities when forecasting and prioritizing sources of users.

IMS has not completely captured the sales data for *Trust* and *Lady* by DKT. As they are the top brands in the segment, it is critical for this information to be available on a regular and timely basis.

Recommendations

PRISM and grantees should conduct business-review meetings more frequently, especially during the first two quarters after the launch.

Frequency of business reviews	
First quarter	Monthly
Second through fourth quarter	Bi-monthly

Each business-review meeting should tackle the grant's key elements, focusing on the items in the following table.

Business review key elements	
1	Sales versus targets, in value and volume
2	Market share versus target, in value and volume
3	Factors affecting positive and negative developments
4	Action plans, including any revision of the strategic marketing plan and the elements of the marketing mix
5	Updated forecast of sales for the balance of the grant period

Conducting business-review meetings should be incorporated into the milestones and deliverables of the grantees. Such meetings can help in the early identification of enhancing and deterring factors and in making timely interventions needed for achieving the grant's objectives.

The project should consider optimizing the use of grant funds by allocating the amount of the grant based on the sales it can generate (in terms of products sold and distribution). It was noted that the first three grantees were given the same amount of money ($250,000) even though the expected sales were within a wide range, as shown in this table.

Grantee50	Product name	Nature of product	Sales target (in PhP, millions)
Schering	*Seif*	COC	57.9
Marvelon	*Marvelon*	COC	22.1
ECE	*Lyndavel Daphne*	Injectable POP	6.4 (for the two products)

While the grants program encourages more brands to enter the marketplace, the projected sales, the nature of the contraceptive (such as COC, POP, injectable, or IUD) and the current size and potential size of the market sub-segment should be considered when determining the grant's amount. The divergence in sales targets among grantees was due partly to the products having different marketing strategies.

According to grantees (Schering, Organon, and ECE) and potential grantees (Wyeth and Marketlink) in information they shared during interviews with the assessment team, there is a need for continuing communication between them and PRISM. The proposed business-review meetings, plus sustained exchanges of communications, can help address this need.

Another factor that affects volume targets is the size (current and potential) of the sub-segment of the market in which the product is competing. For example, *Lyndavel* is an injectable and competes in a much smaller market segment than the COCs. Similarly, *Daphne* is a POP; this sub-segment is also much smaller than the COC sub-segment. Hence, PRISM should modify its policy of providing the same grant fund for different sales targets.

As indicated previously considering the pro-rating of the grant amount to the potential sales can optimize the use of the grant funds. Generally, COCs should be given more grant funds compared to injectables, POPs, or IUDs.

4.4 SUSTAINABILITY

The projected impact of the marketing grants in the medium to long term is the gradual increase in the share of the medium- and low-priced segment from 77 percent in 2004 to 83 percent of the total OC market by 2009. Reviews of the marketing plans indicate that the brands PRISM's grants support can be sustainable and profitable for the firms after the grant period. The critical factors that will affect enhanced sustainability follow in the form of recommendations.

Recommendations

- Achievement of the sales targets during the grant year (2006 to 2007): It is important to establish an initial volume base for further growth. The volume decline in the first half of 2006 must be stopped. This factor highlights the need to help ensure that *Seif* achieves the objectives set during the grant period and that *LoGentrol* is launched as soon as possible.
- Perception of an even playing field with DKT: Pharmaceutical companies feel that the playing field has not been even, as DKT has received marketing grants from Kreditanstalt Für Wiederaufbau (KfW) and other funding agencies. As the nature of external support for DKT is changing in line with the DOH's CSR policy, pharmaceutical companies should be informed of this shift and of their enhanced ability to compete in the market segment as a result.
- Efforts to sustain market growth in the presence of a large social marketing program: As noted previously DKT brands dominate this segment of the market. Of the medium- and low-priced OC market, *Trust* has 83 percent and *Lady* has 14 percent; for injectables, the two products in the medium- and low-priced segment are both DKT brands. In the long term it is best to have a market structure in which the HCPs and users will have easy access to a range of brands in terms of pricing and distribution. It is possible to increase the share of the other brands in the segment. The fact that the other non-DKT brands have sustained market presence is a good indicator that healthy growth rates in sales and market share are achievable, even with a social marketing program in place.

  The following table presents sales data for all medium- and low-priced OCs in the market.

SALES OF MEDIUM- AND LOW-PRICED OC BRANDS (VOLUME IN CYCLES)

Brand	Suggested Retail Price (PhP)*	MAT 2Q 2004	MAT 2Q 2005	Growth Rate	MAT 2Q 2006	Growth Rate
Lady	25.75	394,309	887,878	125%	1,324,931	49.2%
Trust	35.00	6,775,424	8,581,964	27%	7,797,280	-9.1%
Micropil	44.00	243,396	201,120	-17%	235,980	17.3%
Seif	56.00	0	0		2,975	NA
Rigevidon	67.00	9,681	11,505	19%	22	-99.8%
Marvelon	72.00	92,120	83,720	-9%	120,764	44.2%
Daphne	85.50	0	0		6,888	NA
Total		7,514,930	9,766,187	30%	9,488,840	-2.8%

Sources: IMS and ECE (for *Daphne* sales)

These data indicate that *Micropil* has reached a level of 235,980 cycles in 2006 even without a PRISM grant or internal active marketing support. *Micropil* is the third brand in the segment. *Marvelon* reached a volume base in 2005 of 83,720 cycles, also without a grant from PRISM (PRISM's grant started in early 2006). These sales were achieved even though the prices of *Micropil* and *Marvelon* are higher than the prices of DKT's *Trust* and *Lady*. These data suggest that other brands can grow in a market environment in which socially marketed products dominate.

Client groups that companies marketing medium- and low-priced contraceptives should tap include the ones in this table.

Type	Comments
Private midwives	The database of profiled private midwives that PRISM started should be amplified. Profiling should include patient load and level of capacity to pay. Business-development strategies, especially for private midwives with a lot of patients, should be initiated. Microfinance links should be pursued until there are financing options to expand and improve the practices of the midwives concerned. Component 2 should coordinate with Component 3 in forecasting sales the private midwives can generate; these forecasts should be evaluated at least quarterly.
LGUs	A strategy to prioritize LGUs for phaseout of free pills would be useful for targeting contraceptive sales.
Other distribution channels, such as cooperatives and Botika ng Barangays	Efforts to have medium- and low-priced contraceptives in the Botika ng Barangays outlets should be encouraged by the project. Other distribution channels, like cooperatives, should be pursued.
Drug stores and the Drug Store Association of the Philippines (DSAP)	PRISM should encourage its pharmaceutical partners to develop communication strategies and materials directed to drugstores and their staff.
Other women organizations	Communication strategies from PRISM's pharmaceutical partners also can target these groups.

- Limiting the number of grantees to five to six for the OCs: Presently, there are three product grantees for the OCs, and the assessment team recommends PRISM add at most an additional two to three product grantees. The market size for the medium/low-priced segment in 2006 is approximately USD 15.7 million. While the project is mandated to provide more product options to HCPs and users, the pharmaceutical companies will be more interested in participating if there are not too many competitors to contend with relative to the value and growth rates in the segment. Otherwise, they may decide to focus their efforts on the other segments where there is a better likelihood for success.

  This table provides price ranges proposed by the assessment team for the different contraceptives for 2007.

Type of product	Suggested price range, 2007, PhP
COC	50–80
POP	88–99
Generic OC	36–45 (subject to pricing strategy studies)

  The suggested pricing is based on the following table.

CURRENT AND PROJECTED PRICE OF OCP BRANDS IN THE MEDIUM- AND LOW-PRICED SEGMENT

Type	Brand	Company	Current retail price, 2006 PhP	Projected retail price range, 2007, PhP (after grant period)
COC	*Marvelon*	Organon	72	78–86
	Rigevidon	Cuvest	67	72–80
	Seif	Schering	56	60–66
	Micropil	Dyna	44	48–52
	Trust	DKT	35	38–42
	Lady	DKT	26	28–31
POP	*Daphne*	DKT and ECE	86	93–99

The current prices are projected to increase by the middle of 2007 by 8 to10 percent; products a PRISM grant supports may increase their prices after the grant period. The proposed pricing will provide enough resources for the companies to continue with promotions and sustain profitability, even without grant support.

For the COCs (the most popular product among the OC pills), the price range of PhP 50 to 80 per cycle translates to PhP 1.67 to 2.67 per day, which is still affordable. This information will help when explaining to HCPs and users that quality COCs are within their reach.

The suggested price range is higher for POPs, as they typically are more expensive than COCs, mainly because of a more specialized formulation. The suggested price range of PhP 88 to 99 per cycle translates to a range of PhP 2.93 to 3.30 per day. This cost is still affordable for the target women, namely those who are breast-feeding and still want to enjoy the benefits of effective, modern contraception.

For the generic OCs, the suggested price range of PhP 35 to 45 should be subject to pricing studies, especially as the Philippine market has not had a generic OC for many years. The sales trends for DKT's newly launched generic OC also should be monitored; lessons may be learned from this development.

The assessment team also proposes that PRISM conduct market research studies on the optimum pricing for the OC pills and other contraceptives. The factors these studies should consider are affordability by the end user, sustained profitability for the company, and the ability of each company to sustain a good health-communications program.

4.4.1 NOTE ON THE MARKET SATURATION OF THE CURRENT BRANDS

With the exception of the DKT brands *Trust* and *Lady*, the market penetration of current brands in the middle- and low-priced segment is still ongoing. The addition of new brands and the promotion of existing brands in this segment (again with the exception of *Trust* and *Lady*) started just this year with the PRISM grants. The grants began in the first and second quarters of 2006 and these products are still in the launch and relaunch stage. Hence market-penetration information may be too early to be conclusive. (Also, the data this assessment analyzes are for the period ending June 2006.)

Based on interviews with the stakeholders, inputs from the DOH, and the market response to DKT's brands, however, more brands in the medium- and low-priced segment are welcome, as they will provide more options for HCPs and users. Hence, it is critical to monitor the performance of the

brands being introduced and relaunched and to conduct frequent business-review meetings with the grantees.

Sustained market growth can be further achieved through

- prioritizing resources and efforts on brands with more potential for volume generation, such as *Marvelon*, *Seif*, *LoGentrol*, and *Micropil*; *Marvelon* has had a volume growth of 44 percent, while *Micropil*'s sales volume is almost twice that of *Marvelon*
- developing and implementing an aggressive and sustained health-communications program that will reach all stakeholders to keep brands in the minds of the HCPs and users
- encouraging grantees' efforts to strengthen relationships with those who prescribe the products, especially private midwives
- supporting efforts for wider down-scale distribution, including linkages with Botika ng Barangay
- exploring non-traditional partnerships for product placement and distribution

For the OCs, there are existing brands that are affordable with good generic formulations that can be considered for grants, including

- *Micropil*—locally manufactured by Pascual, marketed and distributed by Dyna
- *Perlas*—locally manufactured by Pascual, no known marketing efforts
- *Rigevidon*—imported by Cuvest Pharma, with no marketing efforts

Among the three OCs, *Micropil* has the largest volume base with over 235,000 cycles. This figure can be projected to grow further with additional marketing efforts. It is ranked third in this segment, after *Trust* and *Lady*; as such it s a good candidate for PRISM's support.

Dyna applied for a grant to support the marketing of *Micropil*. Its proposal was among the first ones that PRISM received in 2005. The proposal, however, did not comply with the requirements in the request for assistance. This problem could have happened because Dyna is mainly a distributor and does not have the capability to execute this type of marketing activity. PRISM has been in contact with Dyna to work out a means for helping the company prepare a complete proposal.

PRISM also should consider supporting a generic OC that can provide an additional low-priced product that HCPs and users will find more affordable. This option could increase the sales of OCs to the LGUs. The following table shows two scenarios that PRISM should consider for additional product grants in 2007 (depending on project funding). In scenario A, PRISM supports five OCs, one injectable, and one IUD; in scenario B, PRISM supports six OCs, one injectable, and one IUD.

Recommendations

It is possible to sustainably grow the market in the presence of a large marketing program. Implementing these recommendations will help ensure the market's sustainable growth:

- initiate a strong, continuing health-communications program on top of what pharmaceutical partners are doing
- map LGUs that are ready to purchase contraceptives and monitoring repeat purchases
- sustain and help strengthen the capacities of the private midwives to expand their roles in the

provision of MCH services

- pursue the microfinancing of HCPs so they can expand their facilities and services
- recognize and award deserving HCPs and health institutions
- establish a continuously functioning public/private referral system directed towards midwives in private practice (this suggestion is unlikely to happen until donated and free commodities are not available in the public sector; therefore it may not occur during the PRISM project)

4.4.2 ALTERNATIVE SCENARIOS FOR PRISM'S SUPPORT OF CONTRACEPTIVES

SCENARIOS FOR CONTRACEPTIVES IN THE MEDIUM- AND LOW-PRICED SEGMENT									
Type	**Current 2006 Scenario**			**2007 Scenario A (additional PRISM support for one OC and one IUD)**			**2007 Scenario B (additional PRISM support for two OCs and one IUD)**		
	Brand	**Company**	**Status**	**Brand**	**Company**	**Status**	**Brand**	**Company**	**Status**
OCs									
	Trust	DKT		*Trust*	DKT		*Trust*	DKT	
	Lady	DKT		*Lady*	DKT		*Lady*	DKT	
	Daphne	DKT and ECE	Grant	*Daphne*	DKT/ECE	Grant	*Daphne*	DKT and ECE	Grant
	Seif	Schering	Grant	*Seif*	Schering	Grant	*Seif*	Schering	Grant
	Marvelon	Organon	Grant	*Marvelon*	Organon	Grant	*Marvelon*	Organon	Grant
	Micropil	Pascual and Dyna		*Micropil*	Pascual and Dyna	Grant	*Micropil*	Pascual and Dyna	Grant
	Rigevidon	Cuvest		*Rigevidon*	Cuvest		*Rigevidon*	Cuvest	
	DKT Generic	DKT		*LoGentrol*	Wyeth and Marketlink	Grant	*LoGentrol*	Wyeth and Marketlink	Grant
				DKT Generic	DKT		*DKT Generic*	DKT	
							"Generic A"		Grant
Injectables									
	DepoTrust	DKT		*DepoTrust*	DKT		*DepoTrust*	DKT	
	Lyndavel	DKT and ECE	Grant	*Lyndavel*	DKT and ECE	Grant	*Lyndavel*	DKT/ECE	Grant
IUD									
				IUD A		Grant	IUD A		Grant
Grantees			3 OCs 1 injectable			5 OCs 1 injecatble 1IUD			6 OCs 1 injecatble 1IUD

This table lists the expected implications or project impact for each scenario.

Scenario A Five OCs, one injectable, and one IUD as grantees	• The medium- and low–priced segment will grow at rates faster than in the prior years. • *LoGentrol* will be purchased continuously, especially by core users who had good experiences with the product. • HCPs and users will have access to more health communication materials. • There will be a wider availability of the different types of contraceptives. • *Trust* and *Lady* may increase their prices as donor support declines. • The DKT generic product will monopolize the generic OC sub-segment.
Scenario B Six OCs, one injectable, and one IUD as grantees	The impact of scenario B will be almost the same as with scenario A, except for the following: • The market segment will grow at an even faster rate, as there will be more demand-creation activities. • With two generic OC products in the market, there will be healthy competition, with each company working to provide better pricing, better distribution reach, and better service to clients.

A more detailed study can be done for each scenario if quantitative projections on the project's impact are needed.

In terms of the long-term impact of pricing strategies, the low-priced pill will have more of an impact on the target market in the long term. Retail price levels of PhP 50 per cycle for OCs and PhP 95 per vial for injectables are more sustainable. As mentioned previously, *Micropil* ranks third in its segment; it retails at PhP 45 to 50 per cycle. Unlike the DKT brands, *Micropil* has no donor support, but it has managed to be profitable.

Assigning a price ceiling for PRISM-supported products may not be a practical approach. The sales projections for the brands are at different volume levels, ranging from a low of 20,160 cycles for *Daphne* to a high of 1,500,000 cycles for *Seif*. The corresponding cost of goods as a percent of net sales will likewise vary. A price ceiling would not encourage manufacturers with lower volume levels and it would be a deterrent for the pharmaceutical companies involved. Allowing the pharmaceutical companies to compete in a free market is a more viable and sustainable option.

Affordable commercial IUDs are needed in this market. There are good reasons to believe that such IUDs can be viable in the long term. The proportion of IUD users who obtained the device from a private source has increased from 14.9 percent in 2004 to 18.3 percent in 2005. PRISM aims to further expand this portion to 59.3 percent by 2009. PRISM should support at least two commercial IUDs in the medium- and low-priced segment. PRISM's remaining grant funds are limited, however, but the assessment team suggests the project support at least one commercial IUD in 2007. Other brand introductions can be encouraged as the market segment grows. Ideally there should be two to four commercial brands in this segment. This effort can be matched with a corresponding training of midwives on IUD insertion through Component 3, which private sector midwives have requested.

Fertility-awareness based (FAB) methods, while considered modern, are not as convenient for end users. Data show that FAB methods continue to have a low level of usage. Nevertheless, given the need to provide FAB options, it is important to provide airtime for these methods, although the effect on the increase of CPR is not expected to be significant airtime should be allocated among more widely used methods like OCs, injectables, and IUDs. It should include, however, the following FAB methods, especially in the light of the integration of MCH in PRISM's strategic approach:

- the lactation amenorrhea method, which fits well with the breast-feeding campaign that midwives and other HCPs are conducting

- the standard days method (SDM) and the use of the cycle beads—this method is popular with some midwives as a modern and scientific form of birth control (additional support via more airtime can help increase CPR especially among those who will not avail themselves of modern methods)

4.4.3 APPROACHES IN INTEGRATING MCH INTO PRISM'S STRATEGY

PRISM can encourage existing grantees to promote MCH campaigns, such as safe motherhood and breast-feeding. Other pharmaceutical companies with MCH products for the C and D socio-economic segments (such as pre- and post-natal vitamins, products to encourage lactation after birth, vitamin drops for infants, products used for alleviating fever and pain in children, and supplies midwives use in their clinics) can be invited to PRISM-supported events for midwives and general practitioners. These meetings will help expand the midwives' network as they build clientele and expand their practices. To an extent, PRISM already is encouraging these encounters in collaboration with the Banking on Health project through the Matching Fora (Entre-PINAY Forum) for private midwives. This approach appears to be successful and its continuation is warranted.

4.5 RECOMMENDATIONS

- As a private sector project, PRISM must have a market-driven mindset, including the following mechanisms:
    - developing national and regional forecasts in sales and shares, regularly checking on the forecast's accuracy, and immediately addressing issues encountered
    - monitoring new FP acceptors from efforts in Components 1 and 3, as well as monitoring CPR and private sector use via annual survey data
    - utilizing a functional database of potential sources of new acceptors that includes lying-ins, midwives providing delivery services in homes, and general practitioners; PRISM can develop linkages with the Newborn Screening Project of the National Institutes of Health, which keeps records of all babies born nationwide (these HCPs and health care institutions can be ranked by patient load and clientele to help guide in establishing priorities)
- PRISM needs to better monitor grantee performance and provide support to ensure annual targets are achieved. PRISM can conduct monthly business-review meetings with grantees during the first quarter of the grant period and every other month in subsequent quarters. PRISM also should forecast the number of acceptors per month for each area and product and incorporate this information into efforts in Components 1 and 3. Regular interactions between component managers will help priorities and performance measures be identified.
- PRISM partners, such as pharmaceutical companies, national and local drugstore associations, and midwifery groups, have been proud of their work with PRISM and USAID. Gaps in communication have occurred, however, as Wyeth, Schering, DKT, and Organon expressed. The relationship with the DSAP needs to be revived as well. The continual turnover of personnel in Component 2 may have affected the continuity of communications. There is also a need for close inter- and intra-component coordination.

  Project managers need to program, conduct, and document regular field visits to partners as well. PRISM representation to marketing executives of the pharmaceutical healthcare industry also can support the process of building and strengthening relationships.

The initial strategy for partnership with DSAP that PRISM developed was to train the drugstore staff in providing correct and appropriate information to clients, especially in addressing misconceptions. PRISM, however, decided that grantees and pharmaceutical firms would better implement and this strategy. This decision was appropriate, especially as there will be additional product focus as the different brands are promoted to drugstores and their staffs.

In addition to working with the grantee firms to develop and implement a communications plan specifically for the drugstore staff; PRISM has decided to rebuild its relationship with DSAP and its members. Other ways of working with DSAP include developing training modules for the drugstore staff, implementing them through the grantee firms, and extending support during national conventions and local chapter meetings

- As previously noted, DKT dominates the medium- and low-priced segment of the market, with volume shares of 96 percent for pills and 100 percent for injectables. It is important for USAID and PRISM to be deliberate in crafting the project's approach to DKT.

  The space for PRISM-supported contraceptives, however, is not confined to the 4 percent of the market that DKT does not cover. But even if PRISM's share is tripled to 12 percent, most of the market is still with DKT. As PRISM's mandate is to grow the contraceptives market, there is a need to establish PRISM's strategic intent for DKT products and the other products in the segment. DKT believes that USAID's support for its brands will help achieve PRISM's goal of growing the market at faster rates. The assessment team believes that supporting DKT brands as well as other ones will have the greatest influence on the longterm growth of the contraceptives market. At the same time, it is important to communicate with other contraceptive manufacturers and suppliers about the potential for extensive growth and competitiveness in the market, to ensure market entry and the continuation of other brands.

  It would be useful for PRISM to have access to complete data on DKT's sales. Based on PRISM's analysis, about 90 percent of DKT's sales data can be accessed through IMS Health; the balance, however, is not available for analysis. Suggested measures to access complete data on DKT include

  - build and rebuild a relationship with DKT—there have been gaps in the working relationship with DKT over the past year that should be bridged

  - establish a mutually beneficial relationship with DKT—as PRISM attempts to get regular updates on DKT's sales, PRISM should share with DKT other information and technical support that may be useful for DKT (for example referrals to LGUs and private midwives)

  - communicate and meeting regularly with DKT's managers and holding coordination meetings locally with field personnel

  - build a relationship with KfW, DKT's major donor—the assessment team contacted the head office of KfW during the assessment; KfW is open to coordination activities with USAID and PRISM and it can help support the regular flow of information from DKT to PRISM

  Introducing quality contraceptives with prices comparable to those of DKT will not be sustainable. Prices at the levels of DKT's products only can be maintained with support from donor organizations for the social marketing of the brands. The current prices of DKT products are so low that they are not sustainable once donor funds are exhausted. It also can be assumed that when

donor funds become depleted, the prices of DKT products will increase. Alternatively prices can be held artificially low if pharmaceutical companies provide internal support from other products or other company resources for marketing, communications, and distribution efforts. This strategy, however, may be possible only in a few companies.

- Launching new brands can arrest and reverse the previously noted decline in the market segment. A portion of the grants budget has been allocated for one to two more brands, including *LoGentrol*. While preparatory work has been done for the *LoGentrol* launch, efforts are needed to fast-track it, especially as *Seif* is not meeting its targets. The launch of another contraceptive, such as *Micropil*, through a PRISM grant needs to be fast-tracked as well.

- *LoGentrol* continues to be the most widely used OC in the Philippines. In 2004 the family planning survey estimated 925,000 women use *LoGentrol*, with a corresponding consumption of about 12,025,000 cycles per year. With the phaseout of this free contraceptive, a strategy linked with LGUs is needed to help ensure that the *LoGentrol* users are identified, segmented, and referred to the private sector. This effort needs to be done in conjunction with an aggressive communications strategy.

PRISM should explore the possibility of making *LoGentrol* commercially available through other pharmaceutical marketing firms. As *LoGentrol* users represent the biggest share of OC pill users in the Philippines, they need an alternative source for the brand as the free pills are phased out. If such a source is not possible, the project should develop a strategic-alternative plan and implement it at the earliest possible time.

Alternative options include

- a customized, aggressive communications program targeting HCPs that provide free pills, private HCPs and the current users of *LoGentrol*. This communications plan should include users product options (those that are generically the same as *LoGentrol*), the HCPs with whom they should consult, and other related information. The basic objective of this communication plan would be to maintain the contraceptive practice of the *LoGentrol* users and to address possible gaps in the shift from *LoGentrol* to other products or other methods of contraception. A corresponding monitoring program should be in place.
- an information campaign with current grantees so they can have additional supplies and avoid stockouts that may result from the increased demand of other OCs by former *LoGentrol* users
- fast-tracking support for other brands like *Micropil* and a new generic OC. Care should be taken, however, that the generic OC to be supported is a quality product.
- closer coordination between the private providers and the public providers of free pills should be supported through regular dialogue and meetings

- PRISM's partners continue to express the need for a sustained program to communicate to HCPs, users, and the general public. Addressing misconceptions remains a high priority and it is critical for attaining PRISM's objectives. With the expansion into MCH, there is an even greater need for a well-crafted communications strategy for all the stakeholders, including HCPs, LGUs, workplaces, and users.

  PRISM has planned for the training of medical representatives on the use of EBM for detailing. The project has developed an EBM detailer-training module for implementation in the last quarter of

2006. This module will help enhance communications with the HCPs by medical representatives and address misconceptions.

- There are a number of success stories that PRISM can share to recognize performers and support others in reaching greater heights, including new linkages developed, increases in sales from an activity, and achieving short-term goals.

5. COMPONENT 3: PRIVATE PRACTICE SERVICE EXPANSION

5.1 COMPONENT STRATEGY

Component 3 was designed to expand the services of private practice providers to include the provision of FP MCH services and supplies. PRISM's Component 3 focuses primarily on private practice midwives with birthing homes; it includes training materials, trainers, marketing strategies, policy, linkages, and building capacity to sustain.

The Component 3 strategy is consistent with the project's overall objectives because women of childbearing age need accurate information about family planning options, easy access to the contraceptive methods of their choice, and support to use their chosen method effectively. In addition, midwives contribute to the provision of MCH services, especially for poor, pregnant women. The component's strategy also is consistent with research which shows that women in the Philippines prefer going to midwives for their reproductive health needs and that most women in the Philippines bear their children at home. Thus, it would be futile, and in some cases unsafe, to increase the variety of commodities and demand if primary health care professionals were not prepared to oversee women's use of these products.

It was difficult for the assessment team to identify and measure the performance of Component 3, as the targets have changed from training 10,000 midwives to training 1,800 midwives, 315 doctors, and 307 nurses, to establishing 500 PhilHealth-accredited or accreditable private midwives' birthing homes. Also complicating the picture, the clinical focus of training has been expanded to include more MCH topics and the current performance measures do not reflect these changes in activities. At the time of the assessment visit, consensus had not been reached or communicated among USAID, PRISM, and the DOH regarding what MCH skill sets would be required of the midwives to meet this expanded clinical focus. Plans are underway, however, to revise training manuals, offer expanded training to those midwives who have been trained, and possibly train additional midwives with an expanded focus on the provision of antenatal care, including FP counseling, breast-feeding management, tetanus toxoid immunization for pregnant women, developing a birthing plan, and FP for post-delivery mothers. Fortunately, assuming these topics are agreed upon, this broadening of content should be easy to achieve, as the additional topics are core components of midwifery care.

As of April 25, 2006 the following performance indicators have been identified for Component 3.

Performance indicators	Baseline	Cumulative annual targets				
	2004	2005	2006	2007	2008	2009
3.1: Proportion of participating (workplace) private healthcare providers other than midwives that offer at least one project-supported MCH service			55%	60%	65%	70%
3.2: Proportion of participating midwives who report increased						

Performance indicators	Baseline	Cumulative annual targets				
	2004	2005	2006	2007	2008	2009
revenue from FP service provision six months after training						
3.3: Proportion of participating private midwives who provide tetanus toxoid vaccinations		57%	65%	70%	70%	70%
3.4: Number of claims for PhilHealth reimbursements for covered FP services	TBD	1,149	1,494	2011	3137	5019
3.5: Proportion of participating midwives who are BEST-certified six months after training				60%	70%	75%

5.1.1 STRATEGY 3.1

Proportion of participating (workplace) private health care providers other than midwives that offer at least one of the following project-supported MCH programs, namely prenatal care (at least once), tetanus toxoid vaccine injection (at least one), and post-natal counseling.

Observations

In the first two years, 315 private practice and company physicians and 307 company nurses received training that focused on contraceptive technology updates and skills for FP counseling. A physician developed the training materials. One PRISM staff member observed that the physician attendees needed a review and update on FP methods. Prior to the assessment team's site visit, a decision had been made to focus future health care provider activities on midwives so no additional information was obtained regarding this performance indicator.

Recommendations

The performance indicator needs to be revised to reflect the current plan. In workplace settings where employees receive care from a physician or nurse it is possible that the provider might not have any recent experience providing prenatal care or counseling on FP methods. Thus it would be appropriate to continue to provide training on MCH activities. In addition plans must be made to identify and train new health care professionals whom the workplace clinics hire.

The opportunities for midwives to contribute to the MCH counseling that occurs in workplace clinics should be expanded, as their participation can improve the quality of the counseling, increase the number of acceptors, and reward the midwives who are looking for financially viable distribution points.

5.1.2 STRATEGY 3.2

Proportion of midwives (who underwent BEST training) reporting increased revenue resulting from adding/expanding family planning services to services already offered. The main emphasis will be on revenue from family planning counseling and referral and provision of OCs and injectables.

Observations

In the first two years, PRISM built the capabilities of 989 private practice (private or dual practice) midwives through a five-day course titled Business Enhancement Support and Training (BEST) for Midwives.

While train-the-trainer plans were developed, there are conflicting views regarding the consistency of the delivery of the training. Furthermore, in the training module provided for review, there were many typographical errors that could confuse students. None of the midwives interviewed for this assessment expressed concern with the content of the training; however, several trainers and the assessment team noted the errors, the lack of training, and that the business content in the modules is inappropriate for many of the attendees. Few of the midwives have received education in or beyond basic math and it does not appear that the authors kept that fact in mind. For example, the module content did not transition from simple to complex math calculations and business concepts.

USAID asked the Banking on Health project to review the BEST materials and that project is in the process of revising the business training materials both in terms of content and structure. Business and clinical topics have been separated into different courses. While Banking on Health will conduct a Training of Trainers (TOT) for local training providers in early 2007 on the new materials, it is not clear how PRISM will incorporate these new materials. It is also unclear whether the project will continue to offer business training as was the original plan and how the grants program will be structured to ensure access to training and business support to midwives on a sustainable basis.

An additional program titled Midwife Entre-PINAY Forum has been offered in two of the three target regions and was open to any interested midwife as a means of identifying more private or dual practice midwives. Banking on Health conceived and largely funded this program; PRISM contributed labor. These forums were designed to make up for some of the shortcomings of the BEST program and have increased PRISM's understanding of private practice midwives' needs. The forums provide information on a microfinancing program established for midwives, standards for licensure and accreditation of birthing homes, and examples of midwives who have expanded their provision of FP services and profit via sales of FP commodities. Multiple vendors attend these forums, offering midwives the opportunity to learn about products and services that might enhance their ability to conduct a financially successful business. Attendance at the two forums exceeded expectations and the attendees seemed excited about this opportunity. Many of the midwives appeared reticent to approach vendors and there was some discussion amongst vendors that the midwives do not understand the vendor's role. Vendors, however, may be using strategies designed to market products to physicians instead of creating a new strategy for midwives.

The follow-up plan for BEST graduates is also in transition because of the change in training content. The original plan called for a follow-up monitoring visit that focused on collecting data to measure the success of the project. Monitors (FP coordinators) were to offer technical assistance and there was the potential for the midwife to receive a BEST-midwife certificate, signage, and local publicity regarding her accomplishments. Data have not been identified that report on the results of this follow-up monitoring. Discussions with FP coordinators in Davao and Cebu suggest that the coordinators conducted at least one visit to most BEST graduates. Unfortunately, several FP coordinator positions were eliminated around the time of the assessment site visit so this data may not be available.

While the data-collection tool is detailed, guidance for technical assistance to address the needs of the midwives is not clear. Some midwives expressed disappointment in the lack of continuing support after the BEST sessions. The follow-up assessment the Philippines NGO Council on Population, Health and

Welfare, Inc. (PNGOC) conducted of the initial BEST graduates revealed that few were using the business tools. None of the midwives the assessment team interviewed were interested in a BEST-midwife designation. Interviews with four FP coordinators revealed a great deal of knowledge about the content of the education modules, the strengths and weaknesses of at least some of the individual midwives, and a strong investment in the success of the midwives.

The private midwives who the assessment team interviewed reported selling more commodities than they had prior to attending BEST and stated that their income was increasing. They also reported interacting with pharmaceutical vendors and negotiating deals that facilitated financial success.

The focus on monitoring rather than technical assistance after the initial training is problematic, as is the content of the data-collection tool. The concept of monitoring by watching the midwife interact with patients provides little value to the midwife and is not relevant to the performance measures. If not handled sensitively, the monitor may be seen as passing judgment on the midwife's performance. A lot of the data collected are not relevant to the performance measures and there are a number of barriers to complete data collection. For example, some midwives have limited capacity to maintain records and there are financial disincentives to recording complete information.

The lack of population-based pre-service data will make some measures of success difficult for this component to achieve. There is no central database on midwives, much less information regarding where the midwives work. The project depends upon its original mapping activity, which may not provide an adequate baseline because of the lack of a uniform definition of "private practice" when data were collected. These data were reported to have been mislabeled in the first launch of the ORBIT database and do not appear to be reliable.

Recommendations

The midwives and their clients would be best served if there is continuity in content, logical progression of skill and knowledge development, measurable support for the improvement of clinical services, and clear application of lessons learned as new USAID-funded projects are introduced. Organizations that have worked with earlier projects and continue to support expanding the impact of midwifery care should be involved in future projects, even if just via an advisory board. Without continuity participants are likely to feel they are being used to meet someone else's goals and may be reluctant to adopt new behaviors.

Many private midwives and possibly the majority of public ones in the Philippines are part of the informal sector, otherwise known as the working poor. Members of this sector may appear to lack cohesiveness, but they tend to be unified in their distrust of outsiders. They are likely to compare notes about the benefits of participation in events, expect equal treatment, and only utilize what has value to them. Thus, all program plans and expectations must reflect the knowledge base, life experiences, and needs of the intended recipients.

All plans should consider the limited time and resources available to private midwives who may be the primary support for their families and cannot afford to miss work for training or other project-related activities.

Midwives' access to financing for their basic needs, such as work space, furniture and equipment, and supplies, is limited. Any project that seeks to increase their professional stature and ability to provide safe care should address those concerns.

PRISM should design, implement, and document mechanisms to ensure that training content reflects the preparation and comprehension of the target audience and that trainers are capable and prepared to provide content in a manner that is consistent for all attendees.

Meeting and trainee participants should complete an evaluation form so PRISM can better monitor the achievement of activities' goals, adjust the approach and content, and design follow-up strategies. In addition, all staff at events should contribute to an evaluation of the training methods, particularly as reflected in the response of the attendees. For example, topics such as licensure and accreditation are important but difficult to teach, especially to a large audience of HCPs. While presenting about this topic, it would be helpful if the speaker acknowledged the concerns of the audience, gave examples, and provided an opportunity for participants to ask questions.

As soon as possible plans need to be clarified regarding the provision of IUD-insertion training. Many midwives who attended PRISM training activities expressed interest in learning how to insert IUDs and expectations have been raised that this training will be provided. If possible, this training should be offered, as it is consistent with the need to expand access to FP options and will contribute to the financial success of private midwives.

To maximize and leverage the value of the Entre-PINAY forum, leaders in midwifery organizations should be introduced to the audience and offered the opportunity to speak to attendees.

PRISM needs to design the provision of business coaching, mentoring, and technical support for midwives to provide a balance between midwives, non-midwives, outside experts, and local role models. It can be inspiring for midwives to hear from policy makers, decision makers, and successful business men and women as long as the content is relevant and the messages are consistent with the training's goals. Sometimes it takes a midwife to translate the message into the real-life decisions the midwives face and to acknowledge that change is good for the profession.

The entrepreneur program should teach and model successful midwife-vendor relationships.

PRISM should design a tool that collects data relevant to the project's performance measures. Collecting data related to inventories of commodities may be more feasible than collecting data from individual patient records. Also commodity use might be considered a proxy for trends in HCP activity (much of which can be attributed to midwife promotion of contraceptive use).

As soon as possible, funding for future Banking on Health projects should be clarified, as its activities are important for PRISM's success.

5.1.3 STRATEGY 3.3

Proportion of midwives (who undergo BEST-MCH training) providing immunization on tetanus toxoid for pregnant mothers.

Observations

This performance measure was not part of the training program the assessment team reviewed. Verbal comments suggest that vaccines are easy to access in the Philippines, but no baseline data appear in PRISM publications. Provision of tetanus toxoid can be a life-saving measure and, if supplies and medications are available, incorporating this goal into the PRISM program should be easy.

Recommendations

Revise the performance measure and training materials to reflect the current plan.

5.1.4 STRAGETY 3.4

Number of claims for reimbursements from PhilHealth-covered services in PRISM strategic intervention areas (SIAs). Claims of interest include those for bilateral tubal ligation (BTL), non-scalpel vasectomy (NSV), and IUD insertion conducted in both hospital and outpatient clinics that are PhilHealth accredited.

Observations

This performance measure is an indirect measure of PRISM's success. The project is investing heavily in activities that increase access to birth control pills and injectable contraceptives and is recruiting midwives by focusing on the financial benefits of selling commodities. While it is possible that any conversation about FP will lead to increased utilization of permanent methods of contraception, it is hard to attribute any increase in BTLs or NSVs to PRISM's activities. If PRISM provides training in IUD insertion, this measure might be appropriate but it will not reflect the utilization for women who are not enrolled in PhilHealth.

During the assessment's site visit, a new performance measure was identified that is related to PhilHealth. There appeared to be agreement between PRISM and USAID to focus future efforts on developing 500 accredited or accreditable birthing homes. While a birthing home needs to be licensed before it is accredited, based on information obtained during this assessment, it appears there are 100 licensed birthing homes and approximately 200 PhilHealth-accredited birthing homes. No comparison has been done to identify homes that are both licensed and accredited. It is not known how many of these accredited birthing homes are public versus private, but the assessment team learned that in Visayas funding has been allocated in the public sector to convert four rural health units into birthing homes. PRISM regional directors for Luzon, Visayas, and Mindanao were asked to estimate the number of birthing homes they believe might be assisted to reach accreditation standards; their total estimate was below 300. The assessment team does not believe it is possible to achieve an additional 500 accreditable birthing homes during the remaining three years of the project.

It will be challenging to overcome disincentives for seeking accreditation. It is possible that accreditation will increase the revenue for birthing homes, especially if the number of clients PhilHealth covers who also are interested in a birthing home increases. Given enough time midwives should be able to manage the cash-flow problems delayed reimbursement creates, but many HCPs do not understand or appreciate this concept If the midwife does not have a bank account, delayed reimbursement or large reimbursements will be difficult to manage. In the meantime accreditation is seen as expensive and time consuming with few rewards. Some midwives have noted that providing information to PhilHealth will increase their tax burden without increasing revenue. Work towards achieving this target began with educating the midwives about the criteria for licensure and accreditation. Ideally, this education can decrease misunderstanding and fear while increasing the attractiveness of this accreditation.

Recommendations

Establish expectations between USAID and PRISM regarding how the numbers will be counted. For example, will currently accredited birthing homes be counted and will public-sector birthing centers be counted toward PRISM's goal. Also, a definition of accreditable must be established.

Establish a realistic target number based on information from the field staff regarding potential sites.

More business training for midwives will be needed to help in the transition to the PhilHealth model. The majority of midwives will need assistance to learn about the advantages of accreditation and how to develop a viable business plan, obtain financing, market their services, and manage their money. It appears that Banking on Health has established a good relationship with many midwives in the Philippines and has the knowledge and expertise to provide the needed business training.

Utilize an expert midwife consultant, who is not in competition with the local midwives, to help teach the business concepts. As noted earlier, a midwife expert who can acknowledge the challenges midwives face in their daily work will bring credibility and inspiration to the midwife attendees.

Utilize the data reported in the Banking on Health report titled *Midwife Financing and Training Needs Assessment Survey Results and Analysis* (January 5, 2006) to help plan these activities.

5.1.5 STRAGETY 3.5

Proportion of participating midwives who are BEST-certified six months after training

Observations

At the time of the assessment team's site visit, no midwives had been BEST certified. It is unclear that this certificate has value to the midwives. It should not be a surprise that the midwives seem more interested in rewards that help them offset expenses and thus increase revenue.

Recommendations

This indicator could and probably should be deleted, especially if there is concurrence to keep the focus on accredited birthing homes (see indicator 3.4).

5.2 SYNERGIES WITH OTHER COMPONENTS AND COLLABORATORS

PRISM has leveraged the relationships established in Component 2 to expand the success of Component 3. Specifically, midwives who attend the training programs are introduced to vendors whose products and services may help expand their scope of influence and financial success. More examples of how midwives can incorporate sales of non-prescription pharmaceuticals into their clinics are needed. In relation to Component 1, at least in one instance a midwife has provided FP counseling for a workplace health program with the end result described as an interactive session that the physician praised and increased the patient load of the midwife. There is potential to repeat this success in other workplace settings and it should be pursued

5.3 SUSTAINABILITY

At this point PRISM's activities to ensure sustainability for Component 3 are not clearly delineated. The Well Family Clinics Partnership Foundation (WPFI) may support the private midwives beyond PRISM's project life and there are discussions regarding the role of midwife associations. It is likely that midwives who have expanded their ability to provide FP services will continue to do so after this project ends, especially if demand increases. In fact, if there is financial success associated with this expansion and if a

new scope of practice related to midwives' provision of FP services is codified, the sustainability for midwives who have received training is likely.

Utilizing training and on-going technical assistance to establish contact with and standardize the knowledge base of private midwives is an appropriate strategy for this project, especially given the priority the DOH places on expanding the scope of practice of midwives and that public and private midwives are providing services to the poorest members of the community. The focus on offering expanded FP services to include sales of commodities as a means to increase income is attractive to participants, as many say they already are offering FP counseling. The sessions that encouraged midwives to consider themselves entrepreneurs are unique to this project. As measured by attendance, these business fairs generate a lot of interest. The introduction of microfinancing for this sector has the potential to help some midwives, although it is too early to evaluate the success of this approach. Staff members, especially those who have regular contact with the midwives, express a degree of respect for the midwives as well as an understanding of their circumstances that is conducive to meeting the training's goals.

Recommendations

It would serve the project well to have a midwife with private practice experience on staff to help develop the strategies and work plan, facilitate communication with midwives, and review all midwife training and monitoring materials before and after they are used. Alternative approaches to help develop a more coherent and creative plan to work with midwives include utilization of midwife experts as consultants for specific tasks or the creation of a paid midwifery advisory committee with representation from the public and private sectors, as well as representatives from midwifery organizations.

While plans are underway to contract with the WPFI, clarity is needed regarding how PRISM will coordinate the efforts with the BEST for Midwives activity and what adjustments will be made to that program. For example, the franchise component of the WPFI program, which requires ongoing monetary investment from the midwives, has not been sustainable. If it appears that WPFI is continuing to promote franchise membership, it could deter midwives from joining the project.

Participate in discussions with DOH staff regarding the need for increased support for the education and financial sustainability of public and private midwifery practices. Meetings that focus on the plans and success of PRISM projects provide the opportunity to share observations regarding the status of midwifery. The assessment team notes that actions that improve the status of midwifery should be implemented sooner rather than later. Otherwise, many of the young midwives may become nurses to make more money, get more respect, and ultimately may join the ranks of foreign workers.

A formal plan, with consultation from a midwife, to provide organizational-development support to local and national midwifery organizations is a vital component of a sustainability plan that USAID, PRISM, and the DOH should support. Observations that midwifery associations are more social rather than professional organizations appear to be accurate. The relationships between organizations are strained and their conflicts are common knowledge. These are symptoms of a lack of mature leadership that is to be expected when organizations have limited funding and compete for membership and when members have minimal education and few role models. These organizations, however, have existed for many years are involved with the International Confederation of Midwives; the international midwifery community supports their existence as a national voice for ensuring safe motherhood and promoting the professional status of midwifery. At the local level the organizations exert peer pressure on the behavior of midwives. Ultimately the country is counting on the midwives to fill many gaps in access to women's

health care (starting with FP) and investing in the development of strong standard-setting professional organizations is needed. PRISM cannot solve all of the organizations' problems, but it could offer a proposal to offer organizational development that utilizes examples that are consistent with the project's goals. Progress in this area would complement USAID and PRISM's strategies and contribute to improved access to midwifery care, thus sustaining PRISM's goals beyond the life of the project. Organizational-development topics might include leadership and policy development, the role of professional organizations in improving public health, expanding membership benefits, and consensus development. It would be divisive to support local organizations without also helping the national leadership. PRISM staff is having conversations that reflect some of the ideas in this section. Local and international experts are available to assist with these activities.

The assessment team found many raised expectations in the community that are now marked by frustration from a lack of follow-up and a sense that community experience is not valued. A planned effort to renew relationships established via memorandums of understanding with midwife, doctor, and nurse organizations, as well as other partners, to share the goals and accomplishments of PRISM would enhance support from these groups during and beyond the life of the project.

5.4 OPPORTUNITIES FOR PROGRAM IMPROVEMENT

A critical requirement for achieving project objectives is to increase marketing to generate demand from clients who are prepared to pay for commodities (that is, creating changes in behavior). As reflected in pharmaceutical sales data under Component 2, sales for methods of contraception are growing slowly in the Philippines and it is not clear if this trend reflects a lack of demand, the high cost of the products, or a lack of access. During this assessment a number of consumer advocates reported that they do not believe that free commodities will disappear and HCPs confirmed that they are hearing this sentiment from their clients. While some have experienced a loss of access and appear willing to pay a trusted midwife who offers counseling as well as low-priced commodities, some LGUs are purchasing low-priced commodities and providing them without charge to poor women. In those settings a midwife who charges for the same product will lose credibility with customers. Without a purposeful behavior change component within or complimentary to PRISM, It may be that this component can succeed only where the public experiences a decrease in access; otherwise, demand will not be enough to support acceptance of this expanded business model.

5.5 NEW AREAS OF EMPHASIS

5.5.1 STRATEGIES TO INCREASE PRO-POOR IMPACT

As related to Component 3, there are few references to achieving a pro-poor agenda in the project reports that the assessment team reviewed. The focus on private midwives, however, all but ensures that the poor are the primary recipients of these services; reports could easily reflect this fact. If data are needed, the project could identify them from other sources or consider separate data collection by the project or by another intermediary on the financial status of clients private midwives serve. PRISM then could reference this data in reports. It may be possible to draw some conclusions about economic strata based upon the location of the lying-in clinics and population data the government provides.

5.5.2 APPROACHES IN INTEGRATING MCH INTO THE PRISM STRATEGY

The decision to expand from a FP to a MCH focus is universally accepted. Some informants, however, raised questions regarding the definition of terms, the preparation and ability of the midwives to provide

additional services, and the potential confusion and expense this change created. Plans exist to revise training modules and retrain midwives, but these efforts will be an additional expense and will create data-collection challenges. Taking into consideration limitations on time and finances, the assessment team believes PRISM should apply the expanded MCH focus only with new trainees and among midwives signing on to implement the new birthing-home strategy. It also is recommended that for the purposes of this project, the health of the child be considered a direct reflection of the health of the mother. For example, private midwives could promote childhood immunizations, but it is probably not realistic for them to provide these services.

It is not clear how many private practice midwives are providing the tasks identified as MCH services for this project. It is possible that most are promoting breast-feeding, providing tetanus toxoid, and encouraging a birth plan. Baseline data will be needed to develop training materials and measure success.

The ultimate large-scale success of Component 3 depends upon behavior change from the end users. More women must seek counseling on methods of contraception and be prepared to pay for the counseling and methods for this demand to translate into business value for the private providers who serve the poor. It is appropriate for this project to focus on midwives, as they have contact with many women of childbearing age, have been identified as being closely tied to poor communities, and are less likely to seek employment in foreign countries. Their status is growing and investing in their education will bring returns in terms of access to care for women. Facilitating the introduction of more cost-effective methods of contraception and increasing their distribution are critical means of ensuring business value.

6. OVERARCHING ISSUES

6.1 CROSSCUTTING CONCERNS

6.1.1 GOVERNMENT OR PUBLIC SECTOR INVOLVEMENT

PRISM's success depends on engagement with the public sector at the national, regional, and local levels. The project has engaged with the DOH and other actors on national policy development critical to its success. Engagement of the project at the provincial and local levels varies by the degree of involvement of field staff and the level of project involvement by region and locality.

Local-level Involvement

The project has engaged with regional, district, and local actors directly through field staff and indirectly by encouraging its partners to become involved in project activities, including stimulating business associations to apply for workplace grants, encouraging provider groups to apply for grants, and involving members in training activities. Maintaining relationships with these numerous actors is challenging for the project because of expectations raised by early project activity to stimulate the demand for grants. PRISM could not fulfill many of these expectations and the project's communication with partners about the potential for success and about the timing of decisions about awards was inconsistent. Changing strategies regarding provider involvement also has made it challenging to maintain relationships with partners. For example, in Pangasinan training for drugstore partners was provided with no follow up. Also PRISM provided orientation about referrals between public and private family practitioners, but because clients are in the habit of going to government clinics and donated or government-purchased FP commodities are still available, private practitioners have not received any referrals. Thus private practice and dual practice midwives the project has trained have not received the support they need to realize the potential increase in income from providing FP services.

PhilHealth Involvement

PRISM has engaged with PhilHealth and other national-level actors to agree on a national strategy that encourages licensing and accreditation of birthing homes to increase the number of facility-based births and to allow for PhilHealth reimbursement. As PhilHealth now reimburses for the first, second, and third normal deliveries in birthing homes, the market for private practice midwives is significant. PhilHealth is committed to facilitating accreditation of birthing homes and is eager for PRISM to partner with it and the DOH to promote accreditation. In the view of PhilHealth's director, PRISM has an opportunity to achieve project objectives regarding accreditation of midwives by mapping the PhilHealth-insured population and focusing on assisting midwives in these areas to get the capital and technical assistance to become accredited. The director further suggests that the project "write the book" on accreditation made easy and orient midwives to the potential for increasing their income from reimbursement once they have steady claims and have established a cash flow from reimbursements. The PhilHealth director has committed to accrediting 300 birthing homes by the end of the year (100 more than the 200 already accredited) and believes that if the project focused on identifying the most lucrative localities and making it easy for midwives to understand why and how to be accredited, more homes could be included.

PhilHealth does not believe that advocating for reimbursement for contraceptives is productive, as the organization does not provide reimbursement for pharmaceuticals, except for TB and malaria drugs, and there is therefore not a case to be made for contraceptive reimbursement. The case for reimbursement for surgical contraception is straight forward, however, as PhilHealth does reimburse for similar surgical procedures.

Health Sector Reform and FOURmula One

PRISM's activities are consistent with and supportive of the DOH health sector reform agenda and the FOURmula One (F1) objectives.[11] In support of the F1 health financing objectives of shifting outpatient care to direct out-of-pocket payment and focusing health insurance coverage on in-patient care, the project helps move contraceptive acceptors who are able to pay from public to private provision and encourages reimbursement of private and dual practice midwives for deliveries performed in accredited birthing centers. In support of health regulation, PRISM is working with the DOH and PhilHealth to support the licensing and accreditation of the private midwife-run birthing centers. The government of the Republic of the Philippines (GRP) also includes ensuring access of the poor to essential health products through programs such as the Botika ng Barangay under the regulation aspect of F1. "In the pursuit of equity, access of the poor and the vulnerable sectors to essential health products will be pursued by expanding access points for low-cost drugs through programs such as the 'botika ng Barangay'."[12] While the project already assists in expanding access to low-cost contraceptives through Component 2's market expansion activities, as discussed in sections 3 and 6.7, the assessment team suggests that PRISM expand its scope to support replication of sales boutiques and kiosks. To expand access to and the availability of basic essential health care service delivery, the project supports upgrading midwife-run birthing homes. Finally, governance, the fourth aspect of F1, is essentially the purview of the government and, therefore, requires no direct support by PRISM.

Another aspect of the F1 framework is to establish four-in-one convergence sites (initially 16 of them) where the governance, regulation, financing, and service delivery efforts work together to achieve overall program objectives. The assessment team believes that by continuing its work in the current PRISM Strategic Intervention Areas (SIAs), the project can continue to support the government's program priorities, with or without direct overlap with the F1 convergence sites. According to DOH staff the assessment team interviewed, the GRP appreciates the role PRISM plays as the only assistance program directly supporting the private sector and the DOH sees PRISM efforts as important adjuncts to its primary focus on government-led programs. While serendipitous overlap of PRISM SIAs and F1 convergence sites could provide an opportunity for direct reinforcement, the DOH feels no need for PRISM to relocate for these efforts to overlap.

Health Department and other USAID-assisted health projects

As discussed previously, PRISM's priorities are consistent with government and DOH F1 and health sector reform priorities. The DOH seems comfortable with the degree of its engagement with the PRISM project and requests only to continue being kept informed about project progress and successes. Similarly PRISM should focus on increasing communication with public sector partners at all levels to ensure good support for and coordination of efforts, including enhancing the efforts of both the project and partners where possible. The project, however, should keep its focus on achieving its goals in development of the private sector and not be diverted by the temptation to redirect its emphasis each

[11] This discussion is based on a document the DOH's Bureau of International Health Cooperation provided the assessment team, entitled "FOURMULA ONE FOR HEALTH: Implementation Framework for Health Sector Reform," an undated summary of FOURmula One from a presentation by the Secretary of Health.
[12] Ibid.

time a new public sector priority is identified or new projects come begin. As noted elsewhere the most critical need for PRISM is to build, enhance, and rebuild relationships with all of its many existing partners, including increasing the focus on leveraging partner resources.

6.1.2 CONTRACEPTIVE SELF RELIANCE

PRISM is an important player in the transition from reliance on donated contraceptives to CSR in the Philippines. The project has already contributed to increasing the choice of brands through market development, which has already stimulated the introduction of new brands, as described in the Component 2 section of this report. The project plans to support the introduction of additional new commodities to support the DOH's goal of increasing the choice of brands. The PRISM workplace (Component 1) and private practice expansion (Component 3) activities are beginning to facilitate access to FP services. . Establishing and encouraging the sales of commodities in kiosks in workplaces, clinics, and birthing homes could facilitate increasing the connection between these components and the commodity supply. The missing element in the connection between PRISM and CSR is in the generation of demand. The project has limited scope or resources for demand generation; in addition there is little IEC and BCC activity being done to stimulate more demand. The addition of the new USAID communications project, therefore, will be important to support and complement PRISM and other FP efforts.

6.1.3 MANAGEMENT, ADMINISTRATION, AND ORGANIZATIONAL STRUCTURE

PRISM's current organizational structure is new and appears to be designed to manage the project's components as efficiently as possible, given the need for cost cutting that has required downsizing. While these measures may be necessary, it will be challenging for the project to manage all of its interventions while delivering on the many expectations of the project's clients; optimizing the synergies between components; and increasing communications, outreach to, and relationship-building with partners. In particular employing a midwife to increase the ability to incorporate the midwives' perspectives in implementing Component 3 and improving communication with midwife associations would benefit the project. The project also could benefit from strengthened inputs from staff or consultants with private sector experience, both to create a marketing-oriented mindset in implementing Component 2 and to increase the project's ability to think like the private sector in implementing Component 1.

Management could encourage increased synergies between components by creating inter-component working groups or by designating staff members to focus on increasing synergies between components (for example, by joint development and management of grants to increase the availability of contraceptive and MCH supplies in workplaces and private birthing homes). Finally, the project will be hard pressed to manage relationships with its many and varied clients in the field given the recent downsizing. Therefore it might consider designating an officer or team to focus on field communications and outreach, external relations, and partner relationship-building.

USAID can strengthen the project by providing clarity in its guidance and direction. For example, it will be important for the client and the project to reach an understanding of the definitions of "poor" and "SME" and to agree on what aspects of MCH are within the project's manageable interest. In addition USAID and the project need to establish what the new objective of establishing 500 accredited or accreditable birthing homes means: Does this target include the approximately 200 homes already accredited or is the goal to accredit an additional 500 homes? In addition to insisting on specificity and agreeing on definitions, USAID could assist the project's management by providing clarity and also

requiring it from the project team, including when requesting changes in the project's emphasis (such as the re-emphasis on pro-poor, SMEs, and establishing birthing homes) and when asking the project to assume new mandates (such as the MCH focus). It is important to formalize agreements with the project to avoid confusion.

6.1.4 MONITORING AND EVALUATION

While the assessment team was unable to conduct an in-depth assessment of the project's M&E systems, team members assessing each component had similar observations regarding the need for an increased focus on essential data points, including streamlining data-collection instruments for use in the workplace for Component 1 and with midwife practices for Component 3 and increasing the attention to sales targets and outcomes for Component 2. Furthermore, the team observed that PRISM was collecting useful monitoring information, but it was not analyzed thoroughly, thereby missing the opportunity to apply the information into project implementation.

On the other hand, a great deal of time and attention is focused on the Project Monitoring Plan (PMP) and the web-based information system, ORBIT, which appears to be costly and not relevant to improving project implementation. Finally, assessment team members were concerned that the PMP indicators were creating a focus on arbitrarily set targets in place of a more marketing-oriented focus that would direct the project to identify the most productive markets, setting market targets, and tracking data that would confirm achievement of these market targets. The team also observed that PRISM should focus on monitoring overall project impact by tracking changes in contraceptive prevalence using existing survey data. As the team could not conduct an in-depth assessment of PRISM's M&E, however a more thorough assessment of the project's efforts in this area may be warranted.

6.1.5 POLICY

PRISM is involved in health policy work and should continue to participate in this area. The 10-point policy agenda developed jointly with the DOH, other cooperating agencies, and other donors has provided a good framework for policy development. Progress has been made in several areas critical to PRISM, including establishing an express lane for BFAD approval of pharmaceuticals (including low- and medium-priced contraceptives) and the removal and/or reduction of tariffs on imported hormonal contraceptives and IUDs. Advocacy work is still needed regarding the DOH's enforcement of workplace family welfare program laws and the pharmacy law (discussed in Section 6.2) in relation to USAID's new policy project. Given the broadened project focus on MCH and the award of new USAID policy and LGU projects, the joint policy agenda will likely be revised. The following table summarizes the policy agenda at the time of the assessment and references the agenda items relevant to PRISM in this report.

SUMMARY OF PRISM INVOLVEMENT IN 10-POINT POLICY AGENDA

1. DOH certification and PhilHealth accreditation	PRISM involved	See section 6.1.1
2. Expanding PHIC benefit packages for FP, TB-DOTS, and Vitamin A/MCH	PRISM involved	See section 6.1.1
3. Strengthening of Philippine Health Insurance Corporation (PHIC) operations at the LGU level	No direct PRISM involvement	NA
4. Strengthening of TB policy	No direct PRISM involvement	NA
5. Strengthening of national policies in support of CSR	PRISM involved	Policies in place; BFAD registration procedure discussed in section 4.2

6. Financing of national HIV/AIDS surveillance system	No direct PRISM involvement	NA
7. Strengthening of local policies in support of CSR	PRISM involved	See section 6.1.1
8. Expanding FP services in company health benefits	PRISM involved	See sections 3.2.4 and 3.2.7
9. Strengthening and expanding the private sector's capacity to supply FP products and services	PRISM involved	See sections 4 and 5
10. Policies to implement the Food Fortification Law	No PRISM involvement	NA

Health Financing

Progress is being made toward the policy agenda "to harmonize DOH licensure and PHIC accreditation for private midwives and private midwives' facilities" action, which will allow private and dual practice midwives to receive reimbursement from PhilHealth for deliveries, thus strengthening their financial base. As the DOH only recently began licensing birthing homes, the current situation in which there is no consistency between homes that have been licensed and those that have been accredited is anomalous. There is good cooperation between DOH and PhilHealth in this area and over time the process will become harmonized, ensuring that homes are licensed before becoming accredited. Regularizing policies and removing policy barriers, however, do not in themselves lead to the intended audience's use (in this case, private practice midwives applying for licensing and accreditation), as noted in the previous discussion of Component 3.

Midwifery Practice and Referral Systems

PRISM has made progress in upgrading midwife training materials. PRISM worked with the LEAD project to develop a public-public, private-private, public-private, and private-public referral system for FP in anticipation of the reduction or elimination of donated contraceptives. The assessment team observed that this system cannot be implemented effectively until donated or government-procured contraceptives become scarce. Thus the team suggests that the project focus on two aspects of referrals: referrals from workplace programs to public and private providers and referrals from private midwives to private and public obstetricians and gynecologists for difficult cases prior to delivery and to higher level facilities for complications encountered during the birthing process.

The ARMM

The assessment team does not recommend a specific strategy to implement PRISM in ARMM. The project can work with the newly awarded USAID ARRM project to enhance private sector involvement.

6.2 IDENTIFYING CURRENT AND POTENTIAL SYNERGIES WITH OTHER OPHN PROJECTS

The PRISM team is looking forward to the new USAID projects becoming operational. While it is difficult to say how PRISM would best collaborate with the new USAID projects, the assessment team recommends the following actions by component.

COMPONENT 1

With the new LGU and policy projects, PRISM's main concern in Component 1 is to encourage local monitoring and compliance with Article 134 and Order 56-03. For the ARMM project, PRISM could implement a workplace health program at Datu Paglas, the largest employer in the region. For the new TB project, PRISM could work with the new contracting agency to provide joint TB and FP presentations to companies and determine whether it makes sense to share partners.

COMPONENT 2

Component 2 can collaborate with the LGU project by instituting a functioning referral system through which acceptors and current users of free *LoGentrol* can be referred to private HCPs and retailers, for facilitating LGU purchases of oral and injectable contraceptives, sharing information on the market segmentation LGUs are doing to help identify the LGUs that are more ready to purchase FP products, and to help disseminate information on FP updates.

With regard to the new policy project, PRISM should focus on helping enable midwives and other non-drugstore retails outlets to continue selling contraceptives. This issue is particularly urgent because of the Pharmacy Law, which mandates that pharmacists be part of any pharmaceutical retail activity. The Pharmaceutical Healthcare Association of the Philippines has mandated that all of its member companies comply with this law.

Collaboration with the ARMM project can be achieved through joint efforts to establish a wider range of retail outlets for contraceptives. An example of this type of outlet is the Botika ng Barangay, which are small drugstores in local communities the DOH encourages.

PRISM and the TB project can collaborate on approaches to common targets, such as midwives, general practitioners, workplaces, and point of sales. This cooperation will help optimize resources.

COMPONENT 3

The introduction of new USAID-funded projects focusing on policy and support for LGUs should require interaction and coordination with the PRISM project. When it comes to midwives, activities that might create a chasm between public and private sector ones is not practical. As Dr. Yolanda Oliveros, Director IV of the National Center for Disease Prevention and Control at the DOH, noted, the public will be best served if all midwives receive adequate training and support. Furthermore, it is the position of the director of PhilHealth that projects such as PRISM should build their activities around the policies of PhilHealth rather than suggest policy changes.

6.3 INSTITUTIONALIZATION AND CAPACITY BUILDING

The PRISM project is largely focused on achieving targets set by the projects and tacitly approved by USAID. This high level of target focus reduces attention to capacity building and institutionalization. The assessment team believes that reducing the targets and focusing on more intensive interactions with partners and technical-assistance inputs could lead to improved outcomes, as well as the improved potential for institutionalization of project activities.

Institutionalization in Component 1 involves obtaining greater commitment from grant partners for the continuation and replication of workplace FP programs after PRISM ends. For Component 2 there is an urgent need to provide additional support to faltering grantees. For Component 3 there is a need to

strengthen partner's capacity through follow up and technical assistance. In addition, there should be a concerted effort among all components to forecast and monitor FP acceptors resulting from activities in the workplace, with pharmaceutical companies, and with the HCPs. Sharing successes and lessons learned should be encouraged and done regularly among the different components as well. These efforts will help strengthen the team.

6.4 PURSUING THE PRO-POOR AGENDA

The assessment team identified a number of ways in which PRISM already addresses the pro-poor agenda, as noted in the discussion for each component. In addition to documenting the ways the project is reaching the poor directly, the project could conduct a study to estimate the indirect effect of the project on the poor (for example, how the project's contribution to the segmentation of clients will allow the public sector to provide more services to the poor).

6.5 INTEGRATING CRUCIAL MATERNAL AND CHILD HEALTH CARE TASKS

PRISM has correctly identified the maternal health interventions of tetanus toxoid vaccination, prenatal visits, referrals for warning signs of complicated pregnancies, formulation of birth plans, and breast-feeding as the best and most direct way for the project to incorporate the new MCH focus. All of these interventions have positive effects on infant health (prevention of neonatal tetanus, improved birth outcomes, and improved child nutrition through breast-feeding).The assessment team agrees that these areas of focus are the best and most direct way the project can contribute to improved maternal and child health outcomes.

The PRISM project has already proposed appropriate maternal health interventions, selecting those that will impact both maternal and child health. PRISM is adding and adjusting indicators to track its work toward those new objectives. It is important to acknowledge that the project's ability to achieve outcomes in MCH can be measured only in years four and five, as interventions will be introduced incrementally in year three, beginning with revisions in training curricula, followed by incremental introduction of this training, and then full-scale implementation.

6.6 LEVERAGING PRIVATE INVESTMENTS

PRISM is leveraging large amounts of private investment through its workplace component. These investments, such as the lost employee time for training and counseling, however, are not documented. Suggestions for documenting company contributions to the program are included in Annex 3.

For Component 2 the grantee firms can leverage part of the company's corporate social responsibility budget for FP and other MCH activities. Organon is already doing so through a radio program on FP and maternal health. Private investments also can be leveraged through activities such as promoting safe motherhood and breast-feeding. The companies involved can document and quantify these campaigns. For drugstores, FP training and updates for the clerks will enable them to respond to questions about FP products and methods from their clients. Grantee firms can perform and document these efforts.

Component 3 also can leverage private investment through corporate social responsibility links. Components 1 and 3 could jointly lobby the League of Corporate Foundations to support worksite FP programs and birthing centers. Component 3 can incorporate some of the lessons learned from the

Banking on Health project to leverage commercial financing for private practice midwives in the form of microfinance loans from credit co-ops, rural banks, microfinance institutions, and other entities.

6.7 GRANTS STRATEGY

Grants have been the means for PRISM to leverage the private sector to achieve project objectives. They also have enabled building capacity among the targeted private sector actors, particularly business associations and conglomerates, which so far have been the major recipients of grants. PRISM could redesign aspects of these grants to better ensure the institutionalization of project activities, as discussed in the Component 1 section.

PRISM's initial grant strategy was unfocused and apparently designed to stimulate awareness of the project and interest in its activities. This approach resulted in the submission of many grant applications, raising expectations for PRISM funding. The project needs to manage expectations among its partners. Later requests for grant proposals for Component 1 and 2 applications were more focused and the resulting grants are beginning to achieve their objectives. While there are continuing needs for adjustments to the grant agreements to improve the potential for institutionalization and to enhance partner relationships (as discussed previously) and Component 3's grant strategy is still in formulation, the current grant strategy is achieving numerous project objectives.

Additional value can be provided by the use of grants, however, if new grants are designed to create synergies between project components. One of the most direct means of creating synergy is to use grants to stimulate the establishment of contraceptive and MCH commodity sales outlets to direct the supply of products (from Component 2) to the users generated at workplace programs (Component 1) and through private midwife practices (Component 3). There are several organizations establishing boutiques or kiosks to sell low-cost contraceptives and other essential products, including DKT's Pop Shops and the Botika ng Barangays. Other ways of enhancing inter-component synergies include

- training workplace clinic midwives (Components 1 and 3, see sections 3.2 and 5.1)
- enhancing communications between commercial suppliers and private practice midwives (Components 2 and 3, see section 4.4.3)

6.8 OVERALL RECOMMENDATIONS

- USAID and the PRISM implementation team should clarify their objectives, ensure the coherence of the broadened project's emphases with its overall strategies, and agree about the impact of the broadened focus on the resulting monitoring frameworks.
- The project team should prioritize building and rebuilding partner relationships.
- USAID and the project implementation team should look at the targets for each component and re-examine the targets' relevance in light of the importance of achieving the project's overarching goals.
- The PRISM team should re-evaluate the utility of the ORBIT M&E system versus simplifying approaches to data collection and tracking, such as purchasing and analyzing data about sales and contraceptive prevalence to track progress toward achieving the project's objectives.
- Employing a midwife (or at least a person who is familiar with midwifery and whom the midwives know and trust) on staff, or a team of consultants, to increase the ability to incorporate the midwives' perspectives in implementing Component 3 and to improve communication with the midwife association partners, would benefit PRISM. The project should obtain inputs from staff or

consultants with private sector experience, both to create a marketing-oriented mindset in implementing Component 2 and to increase the project's ability to think like the private sector in implementing Component 1.

- Project management should encourage synergies between components by creating intercomponent working groups or by designating staff to focus on increasing synergies between components.
- Given the need for the project to manage relationships, especially in view of the recent downsizing, PRISM should consider designating an officer or team to focus on field communications and outreach, external relations, and partner relationship-building.
- The public-private, private-public referral system PRISM and LEAD designed cannot be implemented effectively until donated or government-procured contraceptives become scarce. PRISM, therefore, should focus on two aspects of referrals: referrals from workplace programs to public and private providers and referrals from private midwives to higher-level providers and facilities.
- Institutionalization can be increased in the following ways: Component 1—obtain greater commitments from grant partners for continuing and replicating of workplace FP programs post project; Component 2—provide additional support to faltering grantees; Component 3—strengthen partner's capacity through follow-up and technical assistance.
- PRISM should document the ways in which it directly reaches the poor, as well as conduct a study to estimate its indirect effect on the poor.
- PRISM already has proposed appropriate maternal health interventions, selecting those which will impact both maternal and child health. USAID and project management should agree on a limited set of expectations for achieving MCH goals within the project's remaining three years.
- The project should use grants to increase synergy among project components; for example, using grants to stimulate the establishment of contraceptive and MCH commodity sales outlets to direct the supply of products (Component 2) to the users generated at workplace programs (Component 1) and through private midwife practices (Component 3).

ANNEX 1: SCOPE OF WORK FOR PRISM ASSESSMENT

DRAFT Scope of Work
Assessment of the Program and Component Strategies of
The Private Sector Mobilization for Family Planning Program (PRISM)

I. SUMMARY OBJECTIVES OF THE STRATEGY ASSESSMENT

USAID/Manila intends to engage the services of a four-person team for the assessment of the program and component strategy of the Private Sector Mobilization for Family Planning program (PRISM). The consultant team shall also identify areas that PRISM can improve on to ensure, that it achieves its goal of increasing contraceptive prevalence rate in modern methods via private sector involvement and that its major initiatives shall be carried on beyond project life.

II. BACKGROUND

A. USAID/Philippine Population, Health and Nutrition Strategic Objective

USAID's Population, Health and Nutrition strategy is focused on approaches that will improve and expand delivery of key health services so that "desired family size and improved health status [are] sustainably achieved". The cornerstones of USAID's PHN strategy include:

- Strengthening LGU provision and management of health services (IR1)
- Expansion of provision of quality services by private and commercial providers (IR2)
- Promotion of appropriate healthy behaviors and practices (IR3), and
- Improvement of policy environment and financing for provision of services (IR4).

The target areas for these interventions are spread across the country, with additional emphasis on the conflict-affected areas of Mindanao where health indicators are lower than the national averages. SO3 programs are geared to serve the low- and middle-income groups, and where possible, specific programs are designed to actively engage the poor communities including the informal sector.

B. The Private Sector Mobilization for Family Planning (PRISM) Program

PRISM is the Mission's main activity to address the challenge of increasing contraceptive prevalence rate (for modern methods and overall) in the country. PRISM will serve Strategic Objective No.3, "Desired Family Size and Improved Health Sustainably Achieved", particularly the part of Intermediate Result No.2 referring to improving and expanding family planning services provision by the private and commercial sector.

Chemonics International was awarded a five-year (2004-2009) contract (492-C-00-04-00036-00) with a ceiling of USD 32,036,699 by USAID/Philippines to harness private sector motivations and capabilities to increase the share of total need for family planning addressed by the private sector. The PRISM Project

seeks to reduce the unmet need for family planning among women of reproductive age who have the capacity to pay.

In working toward achievement of these objectives PRISM incorporates three project mechanisms the workplace, pharmaceutical market development, and private practice expansion components. The first component targets increasing the formal employment sector's involvement in and support of the promotion and provision of family planning and maternal and child health services among its employees. The second focuses on developing a viable and sustainable market for affordable modern contraceptives in the commercial sector, addressing the lack of suppliers for a commercial mass market for FP products. The third component works to enhance the business value of FP and MCH services provision to encourage more private providers to incorporate these services into their practices, and to develop these services into self-sustaining features of private health/medical practice.

Specific tasks under each component include:

Component 1: Increase support for FP within the Formal employment sector

Task A: Increasing public discussions by business leaders of population and FP issues

Task B: Increase support by firms for FP counseling, motivation, and service delivery or referrals, as appropriate for their workplaces

Task C: Increasing support by labor unions for FP counseling, motivation and service delivery or referrals in the workforce

Task D: Develop cost-effective and sustainable models of FP counseling, motivation and service delivery or referrals, as appropriate, for the workplace

Component 2: Establishment of viable mass market brands of oral and injectable contraceptives in the commercial sector

Task A: Increasing private sector suppliers recognizing the business opportunity in providing affordable oral, injectable and other types of contraceptives

Task B: Increasing readiness of the pharmaceutical industry to respond to market development and commercial opportunities glitch

Component 3: Increasing business value of FP in private providers' practice

Task A: Increasing number of midwives with self-sustaining private practices while incorporating FP services

Task B: Increasing support from medical profession for FP as an essential part of good provider practice

At the end of the five-year contract period in 2009, the project should have made significant progress towards increasing the national Contraceptive Prevalence Rate for modern methods obtained in the private sector to 20.5% from a baseline of 11.3% in 2004. The projected overall CPR is 42% in 2009 from 35.1%. The PRISM target represents an increasing share of the private sector in CPR increase. Towards these ends, participating private sector agencies and institutions should achieve the following intermediate results:

Workplace

- At least 12 by 2009 (a total of 31) national associations/partner institutions with capacity to implement workplace FP/MCH programs, from zero in 2004
- At least 198 by 2009 (a total of 1000) grantee member firms/cooperatives with the capability to implement, monitor, report on progress of PRISM-supported FP/MCH programs
- At least 80% of participating companies with a workplace policy on FP/MCH service provision
- At least 80% of participating companies with improved FP/MCH program as indicated by the score on the FP/MCH index one year after installation
- Proportion of employees in target companies/cooperatives reporting use (or partner's use) of a modern FP method increased
- Proportion of pregnant women in target companies/cooperatives reporting use of project-supported MCH services increased

Pharmaceutical/Market Development

- Over 2004 baseline, number of units of oral contraceptives sold increased by 62%
- Number of units of injectables sold to grow by almost 17 times (1663%)
- 60% increase in the number of units of IUDs sold
- Increase market share for private sector FP products from 32.8% to 70.4%
- Increased proportion of users of OCs who obtained them from a private sector source at last purchase from 41.8% to 72%
- Increased proportion of users of injectables who obtained them from a private sector source at last purchase from 6.3% to 42%
- Increased proportion of users of IUDs who obtained them from a private sector source at last purchase from 17.5% to 59.3%

Private Providers

- At least 75% of participating private healthcare providers other that midwives that offer at least one project-supported MCH services
- At least 70% of participating midwives who report increased revenue from FP service provision six months after training
- At least 75% of participating private midwives who provide tetanus toxoid vaccine services
- Number of claims for reimbursements from PHIC or covered family planning services increased five times
- At least 70% of participating midwives who are BEST-certified six months after training

III. CONTEXT THE OF STRATEGY ASSESSMENT

The PRISM strategy evaluation is especially opportune in light of the new cooperative agreements that OPHN/USAID will enter into including health sector development, health policy, health promotion and communication, integrated health services delivery in the ARMM, and TB/infectious diseases program.

Closer and tighter coordination among health projects, in terms of work planning as well as co-locating in select provinces, will yield optimal impact. A significant shift is the integration of family planning (FP) into the larger framework of maternal and child health.. In fact, Chemonics International's scope of work for the PRISM project is currently being modified to integrate the maternal and child health agenda as a strategy to provide FP in a more holistic manner. Moreover, the pro-poor agenda will be prioritized in all OPHN projects.

IV. OBJECTIVES OF THE STRATEGY ASSESSMENT

A. General Objectives

The strategy evaluation is designed to assess the appropriateness of PRISM's general program strategy and the strategy for each component including, 1) expanding implementation of family planning program in the workplace; 2) developing the commercial market for contraceptives; and 3) expanding the business value of private provider practice that includes family planning services and products.

Vis-à-vis USAID's Strategic Objective No. 3 `Desired family size and improved health sustainably achieved', the assessment shall look at how relevant PRISM's approaches and schemes are in pursuing the target increase in modern contraceptive prevalence rate, and in installing and/or institutionalizing the requisite processes in the workplace, in the commercial pharmaceutical industry, within private provider associations, and within other project stakeholder associations/agencies.

The strategy evaluation shall outline PRISM accomplishments and shortfalls, identify opportunities and constraints, as well as strengths and weaknesses in the program and component strategies, explicit or latent, and propose changes in the strategies of the three components, to better facilitate achievement of PRISM project goals.

B. Specific Objectives

In particular, the strategy evaluation shall examine the overall strategy of the PRISM program as well as the strategies for each of the project's three components, and then assess their advantages/disadvantages and strengths/weakness, with particular attention to the following:

1. Current and potential intra-/inter-component synergies/collaboration; how one component's inputs/efforts are utilized in other components within the PRISM project;
2. Current and potential areas for synergies/collaboration between PRISM, as a whole or by components, and other OPHN/USAID programs, current and upcoming;
3. How component strategies and activities are contributing to achieving institutionalization of PRISM interventions beyond project life, and recommend modifications that will increase the institutionalization capacity of the components. Specifically, identify institutionalization options for the key interventions such as training and business enhancement support for midwives and other health professionals; training and monitoring support for workplace family planning management teams; and encouraging suppliers to sustain market availability of low-priced contraceptives.
4. How the current program addresses the pro-poor agenda and recommend approaches to pursue this within the program (monitoring) framework, with minimal modification;
5. The best ways to integrate the maternal and child health care into the framework to provide a more holistic context to the pursuit of family planning within the private sector; and
6. How grants are currently being used to leverage private sector investments in FP/MCH, and identify

how this and other mechanisms can be more effectively utilized to engage the private sector with progressive intensity.

7. Are the indicators appropriate and do they directly contribute to the overall SO3 indicators?

V. STATEMENT OF WORK

A. Tasks

The strategy assessment report should cover at least the following:

1. Identification and assessment of the program and component strategies of PRISM,
2. Description of current performance of PRISM,
3. Suggested modifications/changes in the program and component strategies of PRISM to better ensure achievement of program goals at the end of the project, and
4. Identification of mechanisms to ensure sustainability of key component interventions beyond project life (2009).
5. Integration of maternal and child health activities into on-going PRISM activities.
6. Provide recommendations to increase pro-poor impact.

B. Suggested Focus Areas for the Strategy Assessment

1. The objectives, strategies, benchmarks and directions of the PRISM project

The evaluation shall ascertain the state of PRISM accomplishments as well as its shortfall within the seven quarters of project implementation (Oct 05 – Jun 06). For each of the components, the strategy evaluation should address the following questions:

a. What is the explicit strategy of PRISM, overall and in relation to the individual components? How consistent are these strategies with the project and component objectives?
b. How well is each component performing in terms of delivery on their objectives/tasks? What are the benchmarks for determining fulfillment of objectives/tasks? What factors contributed to or hindered the completion/achievement of objectives/tasks? How were these addressed?
c. What are the major opportunities that PRISM should be building on relative to the components?
d. What other mechanisms can make the program more attractive for the private sector segments targeted by PRISM components to invest more in health including family planning and maternal and child health?
e. Following the project strategy and mechanisms in all areas, is it possible to achieve project objectives? What are the advantages and weaknesses in the current strategy to achieve project objectives?
f. Provide strategies to increase pro-poor impact where feasible.
g. Provide approaches in integrating MCH into the overall PRISM strategy.

2. Identifying current and potential intra- and inter-component synergies

The strategy evaluation shall identify current and potential intra- and inter-component synergies and collaboration; how component inputs and efforts are utilized in other components within the PRISM

project. The study is expected to thresh out specific issues within each component and provide suggestions to increase cross-fertilization between components, covering but not limited to the following:

a. Component 1 Workplace Component

- What type of companies (by size, industry, location, gender composition, location) are best targets for PRISM? What kind and level of investments can be leveraged from these companies?
- What is the strategic value of engaging SMEs and the informal sector? What are the major opportunities and constraints in engaging these sub-sectors, and what mechanisms can be installed to make their engagement feasible and sustainable? How workable, for instance, might sister company/workplace arrangements, and development and management of a common service facility (CSF) be?
- How can this component facilitate pursuit of poverty alleviation or the pro-poor agenda? What are some of the ways that the pro-poor agenda can be served sustainably?

b. Component 2 Market Development

- How congruent or incongruent are the principles, mechanisms and results of contraceptive self-reliance, social marketing, and PRISM's Component 2 interventions?
- How has PRISM fared in developing alternative mechanisms for FP products and services delivery, and what potentials are there to tap?
- How are the marketing grants to pharmaceutical companies likely to impact on the market in the medium- to long-term? How likely are pharmaceutical firms to supply affordable contraceptives (without social marketing support) beyond PRISM grants?
- Between the low-priced or the mid-priced contraceptives which will have greater impact on the market (i.e. reach greater population, be sustainable in the long term, etc.? How useful would be assigning a price ceiling for products that PRISM will support?
- What is the general prognosis for a commercial IUD market? How might phase out of free IUDs impact on the contraceptive market? Is it feasible for PRISM to accommodate IUD commercialization?
- How might more equal `airtime' for non-commodity family planning methods, such as services and modern FAB methods, complement Component 2 to increase CPR?

c. Component 3 Private Practice Expansion

- How best to expand the business value of FP in (private) providers' practice? How appropriate is the current strategy that focuses on midwives? What approaches would be most effective in mobilizing private health practitioners/providers towards FP services provision?
- What types of organization or institution is best placed to provide business coaching, mentoring and other technical support to midwives?
- How does the current Component 3 strategy impact on the provision of family planning goods and services by participating private providers? *What are the key constraints to or bottlenecks in the implementation of Component 3 tasks/activities?*
- Given the characteristics of midwives associations, what are the most appropriate approaches to motivate their engagement in FP products/services provision?

- How can MCH be incorporated into this component?
- Pro-poor agenda via this component

d. Cross-Cutting Concerns

i. *Government or Public Sector Involvement*. How crucial to PRISM success is engagement of the public sector? What government agency or unit – GRP national, LGUs executives, government instrumentalities at the local level – should PRISM engage and how? What, if any, are the issues in PRISM's working relationship with the DOH and other government institutions? How were they being addressed?

- The Local Governments. How crucial to achievement of PRISM tasks and goals is engagement of local governments? To what extent is the current program strategy encouraging or allowing for LGU involvement? To what extent has the program engaged LGUs? To what extent should it?
- PhilHealth. What is the progress made towards improving the effectiveness and efficiency of PhilHealth's social insurance program in promoting access to priority services? To what extent should PRISM engage PHIC towards supporting implementation of USAID's health program concerns? How might PHIC respond to the demand-generating advocacy of PRISM, eg. accreditation of private midwives, and lying-in clinics, access of workplace population to accredited VS providers?
- Health Sector Reform Agenda and FOURmula One sites. What are the advantages and disadvantages to having PRISM co-locate with other donors to support the GRP Health Department's HSRA and F1 priorities? Are the bases for selection of current strategic intervention areas consistent with GRP program priorities?
- Health Department (DoH) and with other USAID-assisted health projects. What is the connection between PRISM and the GRP's health sector reform agenda? How far should PRISM engage the public sector? What should be the appropriate form of engagement or coordination with specific initiatives in the HSRA like the development of inter-local health zones, planning, budgeting, and national program implementation at the LGU level?
- DOLE (Labor and Employment Department): How crucial is DOLE involvement in implementing and in sustaining workplace interventions? How far can and should PRISM engage or assist DOLE?

ii. *Contraceptive Self Reliance.* How significant is CSR as facilitative factor for PRISM, and (vice-versa or) how significant is PRISM in facilitating CSR success? Is there a need to intensify either role?

iii. *Management, Administration, and Organizational Structure.* Is the current organizational structure supporting or constraining project implementation? Is the current management setup appropriate to/supportive of the project strategy? How can we improve management of USAID's assistance to strengthen the project?

iv. Monitoring/Evaluation – What are the feed back/feed-forward mechanisms to determine how each component and the program is faring? How do these work? Are they useful and responsive, serving to inform the next steps/activities for the program? Are there ways we can improve the monitoring and evaluation systems in the program to capture project impacts?

v. Policy What is the current level of PRISM involvement in health policy work? How crucial is policy work in ensuring the success and sustainability of PRISM tasks and activities? What are the crucial policy issues that PRISM should be involved in, and how?

- Health Financing What is the progress made towards addressing health sector policy and financing concerns that directly affect the success of USAID's programmatic areas? What was the quality of TA and contribution towards facilitation and coordination of inputs from all partners and stakeholders?
- Referral Systems: public-public, private-private, private-public? What are the major constraints and opportunities in installing referral systems? A functional referral system is one that ensures the continuity and complementation of health and medical services. Given the resource imbalance between public and private health systems, and among current and potential MCH/FP clients, how useful and viable are exclusive public-to-public or private-to-private referral systems to improving services in MCH/FP? Would a national policy/legislation/directive facilitate the installation and operationalization of public-to-private referral systems?
- The ARMM. Is there need for a specific strategy to implement PRISM in ARMM? What should be the strategy or key considerations in formulating the strategy for PRISM in ARMM?

3. Identifying current and potential synergies with other OPHN projects

The strategy evaluation team is expected to:

- Identify and assess current/potential areas of friction/non-cooperation and synergy/collaboration between PRISM, as a whole or by components, and other OPHN/USAID programs, current and upcoming.
- Assess whether PRISM is utilizing accomplishments, outputs and lessons of past projects, and building upon or adding value to these?
- Propose ways for PRISM to better utilize resources from other USAID projects, past, ongoing and upcoming
- Describe how PRISM relates with the other USAID/OPHN activities and projects, and suggest mechanisms to strengthen coordination towards more productive collaboration

4. Institutionalization and capacity-building

- Assess how component strategies and activities are contributing to achieving institutionalization of PRISM interventions beyond project life, and recommend modifications that will make components more valuable to achieving institutionalization;
- Identify institutionalization options for the key interventions such as training and business enhancement support for midwives and other health professionals, training and monitoring support for workplace family planning management teams. Identify in what areas could and should PRISM be capacitated in order to pursue FP/MCH in a sustainable manner beyond PRISM life. How can PRISM be capacitated.
- Assess current capacity-building activities in terms of their impact on enhancing private sector delivery of FP and other health services, and on how they address the issue of sustainability; Define the core strategy for capacity building, and identify the gaps that need attention, and what other

kinds of technical assistance are necessary

5. Pursuing the pro-poor agenda

The strategy evaluation will assess how the current program actually addresses the pro-poor agenda, identify and underscore current opportunities embedded within the PRISM project to pursue the pro-poor agenda, and recommend approaches to address the pro-poor agenda within the current program (monitoring) framework with minimal modifications.

6. Integrating crucial maternal and child health care tasks

The evaluation team will identify the best ways to integrate the maternal and child health care into the project framework to provide a more holistic context to the pursuit of family planning within the context of a more comprehensive maternal and child health approach. In particular, it will:

- Identify the best areas of collaboration between PRISM and the Health Department in the pursuit of maternal and child health (MCH), which includes family planning;
- Identify way/s to integrate the following MCH indicators, initially identified as integral to family planning promotion: tetanus toxoid vaccination, at least four prenatal visits, referrals for warning signs of complicated pregnancies, breast-feeding campaign, and midwife-assisted formulation of a birth plan.
- Harmonize, realign, and when appropriate remove indicators from the current/original PRISM key indicators to support the expansion of maternal and child health. When appropriate recommend appropriate MCH indicators.

7. Leveraging private investments

The consultant team for the strategy evaluation shall define mechanisms to pursue and to measure private sector counterpart investments in family planning (within the MCH framework). A fundamental premise of the PRISM project is that the private sector has vast resources that can and need to be tapped for health. PRISM's grant program is one mechanism to engage the private sector progressively meaningfully via investments in health. The PRISM strategy evaluation will assess how this is currently being done, how it can improved, how better to do it, and will identify what complementary mechanisms can be pursued to sustainably leverage private investment in FP and MCH services delivery.

C. Methodology

The strategy evaluation team will review project documents, reports and supplement their project understanding with interviews of key people nationwide in strategic intervention areas, USAID, DOH, DOLE, NEDA, Chemonics International, subcontractors (PBSP, IRHP, PNGOC, Manoff, EngenderHealth, and EMI Systems), business associations, provider associations, pharmaceutical companies, midwife graduates of PRISM training, local government executives in PRISM SIAs, other OPHN/USAID projects with whom PRISM coordinates, provincial/municipal/city health officers in PRISM SIAs.

D. Coverage/Geographical Areas

The final coverage area of the evaluation of PRISM program and component strategies shall be decided by USAID from among the program's current strategic intervention areas.

E. Respondents/Key Informants

Suggested key informants include the following:

1. Private Associations – from (a) the workplace, such as business chambers and cooperatives, (b) the providers sector, such as midwives, pharmacists, doctors, others, and (c) the pharmaceutical industry, particularly the members of the steering committee or participants to the PRISM-organized December 2005 CEO Forum, and the participants to the PRISM-organized Matching Forum held in March 2006;
2. PRISM Grantees – from (a) the workplace, the Lopez group, the Cavité Chamber, and the Cagayan de Oro Chamber, and (b) the pharmaceutical industry, Organon, Schering, and ECE
3. PRISM Subcontractors home office key person or representatives from PBSP, PNGOC, IRHP, Manoff, EngenderHealth, and EMI Systems
4. The Philippine Government (GRP) – from (a) DOH, Usec Nieto, Dr. Oliveros, Drs. Catibog, Apale, and Carol; Dr. Ala, M.Beltran; (b) DOLE – Bureau of Women and Young Workers (BWYW) Executive Director; (c) PhilHealth; and (d) local government units, Local Chief Executives or Provincial/City Health Officer, in PRISM strategic intervention areas (SIA)
5. PRISM directors and staff from Components 1, 2 and 3; from the Grants unit, the Policy Unit, the Operations Unit, the Regional Offices; and the SIA Field Coordinators.
6. OPHN programs contractor key staff, such as LEAD/MSH, TSAP/AED, and others such as WPFI, WFMC
7. USAID Chief, PRISM CTO, and other OPHN Staff
8. BEST (Component 3) participants – random/on-field selection
9. Workplace (Component 1) participants - selected at random, on-field (SIA)
10. Donors doing private sector support project in health

F. Deliverables

- A workplan for the evaluation including design and timeframe
- A draft report of the evaluation
    - Identification and assessment of the program and component strategies of PRISM,
    - Description of current performance of PRISM
    - Suggested modifications/changes in the program and component strategies of PRISM to better ensure achievement of program goals at the end of the project
    - Identification of mechanisms to ensure sustainability of key component interventions beyond project life (2009).
    - Suggested mechanism and indicators to integrate maternal and child health activities into on-going PRISM activities, and
    - Recommendations to increase pro-poor impact.
- A final report of the Evaluation that incorporates comments from USAID not to exceed 50 pages excluding executive summary and attachments.

VI. RESOURCES AND PROCEDURES

A. Data Sources

The assessment team will review program documents, including but not limited to the following:

1. Private Sector DAAD (Development Activity Approval Document)
2. PRISM Project Contract
3. PRISM Annual Workplans
4. PRISM Annual and Quarterly Reports
5. Key PRISM Outputs (TNA of Midwives, Compendium of Companies, others)
6. USAID/OPHN Results Framework
7. Briefer on other OPHN/USAID-supported programs
8. RFAs (request for assistance) for the five upcoming OPHN projects, namely, health sector development – policy; health sector development – LGU systems; health promotions and communications, the Integrated ARMM Project, and the TB-Infectious Diseases project.
9. Assessment documents and key reports from past USAID-assisted private sector programs
10. Other key documents on PRISM and other OPHN projects

The team will conduct personal interviews with central and regional program officers and key staff of PRISM, and a few randomly selected Field Coordinators, representative of Components 1,2 and 3, the Grants and Subcontracts group, the Policy group, and the Operations group. The subcontractors – PBSP, PNGOC, IRHP, EngenderHealth, Manoff and EMI Systems - will also be interviewed, although the latter three shall be interviewed through a telecon. Where possible, the team shall also conduct a telecom with the Chemonics International key officers for PRISM.

The team shall interview PRISM's partners and collaborators within the Department of Health (DOH), the Department of Labor and Employment, and the Philippine Health Insurance Corporation (PHIC). The team will meet with key technical staff of OPHN and of USAID/Philippines. Where possible, the team shall meet with local government stakeholders, either the local chief executive or the city/provincial health officer.

The evaluation team will conduct individual and group interviews with health provider associations, industry chambers, workers' federations, and pharmaceutical companies who are partners of PRISM in plan formulation, policy discussions and/or program implementation. The team shall also engage in discussion with selected midwives and pharmacists who have been PRISM training participants.

The team shall have a briefing from OPHN at the start of the evaluation and a debriefing to the same as well as to PRISM key officers, after fieldwork. As a separate debriefing to a wider group including DOH, DOLE and USAID Philippines officers may be arranged. In between these, the team shall discuss with OPHN program CTOs (or Cognizant Technical Officers) and the key officers of OPHN programs. The team may also meet with technical officers from USAID/Philippines.

B. Methods of Data Collection

The team shall be provided a copy of the most relevant documents prior to their arrival in the Philippines. OPHN will provide a draft itinerary for the team which will be finalized during their first day in-country. In-country activities will include meeting with the OPHN Chief and other OPHN staff, interviews with local staff of selected USAID-supported cooperating agencies, representatives from other selected agencies, government and non-government organizations, other local partners and experts. Field trips to do field interviews and/or focus group discussions will be carried out.

C. Duration and Timing of the Evaluation

The evaluation of PRISM project strategy will be done in three or four weeks. It will begin in the third week of August 2006 (preferably August 14) and will be completed before the end of August. The team will submit a draft report immediately after the field visits/meetings in-country assessment (on or about September 07, 2006). Comments on the first draft report are due after one week (on or about September 14, 2006). Once the team leader receives comments on the first draft, he/she will have one week to incorporate them into the final report. A time line is outlined below:

Week 1:

- > Review of relevant project documents
- > Finalization of strategy assessment schedule and itinerary
- > Meetings with directors, key officers and selected staff of PRISM representative of Components 1-3, the Policy Unit, the Grants/SubContracts team, and the Operations group.

Week 2-3:

In-country fieldwork: meetings/discussion with field staff, stakeholders and partners in GRP (DOH, DOLE, PhilHealth), in the business sector, in civil society, and in the health sector

- Preparation of draft report and debriefing meeting with USAID

Week 4:

- USAID/Philippines comments on draft report
- > Team Leader incorporates comments and finalizes report

A detailed outline of the key findings and recommendations, among others, should be incorporated into the draft report to be provided to USAID/Philippines after the fieldwork is completed. The final report should be printed and ready for distribution not later than the third week of September 2006.

D. Team Composition

The evaluation team will consist of three consultants with technical expertise and experience as described below:

1. An *Institutional Capacity-Building Expert* with extensive background on family planning and contraceptive self-reliance; worked in the Philippines or at least in Asia with experience in evaluation/assessment.

2. A *Health Management and Development Specialist* with background on family planning, and maternal & child health and HIV/AIDS with experience in the evaluation/assessment.
3. A *Business and Market Development Specialist* with track record in operationalizing a business strategy in a new or largely untapped market, with experience in the health sector, and with such experience in the Philippines or Southeast Asia

E. Funding and Logistical Support

All funding and logistical support for the assessment of the strategy of the PRISM project will be borne by USAID via the PSP-*One* contract. Activities that will be covered include recruiting and supporting the assessment team, funding all expenses related to the assessment, providing logistical support including setting up meetings in the Philippines, and producing and dissemination of the assessment report.

ANNEX 2. ASSESSMENT TEAM IN-COUNTRY SCHEDULE

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
TEAM	25 September, Monday	8:00 - 9:00 AM	USAID TEAM BRIEFING	CR, RP, ST, TC			USAID Conference Room			
TEAM		10:30 - 11:30 AM						FREE TIME		
TEAM		1:30 - 2:30 PM	PRISM	COP, DCOP, Senior Technical Directors		635-2397	23F Wynsum Corporate Plaza, 22 F. Ortigas Rd., Ortigas Center, Pasig City	CONFIRMED		
DW		2:30 - 5:30 PM	Component 3	Lemuel Marasigan	Senior Technical Director	635-2397 loc.				
DL			Component 2	Tennyson Levy	COP	635-2397 loc.				
				Agnes Pacho	RD-Luzon					
BB			Component 1	Lorna Jandoc	Senior Technical Director	635-2397 loc.				
BB	26 September, Tuesday	9:00 - 10:00 AM	DOLE- Bureau of Women and Young Workers (BWYW)	Cynthia Cruz	Executive Director	528-0089; 527 2556 Fax: 527-2488	DOLE-BWYW, 6/F B.F. Condominium, Solana corner Soriano St., Intramuros, Manila	Confirmed		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
		10:30 - 12:00 NN	Philippine Business for Social Progress (PBSP)	Jazmin Gutierrez	Assistant Director, Training and Consulting	527-774 to 50; 527-3743 Fax: 527-5972 Mobile: 0918-9191566 Email: JAGutierrez@pbsp.org.ph	PBSP Bldg., Magallanes cor Real St., Intramuros, Manila	Confirmed		
		2:00 - 4:00 PM	Philippine Chamber of Commerce Inc.	Joji Ilagan-Bian	Chairperson, Population	844-3424; 844-5713 loc 113 c/o Ms. Jing	19/F Salcedo Towers, 169 H.V. de la Costa St., Salcedo Village, Makati City	Confirmed		
DW		9:45 AM	Integrated Midwives Association of the Philippines (IMAP)	Patricia Gomez	President	724-4849, 0917-904-8261	IMAP Office Pinaglabanan corner Ejercito St., San Juan, Metro Manila	Confirmed please call Ms. Gomez on the 22nd		
		12:00 NN	PNGOC	Dr. Eden Divinagracia	Executive Director	834-5007, 833-4067/852-1898, 854-6771 loc 116	Room 304 Diplomat Condominium Bldg. Russel Ave., cor. Roxas Blvd., Pasay City	Confirmed		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
		2:00 PM	PRC (with office at DOH)	Dr. Josephine Hipolito	Chair, Continuing Professional Education Council	781-1721 ; 781-1723, 09192001337	Building 12-A, Department of Health, San lazaro Compound, Santa Cruz, Manila	Confirmed		
	26 September, Tuesday	3:00 PM	DOH-BHFS	Dr. Mercedes Palma	Chief Licensing Officer		Building 12-A, Department of Health, San lazaro Compound, Santa Cruz, Manila	Confirmed		
DL		8:00 - 9:00 AM	Wyeth Philippines	Noel Fortin	Associate Marketing Director	884-6783/ 884-6600 Fax: 884-6605	PRISM Office (since all of them are in the area during this time they requested to meet at the PRISM office)	Confirmed		
		9:00 - 10:00 AM	Marketlink International Corp.	Oscar Aragon	President/ Chief Operations Officer	638-1461 to 70 Mobile: 0918-9302135				
		10:00 - 11:00 AM	ECE Pharmaceuticals	Cox Ortega	Sales and Marketing Director	426-3360/ 928				

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
BB	27 September, Wednesday	8:00 - 9:00 AM	Cavite Chamber of Commerce	Bing Martinez	Project Coordinator	(046) 870-2999; 417-3906	2nd Flr. Walk-In Activity and Trade Center Emilio Aguinaldo Highway corner Andrea Village II, Panapaan, Bacoor, Cavite	Confirmed		
				Teresita Leabres	President					
				Edna Ibrado	Secretary General					
		11:00 - 12:00 NN	CADPI-Community Development Office or RGF Office Nasugbu, Batangas	Roy Luntayao	Group Manager	c/o Eric Camacho (PBSP) 0918 933-2935		Confirmed		
		3:00 - 4:00 PM	Lopez Group of Companies	Diane Ebarle-Minon	FP Project Coordinator	0921-3725261	BenPress 4th Floor, Ortigas Center, Pasig City	Confirmed		
		4:30 - 5:30	SIA	Ruby Amores	Coordinator		PRISM Office	Confirmed		
		5:30 -6:30 PM	PRISM Office	Lorna Jandoc	Senior Technical Director					
				Odilyn de Guzman	Technical Resource Group Manager					

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
NP & DW		8:00 - 9:00 AM	LEAD for Health Project	Dr. Dolores Castillo	Chief of Party	526-3877	11/F Ma. Natividad Bldg., T.M. Kalaw Ave. cor. Cortada St., Ermita, Manila	Confirmed; meeting could be disrupted or ended at 8:30 a.m. by a call from Cambridge that Dr. Dolly is expecting to get through		
NP & Tere		1:00 PM & onwards	Pangasinan Population Office (PPO)	Luz Muego	PPO Head		Pangasinan trip	Confirmed; upon arrival, dinner with Luz		
DW	27 September, Wednesday	1:30 - 2:30 PM	SME: PCCI Regional Office	Apolinar Aure	Ex-Officio/ Governor, Region IV	844-5713 loc 113 c/o Angie	19/F Salcedo Towers, 169 H.V. dela Costa St., Salcedo Village, Makati City	Confirmed		
		3:00 - 4:00 PM	Rotary	Atty. Penny Policarpio	Asst. Governor	0917-5395236	PRISM Office	Confirmed		
DW & DL		7:00 - 8:00 PM	Schering Philippines Corp.	Charito Magno	Director for Business Expansion	887-9700 Fax: 818-1858 Mobile: 0917-8417457	36th Flr., PBCom Tower, 6795 Ayala Ave., cor VA Rufino St., Makati	Confirmed		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
							City			
DL	28 September, Thursday	1:00 - 3:00 PM	Finance & Administration	Kristen Wiebe	Director		PRISM office	Confirmed; Both Odilyn and Kristen have previous appointments in the morning. (Odilyn- training and Kristen- doctor)- Cecile Pascasio		
			TRG	Odilyn de Guzman	Manager					
		5:30 PM until dinner	Organon Philippines, Inc.	Emie Flores	Product Manger	817-5270 Fax: 817-5221 Mobile: 0917-6282041	5th Flr, Feliza Building, 108 VA Rufino St., Legaspi Village, Makati	Confirmed		
NP & Tere		8:00 - 9:00 AM	Urdaneta City, Pangasinan	Luz Muego	PPO Head		City Health Office, Brgy. Bactad, Urdaneta, Pangasinan			
				Dr, Bernardo Macaraeg	City Health Officer					

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
		9:00 - 10:00 AM		Dr. Queliza	BTL Consultant		Urdaneta District Hospital			
		10:00 - 11:00 AM		FP Nurse c/o Doris						
		11:00 AM - 12:00 PM		Urduja dela Cruz	Brgy. Service Point Officer					
		1:00 - 2:00 PM		Norma Cadamas, Felicidad Aguilar, Melani Oliveros, Mary Anny Simon, Annie Solis	BEST Graduate Midwives	Norma Cadamas (0920 867-0129); Felicidad Aguilar (0920 806-0324); Melani Oliveros (0927 687-7292); Mary Ann Simon (0920 220-8097); Annie Solis, IMAP Pres., 0906 263-4598)	Urdaneta District Hospital Conference Room			
		2:00 - 3:00 PM		Rosie Rivera (Sto. Tomas)	PLGMPMI					
		3:00 - 3:30 PM		Dr. Carlos Prudencio	PAFP past President		Prudencio Clinic			
	28 September, Thursday	3:30 - 4:00 PM		Helena Hidalgo	Hidalgo Pharmacy (DSAP member)	no contact number	Stall 151-A Binalonan Public Market			
		5:30 - 6:00 PM	Lingayen	Janet de Asis	PMAP Secretary		PESO Office, Lingayen			

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
BB		CANCELLED DUE TO TYPHOON	A. Yuchengco Foundation Forum for Family Planning (conglomerate)	Dr. Alberto Romualdez	President	Marlea 0919 504-0135; marleaus@yahoo.com & forum4fp@yahoo.com	Bahay Alumni, UP Diliman, Quezon City	Bettina sent email questions thru email; responses expected week of Oct. 9 or later		
				Michael Dee Santos	Executive Vice President					
				Perlita Libiran						
				Marlea Muñez						
		CANCELLED DUE TO TYPHOON & NOT TO BE RESKED (BB)	Trade Union Congress of the Philippines	Ariel B. Castro	Union Representative	922-0917; 433-2208 Fax No.: 433-2208; abcastro@pldtdsl.net	TUCP-PGEA Compound, masaya & Maharlika Sts., Diliman, Quezon City			
NP & Tere	29 September, Friday	8:00 - 9:00 AM	San Fabian, Pangasinan	Dr. Rodolfo Rafael	PAFP President	no contact number	Cayanga Clinic	Confirmed		
				Dr. Amelyn Ramos-Rafael						
		9:30 - 10:30 AM	Mapandan, Pangasinan	c/o Doris			Women's Unity for Progress	Confirmed		
		Last Meeting		Luz Muego	PPO Head			Confirmed		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
DW & DL		FLIGHT TO DAVAO: PR 809 0500/0645	Family Care Clinic Davao	Ruth N. Talisic	Clinic Manager	0918-6033125	Yakal St., New Pandan, Panabo City	transport for meetings provided by PRISM Davao office		
		9:00 - 10:00 AM								
		11:00 - 12:00 NN	PRISM Office, Davao City	Keith Abilar	Regional Manager, Operations	(082) 222-5590		Confirmed		
		2:00 - 3:00 PM	WFMC MW	Anabelle Ledesma	Midwife-Owner of the clinic	0920-6234627)		To be confirmed		
		3:00 - 4:00PM	WPFI	Dr. Warlito Vicente	Executive Director		Room 307-B, Central Plaza I, JP Laurel Ave., Davao City	Confirmed except for the venue- his office		
			Kinangsa'an Foundation							
		TBD	Midwives Foundation of the Philippines (MFPI)	Beth Dumaran	Secretary	0922-831-5110	PRISM Davao Office	Confirmed		
		TBD	DOH-NCDPC	Meeting with Dr. Honorata "Dang" Catibog	Director III, Family Health Office	0920 920-4312		Confirmed		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
DW	29 September, Friday		Banking on Health	Julio Banzon				Confirmed		
			PRISM Office, Davao City	4 FP Coordinators				Confirmed		
				Fabe Rosiana (midwife)				Confirmed		
			IMAP Davao City	Rebecca Valdivia	Midwife/Local Chapter VP	173 Mars St., GSIS, Davao City; 296-2351		Confirmed		
DW & DL	30 September, Saturday		MIDWIVES' MATCHING FORUM (Davao City)							
		FLIGHT TO MANILA: PR 812 1315/1500								
TEAM		6:00 PM & onwards	Dinner/Meeting for updates and "despedida (send-off party)" for Bettina				TBD			

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
TEAM	2 October, Monday	10:00 - 11:00 AM	Bureau of Food and Drugs	Joshua Ramos	Director	842-5606 (Marissa)	Civic Drive, Filinvest, Corporate City, Alabang, Muntinlupa City	Confirmed		
		1:00 - 2:00 PM	DOH & PHIC	Atty. Nicolas Lutero (DOH/BHFS) and Dr. Eduardo Banzon (PhilHealth)		DOH/BHFS (743-8301 ext. 2502), Dr. S. Antonio (743-8301 ext. 1337; 0920 225-6914) & PhilHealth (TFx 638-3607; DL 687-3129)	Shangri-La Plaza Mall	Confirmed except for Dr. Antonio		
		3:00 - 4:00 PM	KfW	Mr. Nicolai Tust	Project Manager for Health in the Phils. (based in Frankfurt, Germany)	49 69 7431-4498 (Germany); 812-3165 loc. 27 (Ms. Olga Caday, KfW Local Expert)	PRISM	Olga can't come		
DW		PM	PRISM Office	Cynthia Garcia	Training Specialist					
				Sheelah Villacorta	Quality Assurance & Improvement Specialist					
DL		PM	PRISM Office	Odilyn de Guzman	Technical Resource Group Manager		PRISM			

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
				Agnes Pacho	RD-Luzon					
	2 October, Monday	5:30 PM	Organon Philippines, Inc.	Emie Flores		817-5270 Fax: 817-5221 Mobile: 0917-6282041	5th Flr, Feliza Building, 108 VA Rufino St., Legaspi Village, Makati			
TEAM	3 October, Tuesday	9:00 -10:00 AM	DOH	Dr. Ethelyn Nieto	Undersecretary	743-8301 (trunkline)	DOH, San Lazaro Hospital Compound, Sta. Cruz, Manila	Confirmed; 2/F Bldg. 2		
NP		10:00 AM - 12:00 PM	DOH	Jezebel Dado	representative staff of Dr. Virginia Ala, OIC, Director, Bureau of International Health Cooperation	743-8301 (trunkline)				
				Dr. Ciriaco Manrique						
			DOH	Carol Bandahala, Dr. Florence Apale, Dr. Odette Paulino		Carol (ext 1728/1725); Dr. Apale; Dr. Paulino (ext. 1700/1707; 0917 631-1058)		Confirmed for Carol only; Dr. Apale in Baguio until Oct. 6; Dr. Paulino in Iloilo until Oct. 6		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
			Institute for Reproductive Health	Mitos Rivera	Executive Director	0917 534-1442	DOH (c/o Mitos Rivera)	Confirmed		
		1:00 - 3:00 PM	USAID/OPHN	Aye Aye, Marichi, Siana, Chat, Tere, etc.				Mid-term/progress discussion		
		CANCELLED DUE TO CONTINUED POWER SHUT-OFF IN CAVITE AFTER RECENT TYPHOON	Workplace Assessment Trip			Madeline Gainza (PCCI-Cavite) (046) 437 0417; Fx 046 437-0421; 0919 574-0765; info@csgarment.com	Cavite Economic Zone, Rosario, Cavite	Bettina sent email questions thru email; responses expected week of Oct. 9 or later		
			Speedy Tech	Joy Pearl Camungan						
			MD Tech	Emelito Resurreccion						
			Mitsuwa	Rachel Cruz						
			CS Garment Inc.	Mrs. Concisa Sudhoff	Vice President					
DW & DL		FLIGHT TO CEBU: PR 857 1300/1415	JOLS Pharmacy (DSAP-member)	Lorenzo Ong	President of DSAP Cebu Chapter	256-1032 Mobile: 0920 -9132757	Magsaysay St., Cebu City	Flights confirmed as of 9/28		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
		3:00 -4:00 PM			(Owner of JOLES PHARMA)			(CMPAX6); Ces to arrange airport pick up and transport arrangements for meetings		
		3:30 PM	City Health Office	Dr. Fe Cabugao	City Health Officer					
	3 October, Tuesday			Dr. Milagros Padron	Division Chief, Field Programs					
				Mrs. Bernardita Pangan	FP Coordinator					
		4:30 PM	Provincial Health Office	Dr. Cristina Giango	Provincial Health Officer		G/F Capitol Bldg., Cebu City			
		5:00 - 6:00 PM	International Pharmaceutical Inc.	Pio Castillo Jr.	Chief Operations Officer	Phone c/o Jerold Geolingo		for reconfirmation		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
		6:00 - 7:00 PM	PRISM Project	June Gambe	SIA Coordinator	(032) 232-603436 Fax: (032) 2326034 loc. 112 Mobile: 09176249575	PRISM Visayas Regional Office, 2nd flr, Cebu Holdings Center, Cardinal Rosales Avenue, Cebu Business Park, Cebu City	for reconfirmation		
DW & DL	4 October, Wednesday	7:30 - 8:30 AM	PRISM	Emma Magsino	Regional Operations Director - Visayas		PRISM Cebu			
				Boyet Chantengco	Regional Operations Manager - Visayas					
		9:00 - 10:00 AM	Rose Pharmacy (DSAP Member)	Visayas Tablante	National Operations Manager	(032) 254-1491		for reconfirmation		
		10:00 AM	Cebu Youth Center	Ms. Odette Jereza	Board of Director		Alumni Hall, USP, Lahug			
			Mandaue Chamber of Commerce & Industry	Mr. Eric Mendoza				for confirmation		

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
DW		10:00 -11:00 AM	Brgy. Punta Health Center	Monina Uy	RH Midwife ECE LGU Client	0915-7805210	Brgy. Punta, Guadalupe City	for reconfirmation		
		11:00 AM - 12:00 PM	Brgy. Tisa Health Center	Eliseo Alcoseba	RH Midwife ECE LGU Client	TBI	Brgy. Tisa Health Center	for reconfirmation		
		12:00 - 1:00 PM	Kappel Shipping Group	Aster Omolon			PRISM Cebu			
		1:30 - 2:30 PM	Mendoza Maternity Clinic	Evelyn Mendoza						
DL		1:00 - 2:00 PM	ECE Pharmaceuticals Inc.	Giselle Montebon	District Visayas Manager	(032) 343-8135 Mobile: 0915-7312451	ECE Office, Cebu City	for reconfirmation		
				Enrico Tatad	Branch manager-Visayas					
	4 October, Wednesday	1:30 PM	Coastal Conservation & Education Foundation	Atty. Rose Liza Osorio			3/F PDI Bldg., Banilad, Cebu City			
		FLIGHT TO MANILA: PR 866 1930/2045								
NP		8:30 - 9:00 AM	USAID/OEE	Daniel Moore	Chief, OEE					

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
		9:00 - 10:00 AM	USAID/OPHN	Marichi de Sagun	Deputy Chief, OPHN					
NP, Chat & Tere		2:00 - 3:00 PM		Victor Agbayani and Luz Muego	Pangasinan Governor & PPO Head, respectively		Dusit Hotel Makati			
TEAM	5 October, Thursday	8:00 - 9:00 AM	UNFPA	Dr. Hendry Plaza	RH Program Officer	901-0317 (Pearl); Fx 901-0348	30/F Yuchengco Tower, RCBC Plaza, 6819 Ayala Ave., Makati City	Dr. Plaza confirmed; Ms. Tayzon for confirmation		
				Florence Tayzon	Assistant Representative					
		10:00 - 11:00 AM	Zuellig Foundation	Dr. Kenneth Hartigan-Go	Executive Director	Fax 892-2871; Ching Araneta 864-0197	PRISM			
DL		11:00 AM - 12:00 PM	Finance & Administration	Kristen Wiebe	Director		PRISM			
DW		11:00 AM - 12:00 PM	Component 2	Agnes Pacho	RD-Luzon					
DL		1:00 - 2:00 PM	Component 2	Agnes Pacho	RD-Luzon					

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
TEAM		2:30 - 3:30 PM	World Bank Office Manila	Dr. Florence Tienzo	Human Development Specialist	637-5855; Loraine 0918 916-6865	23/F Taipan Place, Emerald Ave., Ortigas Center, Pasig City (Visayas Room)	Confirmed		
		4:00 - 5:00 PM	ADB	Dr. Karima Saleh	Senior Health Economist	632-444; 632-6892 (assistant)	6 ADB Ave., Mandaluyong City (Rm 6328W)	Confirmed		
		5:30 - 6:30 PM	DKT	Terry Scott	Country Director	687-5567 loc. 137	8/F Linden Suites, San Miguel Ave., Ortigas Center, Pasig City	Confirmed		
				Tina Fuentes	HQ Management Head					
				Michael Santos						
TEAM	6 October, Friday	8:00 - 9:15 AM	OPHN debriefing	Aye Aye, Marichi, Siana, Chat, Tere, etc.			OPHN	Confirmed, including arrangements for laptop & LCD projector		
	6 October, Friday	10:00 - 11:00 AM	Joint DOH/OPHN debriefing	Dr. Honorata "Dang" Catibog			DOH: Conference Room near			

USAID STRATEGY ASSESSMENT TEAM WORK SCHEDULE

(OCT. 6, 2006)

Team Member Assigned	Date	Time	Organization/ Office/ Department	Key Person/s	Designation	Contact Information	Venue	Remarks	OPHN STAFF	SUGGESTED DATE
				Carol Bandahala & Jezebel Dado as Dr. Virginia Ala's and ASec Villaverde's representatives	DOH/BIHC		Dr. Yoly's office (Bldg. 13, G/F; reserved thru Gina 10/4)	Confirmed with Baby		
				Dr. Yoly Oliveros	DOH/NCDPC			Confirmed as per Tere		
				Dr. Honorata "Dang" Catibog						
				Siana, Chat, Tere	OPHN			Confirmed with Dolly, including transport arrangements		
		1:30 - 2:30 PM	PRISM debriefing	PRISM key staff			PRISM	Confirmed with Ces, including arrangements for laptop and LCD projector		

ANNEX 3. SUMMARY OF PERFORMANCE INDICATORS AND ANNUAL TARGETS

COMP.	Performance Indicators	Definition	Baseline (2004)	Actual 2005	Annual Targets 2005	2006	2007	2008	2009
SO3	Contraceptive Prevalence Rate (CPR) for modern methods obtained in the private sector	The proportion of currently married women between ages 15-49 (or their partners) reporting current use of any modern family planning method	11.5%	12.8%	12.1%	14.7%	16.8%	18.8%	20.8%
Workplace FP Initiatives	1.1: Number of national associations/ partner institutions with capacity to implement workplace FP programs	PRISM supported business associations or other umbrella organizations implementing capability building activities, outreach, program monitoring and evaluation for workplace FP program among their member firms	0	0	1	3	6	9	12
	1.2: Target companies/ cooperatives implementing PRISM-supported FP programs	Refers to the number of companies or cooperatives participating in project interventions that execute project supported FP programs or those firms that improve on their existing programs.	0 (2006)	0	2	200	300	300	198
	1.3: Target companies/ cooperatives implementing PRISM-supported MCH programs	Refers to the percent of companies/ cooperatives participating in project interventions that implement project supported MCH programs or improve on their existing programs.	0 (2006)			0	TBD	TBD	TBD
	1.4: Proportion of employees in target companies/ cooperatives reporting use (or partner's use) of a modern FP method	The percent of male and female employees of reproductive age in participating companies/cooperatives who report current use of a modern family planning method.	TBD (2006)			TBD	TBD	TBD	TBD
	1.5: Proportion of expectant mothers/mothers with newly born babies who have used company supplied MCH services	Refers to the percent of employed mothers of newborns/expectant mothers who report using MCH services provided at the workplace in participating companies	TBD (2006)			TBD	TBD	TBD	TBD
Contraceptive Market Dev't	2.1: Number of cycles of oral contraceptives sold	Total annual sales of each brand of oral contraceptives measured in cycles sold	10.9 M	11.8	11.4 M	12.8 M	14.7 M	16.2 M	17.8 M
	2.2: Number of IUDs sold	Total annual sales of each brand of IUDs			.093 M	.100 M	.112 M	.129 M	.148 M
	2.3: Number of vials of injectables sold	Total annual sales of each brand of injectables measured in vials.	.116 M	.219 M	.146 M	.417 M	.751 M	1.276 M	2.042 M
	2.4: Market share for private sector FP products	Proportion of current users of a modern FP method who obtained their method from a private sector source at last purchase.	32.8%		35.6%	40.6%	50.0%	60.4%	70.4%

COMP.	Performance Indicators	Definition	Baseline (2004)	Actual 2005	Annual Targets 2005	2006	2007	2008	2009
	2.5: Source of oral contraceptives at last purchase	The proportion of users of oral contraceptives who obtained OC's from a private sector source at last purchase	41.8%		46.5%	51.5%	58.5%	65.5%	72.0%
	2.6: Source of injectable contraceptives at last purchase	The proportion of users of injectable contraceptives who obtained their injection from a private sector source at last purchase	6.3%		9.9%	15%	22%	32%	42%
	2.7: Source of IUDs at last purchase	The proportion of users of IUDs who obtained their device from a private sector source at last purchase	14.9%		18.3%	24.3%	35.3%	47.3%	59.3%
	2.8: Proportion of continuing modern family planning users who obtained their method from the private sector	Proportion of MWRA who are ever users of modern FP and continue to use modern methods obtained from private sector sources	TBD		TBD	TBD	TBD	TBD	TBD
Expansion of Private Practice	3.1: Proportion of participating (workplace) private healthcare providers other than midwives that offer at least one project supported MCH service	Proportion of participating *(workplace*) private healthcare providers other than midwives that offer at least one of the following project-supported MCH programs, namely: prenatal care (at least once), tetanus toxoid vaccine injection (at least one), post-natal counseling	TBD			55%	60%	65%	70%
	3.2: Proportion of participating midwives who report increased revenue from FP service provision 6 months after training	Proportion of midwives (who underwent BEST training) reporting increased revenue resulting from adding/expanding family planning services to services already offered.	59%		59%	65%	70%	70%	70%
	3.3: Proportion of participating private midwives who provide Tetanus Toxoid Vaccine services	Proportion of midwives (who undergo BEST-MCH training) providing immunization on tetanous toxoid to pregnant mothers	TBD (2006)				65%	70%	75%
	3.4: Number of claims for reimbursements from PhilHealth for covered family planning services	Number of claims for reimbursements from PhilHealth covered services by private physicians.		TBD	1,149	1,494	2,091	3,137	5,019

ANNEX 4. IMPLEMENTATION STEPS IN THE PRISM WORKPLACE FAMILY PLANNING PROGRAM

PRISM first approaches chambers, NGOs and other prospective grantees to determine their interest in a partnership. Since most NGOs need assistance in writing grants, PRISM conducts grant-writing seminars for prospective grantees. The prospective grantee determines company interest in FP workplace programs and writes a specific company target into its grant proposal. Once the organization receives board approval, the grant is submitted to PRISM, which evaluates the grant and usually sends it back for modification. Once the grant is approved, PRISM begins training the organization on the Family Planning Needs Assessment (FPNA), the FP Index, and the peer educators training. In principle the organization receives the M&E software and training and it now begins soliciting participation of companies.

GRANTEE PROCESS

Step 1 Solicit chamber or NGO for participation and begin dialogue	**Step 2** Prospective partner attends grant writing workshop	**Step 3:** Prospective partner determines company participants	**Step 4:** Prospective partner writes grant and seeks board approval	**Step 5:** Contract deliberations begin; PRISM assesses partner; Rewrites	**Step 6:** PRISM approval of partner Work Plan	**Step 7:** Partner training on FPNA, FP Index, Peer educators training;	**Step 8:** M&E training and software installation	**Step 9:** Partner begins company workplace health programs

There are also many steps involved in setting up a Workplace Health Program. Initially, a grantee approaches a target company and solicits their participation in the workplace program. If the dialogue is successful, discussions continue until the partnership is launched with a letter of commitment. At this point, the company briefings begin, as the grantee explains the workplace FP program process. Next the Family Planning Monitoring Teams (FPMT) is formed and begins operations, which include gauging current FP efforts through the FP Index, and determining employee characteristics and needs through the FPNA. The FPMT training comes next and the work plan is approved. Then peer educator training takes places and the company's policy is developed and approved by company management. M&E training begins and the monitoring software is installed. Only when a company goes through all these steps can it be said to have a fully functioning Workplace Family Planning Program. There may be delays at each step due to urgencies in the production cycle and communication delays. This process is repeated for each company, and the entire process averages 6 months to 1 year.

COMPANY WORKPLACE HEALTH PROGRAM PROCESS

Step 1: Solicit company participation and begin dialogue	**Step 2:** Launch Partnership; Letter of Commitment	**Step 3:** Company briefings on installation process	**Step 4:** Formation of Family Planning Monitoring Teams	**Step 5:** Pre-installation data gathering: FPNA and FP Index	**Step 6:** FPMT training; approval of Work Plan	**Step 7:** Peer educators training; education plan	**Step 8:** Policy Formation and approval	**Step 9:** M&E training and software installation

ANNEX 5. EXAMPLE OF WORKPLACE FP PROGRAM LEVERAGING CHECKLIST

1. Company's direct financial investments, which includes equipment, FP promotion costs, incentives for peer advisors, FP products provided by company, and any other miscellaneous direct costs.
2. Number of employees the FP peer educator(s) accompanies to clinic x time required to take employees to clinic x hourly wage(s) of peer educator(s).
3. Number of hours of training x hourly wage of each FPMT team member (add up totals).
4. Number of hours of training x hourly wage of each peer educator (add up totals).
5. Number of employees counseled on FP in clinic x average hourly wage of employees x total FP counseling time.
6. Worker's time for FP training (hourly wage x # of workers x hours of training).
7. FP training loss in productivity: # of employees x output per employee per hour x total # of hours= the loss in productivity.
8. Employee time to fill out the FP Needs Assessment x hourly wage; Loss of productivity can also be tabulated for the FP Needs Assessment.
9. Time to fill out the FP Index by HR mgr. x hourly wage.
10. Total time for training of clinic providers x hourly wage x # of providers trained.
11. Provider time for FP counseling in the clinic.

ANNEX 6. CONTRACEPTIVE STATISTICS IN THE PHILIPPINES, 2004-2006

The table below shows the trends in commercial contraceptive sales from 2004 to 2006.

TOTAL CONTRACEPTIVES (VALUE IN PHP)					
	MAT 2Q 2004	MAT 2Q 2005	GR	MAT 2Q 2006	GR
1. Oral Contraceptives					
Premium (P101 and above)	454,265,587	516,967,758	14%	547,848,344	6%
Med/Low (P100 and below)	179,059,464	219,335,631	22%	233,050,968	6%
Sub-total:	633,325,051	736,303,389	16%	780,899,312	6%
2. Injectables					
Premium	6,102,989	7,339,931	20%	6,961,799	-5%
Med/Low	1,078,705	8,502,424	688%	12,694,576	49%
Sub-total:	7,181,694	15,842,355	121%	19,656,375	24%
TOTAL:	640,506,745	752,145,744	17%	800,555,687	6%
Source: IMS and ECE (for Daphne and Lyndavel sales)					

The next tables below show the trends in the market segment for oral and injectable contraceptives from 2004 to 2006. Table Sales of Medium/Low Oral Contraceptive Brands also shows the suggested retail prices (SRPs) per cycle of each oral contraceptive brand in the segment.

TOTAL CONTRACEPTIVES (VOLUME IN CYCLES)					
	MAT 2Q 2004	**MAT 2Q 2005**	**GR**	**MAT 2Q 2006**	**GR**
1. Oral Contraceptives					
Premium (P101 and above)	2,303,207	2,432,003	6%	2,142,070	-12%
Med/Low (P100 and below)	7,514,930	9,766,187	30%	9,481,952	-3%
Sub-total:	9,818,137	12,198,190	24%	11,624,022	-5%
2. Injectables					
Premium	135,927	160,839	18%	158,286	-2%
Med/Low	51,588	406,620	688%	492,969	21%
Sub-total:	187,515	567,459	203%	651,255	15%
TOTAL:	10,005,652	12,765,649	28%	12,275,277	-4%
Source: IMS and ECE (for Daphne and Lyndavel sales)					

SALES OF MEDIUM/LOW ORAL CONTRACEPTIVE BRANDS (VOLUME IN CYCLES)						
Brand	**SRP (PhP)***	**MAT 2Q 2004**	**MAT 2Q 2005**	**GR**	**MAT 2Q 2006**	**GR**
Lady	25.75	394,309	887,878	125%	1,324,931	49.2%
Trust	35.00	6,775,424	8,581,964	27%	7,797,280	-9.1%
Micropil	44.00	243,396	201,120	-17%	235,980	17.3%
Seif	56.00	0	0		2,975	*
Rigevidon	67.00	9,681	11,505	19%	22	-99.8%
Marvelon	72.00	92,120	83,720	-9%	120,764	44.2%
Daphne	85.50	0	0		6,888	*
Total		7,514,930	9,766,187	30%	9,488,840	-2.8%
Source: IMS and ECE (for Daphne sales)						

INJECTABLES (VOLUME IN CYCLES)						
Price Category	**Brand**	**MAT 2Q 2004**	**MAT 2Q 2005**	**GR**	**MAT 2Q 2006**	**GR**
Premium						
	Depo-Provera	123,543	148,380	*20%*	151,155	*2%*
	Noristerat	12,384	12,459	*1%*	7,131	*-43%*
	Subtotal	135,927	160,839	*18%*	158,286	*-2%*
Med/Low						
	Depo-Trust	51,588	406,620	*688%*	452,229	*11%*
	Lyndavel	0	0		40,740	*
	Subtotal	51,588	406,620	*688%*	492,969	*21%*
TOTAL		187,515	567,459	*203%*	651,255	*15%*
Source: IMS and ECE (for Lyndavel sales)						
** growth rate not applicable, 2Q 2006 refers to beginning sales value*						

SALES VS. TARGETS OF GRANTEES AS OF JUNE 2006 (VALUE IN PHP)						
	Actual Sales (June 2006)	**Target Sales (June 2006)**	**% of June 2006 Target Accomplished**	**End of Grant Target**	**% of End of Grant Target Accomplished**	**Date of End of Grant Period**
Seif	114,984	23,190,000	0.5%	57,975,000	0.2%	Jul-07
Marvelon-28	12,185,432	8,847,711.15	137.7%	22,119,278	55%	Mar-07
Daphne	588,924	2,068,416	28.5%	5,171,040.0	11%	May-07
Lyndavel	2,383,290	471,744	505.2%	1,179,360.0	202%	May-07
TOTAL	15,272,630	34,577,871	44.2%	86,444,678	18%	
Source: IMS, Grant Agreements						

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