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The Potential Market for Expanded Private-Sector Family Planning in the Philippines

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COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

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COMMERCIAL MARKET STRATEGIES

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ABSTRACT

The Philippines, with a population of 80 million and an annual growth rate of 2.36 percent, had 3.2 million women using modern family planning methods in 1998. This number is projected to grow to 5.8 million by 2007. Seventy-two percent of users obtain their contraceptives from the public sector, where the majority of contraceptive supplies have been donated by USAID. Since USAID recently began to phase out its contraceptive donations, and the Philippines Department of Health has yet to demonstrate its willingness to procure contraceptive supplies, the question of how many clients can be served by the private sector is crucial. This study analyzes patterns of contraceptive use, makes projections about how the market will grow by method, and defines groups of clients based on their attractiveness to the private sector. The resulting market segments indicate opportunities for private-sector expansion.

KEY WORDS

Philippines, private sector, family planning, contraceptive social marketing, market segmentation, willingness to pay

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Executive Summary

EXECUTIVE SUMMARY

This report provides information on the growing number of contraceptive users in the Philippines and the market this might create for the private sector in light of the United States Agency for International Development's (USAID) plans to reduce its contraceptive donations to the Philippines. As health and development professionals grapple with the question of how to meet the family planning needs of a growing population, this analysis sheds light on the potential of the private sector to meet a substantial portion of the country's contraceptive demand and the policy and programmatic interventions required to achieve that potential. This paper analyzes patterns of contraceptive use, forecasts how the market will grow by method, and defines groups of clients based on assumptions about their attractiveness to the private sector.

As of 1998, there were 3.2 million women in the Philippines using modern family planning methods. That same year there were another 2.5 million women not using modern methods, but reporting that they intended to use family planning. Recent surveys show that contraceptive use is on the rise. Because of the momentum of population growth, there are many young women and men entering their reproductive years. Therefore, Commercial Market Strategies (CMS) estimates that based on trends in contraceptive prevalence and population growth, the number of family planning users in the Philippines will grow to 5.8 million women by 2007.

By extrapolating current trends in method mix, CMS projects that from 1998 to 2007:

- injectable users will triple to 900,000
- condom users will double to almost 400,000
- pill users will almost double to more than 2.2 million
- IUD users will increase only slightly to just under 500,000
- sterilization users will grow by 40 percent to 1.75 million

In 1998, the public sector supplied 72 percent of family planning clients in the Philippines; it remains the predominant provider. The government maintains a policy of providing public-sector care to anyone who requests it, regardless of income or ability to pay. Many of the women who use public-sector services, however, have the means to pay for private services. Nearly 60 percent of public-sector family planning clients are from the three highest standard of living quintile groups and can afford to pay for contraceptives in the private sector. There are other segments of the population that require subsidies for contraceptive services because of poverty or geography.

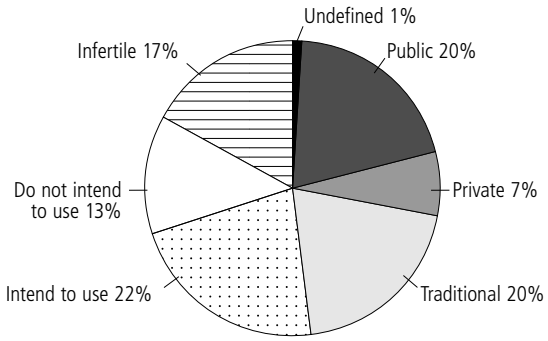
Users of oral contraception, the most popular method after sterilization, illustrate the opportunities and challenges facing the private sector. When pill users were asked about their willingness to pay for products, more than 50 percent of women in almost all categories (including public-sector clients and women in rural areas) stated that they were willing to pay at least 25 pesos for a cycle of pills.[1] Socially marketed pills have been available for 25 pesos or less since 1998. Nevertheless, private-sector utilization remains low because the public sector offers high-quality pills for free.

By 2007, the number of pill users is projected to reach more than 2 million women. If all women willing to pay 25 pesos obtained their contraceptives from the private sector, there would be nearly 1.5 million private-sector clients. Shifting so many clients from the public to the private sector, however, would require substantial changes to the public-sector program and concerted efforts by the private sector targeting consumers and private providers.

To understand the mix of current and potential family planning clients, CMS divided married Filipino women into categories (see Figure 1).

1 In 1998 when these data were collected, 25 Philippine pesos were equivalent to US $0.61. Table A1 provides exchange rates since 1996.

Figure 1. Married Filipino women and family planning use



As illustrated above, 70 percent of married women are using or intend to use family planning methods.

Shifting large numbers of public-sector clients to the private sector will need to be precipitated by significant changes in the public-sector program, such as stock-outs caused by the USAID phase down or policy and programmatic actions to target the limited public resources to the neediest clients. Following such changes in the public sector, the private sector may respond with increased marketing efforts to capture some of this new market or expanded training and pharmaceutical detailing activities to providers. Traditional-method users and women who intend to use contraception may be recruited to the private sector if the availability of services and counseling increases, but this change would require intensive provider-focused activities.

To determine which clients are most accessible to the private sector, CMS divided the existing and potential market of women of reproductive age into three groups based on their attractiveness to the private sector. The three factors used to determine attractiveness are ability to pay, urban or rural residency (which serves as a proxy for access to private-sector services), and the number of women in a market (sales volume is key for the private sector to make products and services widely available). The number of women in each of the three groups and their income and geographic features are as follows:

- very attractive customers (3.6 million women): urban well-off and urban upper-middle
- moderately attractive customers (4.4 million women): urban middle, urban mid-poor, rural well-off, rural upper-middle, and rural middle
- least-attractive customers (4.0 million women): urban poor, rural mid-poor, and rural poor

There are differences in market behavior among the women who are very attractive to the private sector. The wealthiest women in this group (urban well-off) are much more likely to use the private sector than those in the urban upper-middle. As a result, there is a need for marketing strategies to convince these women to use unsubsidized family planning products in addition to policies that exclude women with an ability to pay from public-sector services. In the moderately attractive category, the profiles of consumers suggest they are amenable to more aggressive marketing of low-priced family planning products. Although the least-attractive market segment would be a difficult group for the private sector to attract, there are possibilities for marketing spacing methods to young women in this group, perhaps as a secondary market for subsidized family planning products that are marketed to middle-income women.

Overall, recommended strategies to increase the use of private-sector products and services involve a combination of targeted-supply activities (push) and demand-creation activities (pull). Targeting of supplies to the neediest population may be accomplished by geographic targeting, means testing, user fees, or other mechanisms. These instruments, together with stock-outs resulting from reductions in USAID donations, can move clients with an ability or willingness to pay to the private sector. Activities that attract clients into the private sector include method-specific mass media campaigns that direct consumers to private-sector products and outlets, intensified detailing activities by pharmaceutical companies, training of private providers, and marketing interventions that increase access to affordable brands.

1 Introduction

INTRODUCTION

The Philippines had a population of 80 million people with an annual growth rate of 2.36 percent in 2000. Contraceptive use among married women was 49.5 percent in 2001 — 33.1 percent for modern methods — and has been increasing. The Philippines has a very young population. Women age 15 to 19 outnumber women age 45 to 49 by a ratio of more than 2:1. In addition, millions of women who report wanting to space or limit births are not using family planning. As a result, demand for contraception is likely to increase in the coming years.

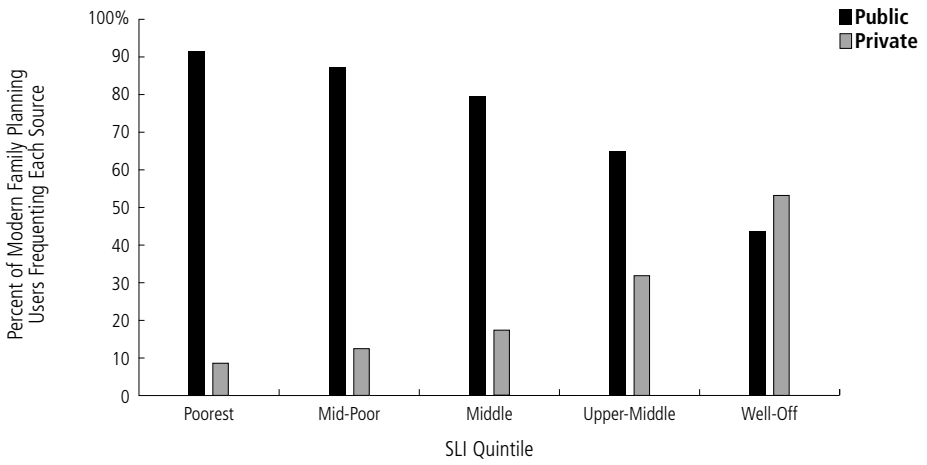
The government of the Philippines provides family planning services and supplies through public-sector clinics and hospitals across the country. These services are offered regardless of clients' income or ability to pay. The public sector supplies 72 percent of family planning users in the country. Many women who utilize the public sector, however, have the financial means to pay for private services. Almost half of all women in the wealthiest quintile obtain their contraceptives from the public sector, as do nearly 70 percent of women in the upper-middle quintile (see Graph 1).[2] The vast majority of these women indicate they are willing to pay for family planning services. Segments of the population who live in poverty or reside in rural areas do not have access to family planning other than public-sector clinics.

The majority of public-sector contraceptives provided in the Philippines are donated by the United States Agency for International Development (USAID). USAID recently announced plans to decrease its donations by implementing a transition to contraceptive self-reliance. Despite a budget allocation for contraceptive procurement, the Philippines Department of Health has yet to procure contraceptives for the public-sector program. Possible future scenarios include limited supplies or stock-outs in the public sector and greater demand for private-sector products and services. As public-sector resources and supplies are likely to decline in all scenarios, the government could target those limited resources to clients with the greatest need. Clients with an ability to pay could be encouraged or required to obtain their contraceptives from the private sector. Another possible future scenario is a reduction in the prevalence of modern contraceptive methods.

This report analyzes the size of the potential market for the private sector and encourages discussion and action to direct clients to the private sector for family planning. The report shows that in the private sector, pharmaceutical manufacturers, distributors, retailers, and private providers — doctors, midwives, nurses, and pharmacists — can expand their marketing and service-delivery activities to tap into new markets. For the public sector, these findings demonstrate to policymakers and service providers that many public-

2 Quintiles are based on partitioning the sample population into five equal groupings based on their ranking in an aggregate index of assets. See the section on Method of Analysis for more details.

Graph 1. Source of contraceptives for modern-method family planning users by standard of living index (SLI) quintile, 1998



sector clients can gain access to and afford family planning products in the private sector. By providing data on market size and projections of market growth, descriptions of potential clients, and strategies for reaching them, this report encourages efforts to direct clients to the sector that meets their needs most efficiently.

METHOD OF ANALYSIS

Commercial Market Strategies (CMS) used data collected in the 1998 Philippines National Demographic and Health Survey (NDHS) for the analysis presented in this report.[3] This survey collected detailed information on household composition and assets, family planning knowledge and use, and maternal and child health. The survey is nationwide and provides statistically sound estimates of various family planning and maternal and child health indicators at the national level, as well as for subgroups, such as urban and rural populations. A second survey, the Family Planning Survey (FPS), is conducted yearly to assess use of family planning services. This survey is not nearly as detailed on issues such as household composition and assets. Therefore, the FPS cannot provide points of comparison for the results presented below that depend upon break-outs by household standard of living. For certain overall indicators, such as total contraceptive prevalence and method mix, however, comparisons and trends are presented.

The principal method of analysis in this report is the cross-tabulation of contraceptive-use data with potential market segments. For private-sector marketing, the two most important factors for segmentation are ability to pay and access to contraceptive services and supplies. These factors are represented by standard of living and residency status (urban or rural), respectively. Standard of living is important because it indicates ability to pay for family planning services and is often correlated to willingness to pay for services. Residency status is significant as private-sector access and supply are much greater in urban areas than in rural ones.

Standard of living is defined by an aggregate index of assets, the Standard of Living Index (SLI), reported in the household module of the NDHS. Households are then ranked and partitioned into five equal groupings called SLI quintiles. Macro International and the World Bank performed the calculation of the index and the quintile groupings. Complete details on the calculations may be downloaded from the World Bank's Web site at www.worldbank.org/poverty/health/data/philippines/philippines.pdf.

The National Statistics Office in the Philippines defines urban and rural residency status. It is based on a complex assessment of population aggregates, including population size, population density, and the existence of urban infrastructure.

3 National Statistics Office (NSO), Department of Health (DOH) [Philippines] and Macro International Inc. (MI). 1999. *National Demographic and Health Survey 1998*. Manila: NSO/MI.

2 Analysis of Market Segments

ANALYSIS OF MARKET SEGMENTS

CONTRACEPTIVE USE

Table 1 shows contraceptive prevalence among married women across the five SLI groups. Tables 2 and 3 show the same information broken out by residency status. Contraceptive use is lowest for women in the poorest quintile, with less-pronounced variation among the other four quintiles. The rate of traditional-method use is constant across all SLI groups. In urban areas, contraceptive use holds steady at about 30 percent for the top four SLI groups. In rural areas, the top three SLI groups have a contraceptive prevalence of about 30 percent, while the lower two groups have prevalence of 20 percent to 25 percent.

Table 4 shows the residency distribution of users of modern methods of family planning broken out by SLI. Nearly 75 percent of the upper-middle and well-off modern-method family planning users live in urban areas. More than half of the poorest and mid-poor family planning users live in rural areas.

A strategy to focus limited public-sector resources on the clients with the greatest need could use residency status as a targeting tool because poor people are overly represented in rural areas. This strategy also makes sense because the private-sector products and services are concentrated in urban areas, as are clients with a greater ability to pay.

METHOD MIX

Tables 5 and 6 present the method mix of the most popular modern methods by residency status and by SLI, respectively. The proportion of wealthy women who utilize sterilization is higher than that of poorer women, and sterilizations are more frequent in urban areas. The share of wealthy women who use oral contraceptives is lower than that of poorer women.[4] Intrauterine devices (IUDs) are more frequently used

4 The percents are converted to actual numbers of users later in the report. Since wealthy women have higher contraceptive usage, the number of users in the wealthiest two quintiles exceeds the number of users in the poorest two quintiles.

Table 1. Type of method by SLI, all married women, percent

Married Women	Poorest	Mid-Poor	Middle	Upper-Middle	Well-Off	Total
Not using	63.0	54.2	47.3	45.5	50.8	52.2
Modern method	19.6	26.2	33.0	33.0	29.4	28.2
Traditional method	17.4	19.6	19.6	21.5	19.9	19.6
Total %	100	100	100	100	100	100
Number of observations	1,682	1,717	1,641	1,713	1,582	8,335

Table 2. Type of method by SLI, urban married women, percent

Urban Married Women	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off	Urban Total
Not using	61.1	51.2	44.9	44.3	51.0	48.4
Modern method	21.7	29.2	34.9	33.8	29.1	31.3
Traditional method	17.3	19.6	20.3	21.9	19.9	20.3
Total %	100	100	100	100	100	100
Number of observations	226	596	920	1,176	1,304	4,222

Table 3. Type of method by SLI, rural married women, percent

Rural Married Women	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off	Rural Total
Not using	63.3	55.8	50.5	48.2	49.5	56.1
Modern method	19.3	24.6	30.7	31.1	30.5	25.0
Traditional method	17.4	19.5	18.9	20.7	20.1	18.9
Total %	100	100	100	100	100	100
Number of observations	1,456	1,121	721	537	279	4,114

Table 4. Residency of modern contraceptive users, percent

	Poorest	Mid-Poor	Middle	Upper-Middle	Well-Off	Total
Urban	14.8	39.0	59.3	70.8	82.0	56.6
Rural	85.2	61.0	40.7	29.2	18.0	43.4
Total %	100	100	100	100	100	100
Number of observations	330	456	550	571	479	2,386

Table 5. Method mix by residency status, percent

Method	Rural Total	Urban Total
Pill	36.6	33.7
IUD	16.0	10.7
Injectable	9.6	7.3
Female sterilization	32.5	41.9
Condom	5.3	6.3
Total %	100	100
Number of observations	1,027	1,349

in rural areas and among the poorest women. Condoms are not a popular method, but the percentage of well-off women using condoms is twice that of the poorest women. Method mix data analyzed by SLI for urban and rural areas are shown in Tables A2 and A3 in the Appendix.

SOURCE MIX

This section examines the source mix for contraceptive methods. The sources are divided into three categories:

- public: all government facilities or sources
- private providers: private clinics, hospitals, and practitioners
- pharmacy: pharmacy or store

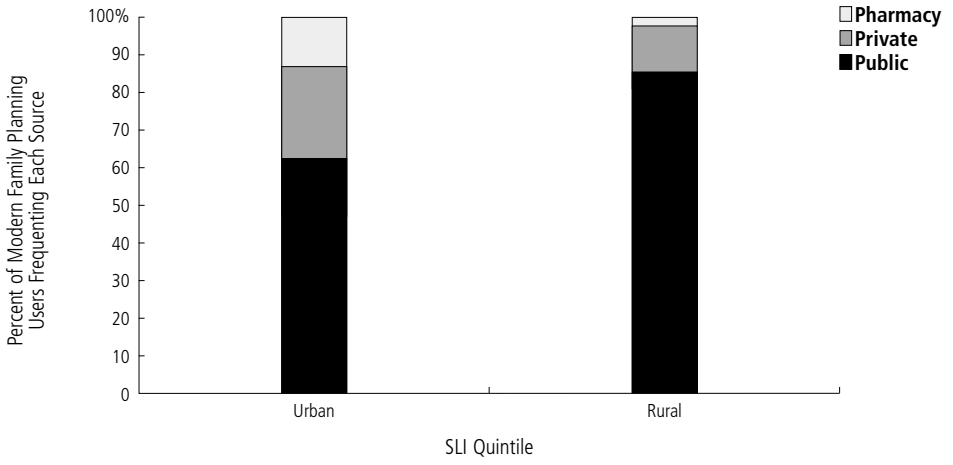
The private providers and pharmacies constitute the private sector. Some sources mentioned in the survey were not classified. These unclassified sources served less than 2 percent of the family planning users.[5]

5 The unclassified sources included other private, relatives, friends, non-governmental organizations, industry-based clinics, puericulture centers, churches, other, and "don't know."

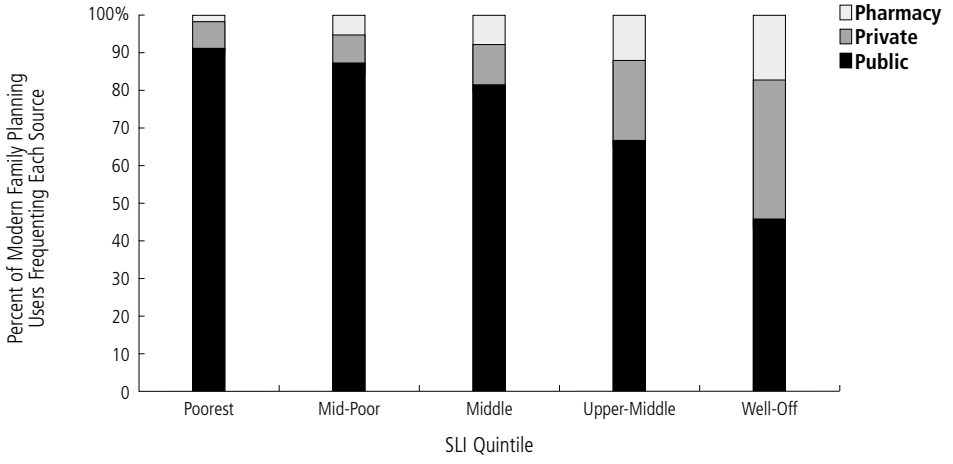
Table 6. Method mix by SLI, percent

Method	Poorest	Mid-Poor	Middle	Upper-Middle	Well-Off	Total
Pill	45.8	36.4	38.2	32.9	25.0	45.8
IUD	14.2	17.7	13.5	12.0	8.6	14.2
Injectable	14.8	9.5	6.9	6.5	6.7	14.8
Female sterilization	20.9	32.4	36.2	42.9	50.4	20.9
Condom	4.2	4.0	5.3	5.8	9.2	4.2
Total %	100	100	100	100	100	100
Number of observations	330	451	550	569	476	2,376

Graph 2. Source mix for all modern methods by residency, percent of identified cases



Graph 3. Source mix for all modern methods by SLI, percent of identified cases



Graph 4. Source mix for all modern methods by family planning method, percent of identified cases

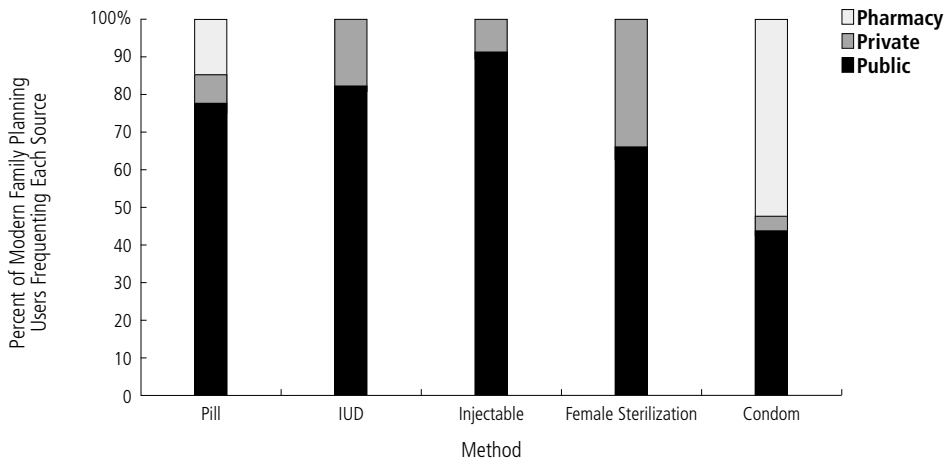


Table 7. Source mix for oral contraceptives by SLI, urban married women, percent

Oral Contraceptive Source	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off	Urban Total
Public	95	80	82.1	59.4	42.9	67.9
Private	–	1.3	3.7	10.9	17.6	8.0
Pharmacy	5	18.7	14.2	29.7	39.6	24.1
Total %	100	100	100	100	100	100
Number of observations	20	75	134	128	91	448

Table 8. Source mix for oral contraceptives by SLI, rural married women, percent

Oral Contraceptive Source	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off	Rural Total
Public	94.6	97.7	83.3	85.7	55.2	88.7
Private	3.1	1.2	6.9	3.6	10.3	4.0
Pharmacy	2.3	1.2	9.7	10.7	34.5	7.2
Total %	100	100	100	100	100	100
Number of observations	129	87	72	56	29	373

Graphs 2 and 3 show the source mix for modern family planning methods by residency and SLI, respectively. While the public sector predominates in both urban and rural areas, it is the source of about 85 percent of contraceptives in rural areas. In urban areas, the private sector accounts for more than one-third of supply, with 13 percent from pharmacies and 24 percent from private clinics. Overall, pharmacy use is relatively small. There are significantly more private-sector users in the wealthier quintiles, although it is just 50 percent for the well-off and only one-third for the upper-middle. In the bottom two quintiles, private-sector use is about 10 percent.

Graph 4 shows source mix by method. As expected, pills and condoms comprise all of the pharmacies' provisions. Pharmacies, however, only supply 15 percent of all pills. Female sterilization has a high share of private provision at one-third. The public sector dominates injectable and IUD provision.

ORAL CONTRACEPTIVES

Overall, few women use the private sector for oral contraceptives — about one-third of pill users in urban areas and less than 15 percent in rural ones. As expected, wealthy women are more likely to use a private source. Tables 7 and 8 show the sources for pill users. Per the last column of the two tables, urban family planning users are more likely to use private sources to obtain pill services or supplies. Almost none of the poorest women in urban areas use the private sector. About 20 percent of women in the urban mid-poor and middle SLI groups use the private sector. Finally, approximately half of the urban upper-middle and urban well-off women use the private sector.

In other words, many middle, upper-middle, and well-off women get their supplies in the public sector. These women can afford to purchase oral contraceptives, have access to them, and are a prime potential market for private efforts.

In rural areas, few women in the two poorest groups use the private sector. Approximately 15 percent of women in the middle and upper-middle quintiles use the private sector. More than 44 percent of rural women in the wealthiest SLI group use the private sector. This finding suggests that although marketing to rural women may not be as easy as in urban areas, there are some sales outlets and providers available to rural women.

Given the small number of users of injectables, IUDs, and condoms, CMS is not confident of the accuracy of the NDHS data. A few facts, however, bear mentioning (complete source mix data for IUDs, condoms, and injectables are located in the Appendix; see Tables A4–A9):

- IUDs: There is not a strong segmentation of the market according to SLI status. Between 60 percent and 90 percent of IUD clients in all SLI categories, urban and rural, obtain their IUDs from the public sector.

- Injectables: Just 15 percent of urban injectable users obtain services from the private sector; virtually none do in rural areas. This finding most likely reflects a lack of access to private injectable services, especially in rural areas.

- Condoms: There are few condom users in the NDHS sample. However, there appears to be a strong trend toward use of the private sector in the two wealthier SLI groups, with more than 75 percent in urban areas and 60 percent in rural areas buying their condoms from pharmacies.

Many women in the Philippines have obtained sterilizations. Tables 9 and 10 show the sources where women obtain this service. In spite of the high cost, many women use the private sector to obtain sterilizations. In rural areas, use of sterilization is lower overall; in the private sector, sterilization use is lower in rural areas than in urban ones. Nevertheless, in urban and rural areas, percentages of people obtaining sterilization in the private sector are higher than the percentages who obtain contraceptives in that sector. Also, as with pills, there is a strong trend toward use of the private sector among the wealthiest women.

WILLINGNESS TO PAY FOR FAMILY PLANNING

The 1998 NDHS asked family planning users questions concerning how much they paid for their method and their willingness to pay for it. For oral contraceptives, questions included the following:

Table 9. Source mix for female sterilization by SLI, urban married women, percent

Female Sterilization Source	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off	Urban Total
Public	83.3	80	75	62.5	40	59.0
Private	16.7	20	25	37.5	60	41.0
Pharmacy	–	–	–	–	–	–
Total %	100	100	100	100	100	100
Number of observations	12	50	116	176	200	554

Table 10. Source mix for female sterilization by SLI, rural married women, percent

Female Sterilization Source	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off	Rural Total
Public	83.6	86.2	84	75	61.5	80.1
Private	16.4	13.8	16	25	38.5	19.9
Pharmacy	–	–	–	–	–	–
Total %	100	100	100	100	100	100
Number of observations	55	94	75	64	39	327

- How much (in cash) does one packet (cycle) of pills cost you?
- How much would you be willing to pay for the packet of pills?

Table 11 presents the tabulations of these two questions, which yield some interesting insights. Across the columns are the SLI quintiles. The table is then divided into four parts, corresponding to where a woman obtained her pills:

- urban women who obtained their pills in the public sector
- urban women who obtained their pills in the private sector
- rural women who obtained their pills in the public sector
- rural women who obtained their pills in the private sector

Some cells are empty because there were not enough women in the NDHS sample who fit the category. For example, there were less than 10 women who were in the poorest SLI category and obtained oral contraceptives from the private sector in urban areas.

Overall, 85 percent to 100 percent of the women are willing to pay at least something for their pills. In all but one of the groupings (well-off rural women), more than 50 percent of the women are willing to pay at least 25 pesos for a cycle of pills.[6] These results hold true even for women who obtain their pills from the public sector.

At present, the social marketing firm DKT markets *Trust*, the best-selling oral contraceptive in the Philippines, for 25 pesos a cycle; Pascual sells *Micropil* for about 40 pesos. These brands experience frequent stock-outs, indicating that there is unmet demand for low-priced pills in the private sector.

6 Table A1 presents the peso–dollar exchange rates since 1996. Table A10 presents the average retail prices for the best-selling oral contraceptives for 2000.

Table 11. Willingness to pay for oral contraceptives, 1998 NDHS

Sector	Willingness to Pay	Poorest	Mid-Poor	Middle	Upper-Middle	Well-Off
Public-Urban						
	% Who are willing to pay something	*89.5* [a]	88.1	90.8	86.5	97.3
	% Willing to pay at least 25 pesos	*55.0*	61.0	56.4	58.1	71.8
	% Willing to pay at least 50 pesos	*10.5*	30.5	28.2	34.7	55.3
	% Median willingness to pay	***25***	**25**	**25**	**25**	**50**
	% Who paid nothing	*40.0*	45.8	45.4	37.3	30.6
	Median price paid	*5*	2	3	5	5
	Median price among those who paid	***5***	**5**	**5**	**5**	**14**
Private-Urban						
	% Who are willing to pay something		*100.0* [a]	100.0	98.0	100.0
	% Willing to pay at least 25 pesos		*92.3*	77.8	82.4	96.2
	% Willing to pay at least 50 pesos		*69.2*	50.0	60.8	86.5
	% Median willingness to pay		***50***	**25**	**50**	**100**
	% Who paid nothing		*0*	18.5	2.0	3.8
	Median price paid		*65*	21	70	75
	Median price among those who paid		***65***	**35**	**70**	**78**
Public-Rural						
	% Who are willing to pay something	91.7	92.9	88.3	91.5	86.7
	% Willing to pay at least 25 pesos	51.2	51.2	55.7	55.3	43.8
	% Willing to pay at least 50 pesos	23.1	19.8	23.3	36.2	25.0
	% Median willingness to pay	**25**	**25**	**25**	**25**	**10**
	% Who paid nothing	46.7	43.0	48.3	53.2	43.8
	Median price paid	2	2	2	0	5
	Median price among those who paid	**5**	**5**	**5**	**5**	**5**
Private-Rural						
	% Who are willing to pay something				*100.0* [a]	*100.0* [a]
	% Willing to pay at least 25 pesos				*89.6*	*81.8*
	% Willing to pay at least 50 pesos				*87.4*	*72.7*
	% Median willingness to pay				***85***	***75***
	% Who paid nothing				*11.8*	*18.2*
	Median price paid				*57*	*67*
	Median price among those who paid				***69***	***87***

a *All numbers in italics in this column indicate that calculations are based on less than 25 observations.*

Since 1998, oral contraceptives have been available in the private sector for 25 pesos or less. According to the 1998 data, the commercial market for oral contraceptives is limited — about one-third of urban users and less than 15 percent of rural users get their pills from a private-sector source, as shown in Tables 7 and 8.[7] Table 11 gives an indication of why. In all but the two upper categories of the public-urban group, 40 percent or more of the public-sector clients paid nothing for their pills. Among those who did pay something, the median price paid in the public sector was 5 pesos. Thus, although women apparently are willing to pay for pills, they do not — most likely because the public sector offers high-quality pills for free or almost free. Virtually all pills available in the public sector are donated by USAID, which procures only United States Food and Drug Administration-approved products. With phase-out of USAID-donated contraceptives, access to free or almost free pills likely will disappear, at least for many clients. This gap in the market will be a prime opportunity for the private sector to expand its sales.

Unfortunately, women's willingness to pay for sterilizations was not included in the survey data CMS analyzed. Table 12 includes information on how much women paid for sterilizations. In the public sector, 60 percent to 70 percent of women paid some amount of money for their sterilization. Unlike pill prices, which were usually token payments of 5 pesos, these women paid significant prices (300 to 400 pesos). In the private sector, these costs often exceeded several thousand pesos. Some women reported paying nothing for sterilizations in the private sector. This likely reflects women who obtained sterilization after delivery, where the charge for the procedure was incorporated into the delivery fee. The high prices that women pay for sterilizations is further evidence that family planning users in the Philippines are willing to pay for high-quality services.

7 According to the 2001 National Family Planning Survey, 27.5 percent of oral contraceptive clients obtained their pills from the private sector.

Table 12. Prices paid (in pesos) for sterilizations, 1998 NDHS

Sector	Price Paid	Poorest	Mid-Poor	Middle	Upper-Middle	Well-Off
Public-Urban						
	% Who paid nothing		32.5	32.9	35.8	34.2
	Median price paid		200	100	90	100
	Median price among those who paid		**300**	**400**	**300**	**300**
Private-Urban						
	% Who paid nothing		30.0	41.4	27.3	7.0
	Median price paid		150	50	2,000	6,000
	Median price among those who paid		**200**	**1,300**	**5,000**	**8,000**
Public-Rural						
	% Who paid nothing	57.1	44.3	45.0	40.4	43.5
	Median price paid	0	25	25	100	100
	Median price among those who paid	**500**	**500**	**800**	**500**	**1,000**
Private-Rural						
	% Who paid nothing		33.3	36.4	26.7	30.8
	Median price paid		200	110	2,500	1,800
	Median price among those who paid		**450**	**200**	**5,000**	**3,000**

3 Scenarios of Future Family Planning Use

SCENARIOS OF FUTURE FAMILY PLANNING USE

TRENDS IN USE PATTERNS

Family planning use has grown slowly in the Philippines — about 1 percent per year. Graph 5 shows trends in contraceptive prevalence among married women over the past eight years, according to NDHS and family planning surveys.[8]

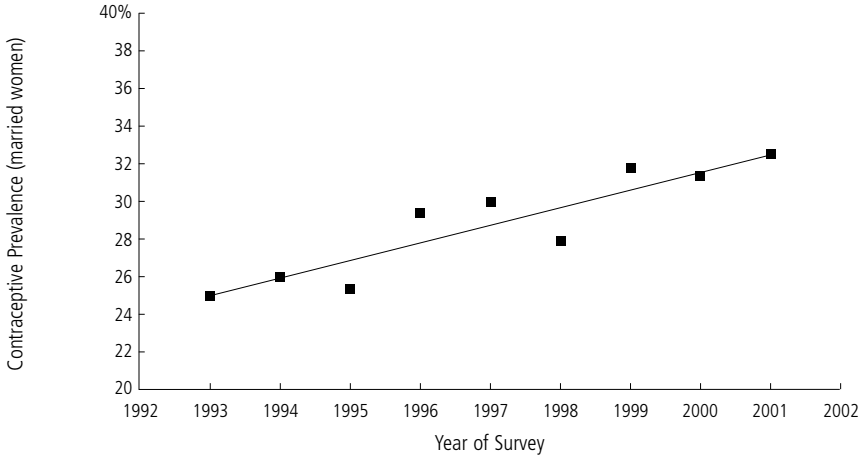
Graph 6 shows the evolution of the modern contraceptive method mix. Although the trends in the graph are ambiguous, CMS believes that:

- injectables and pills are gaining share, although the increase for pills is small[9]
- female sterilization is losing share
- IUDs and condoms are maintaining a steady share (at 10 percent to 12 percent and 4 percent to 5 percent, respectively; varies by survey)

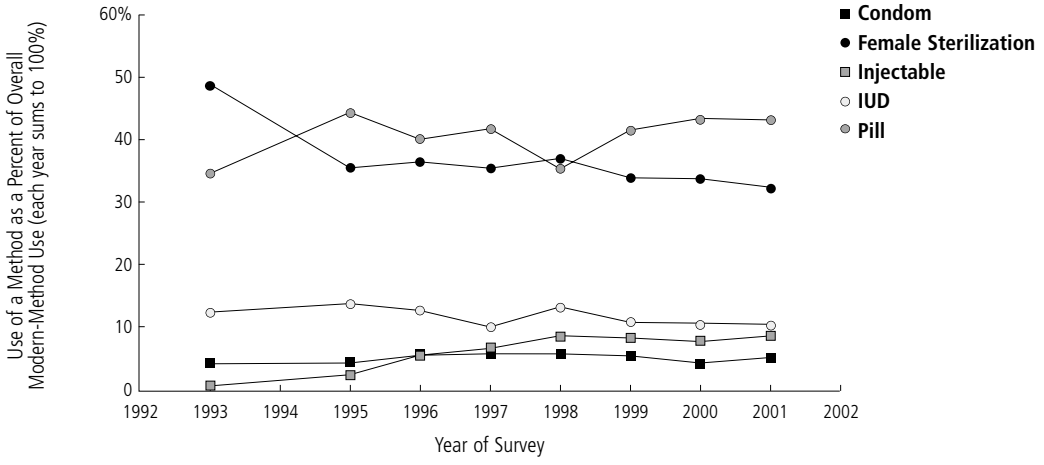
8 Historical trends of contraceptive prevalence, method mix, and source mix data were obtained from Aurora Perez (Policy Project).

9 A reduction in the share of the method mix does not necessarily mean an overall decrease in numbers of users, as contraceptive prevalence is increasing.

Graph 5. Trends in modern contraceptive prevalence among married women, percent



Graph 6. Evolution of family planning method mix in percent, 1993 to 2001



Graph 7 shows that the source from which women obtain their family planning methods has not changed significantly over the past eight years, in contrast to more significant changes in method mix:

- IUDs, injectables, and sterilization: There was a slight decrease in the percent of women using these methods who obtained their method from the private sector.

- Pills: There was a slight increase in the private-sector share of sales for pills.

- Condoms: There was a large increase in the percent of women who obtain their method from the private sector and, conversely, a decrease in the share of women who obtain them from the public sector.

DESCRIPTION OF SCENARIOS

CMS put together three scenarios for the growth of the family planning market in the Philippines from 1998 to 2007. The first year of the projection is 1998 as it is the last year for which CMS has complete information. These scenarios are based on extrapolations of the trends observed in Graphs 5 through 7 and the distribution of the family planning market across the SLI groups outlined in the first section of this report. For each of the scenarios, CMS assumed that the population of women age 15 to 49 years would grow according to the United Nations' population projection (medium variant).[10] CMS further assumed that the residency and SLI distribution of the population would remain constant over the 10-year period.[11]

Scenario 1: Steady-state increase in contraceptive prevalence rate (steady-state increase)

In this scenario, contraceptive prevalence measured over all women increases by 1 percent per year from 1998 to 2007. The method mix and source mix remain as they did in 1998.

Scenario 2: Trended method mix and source mix (trend increase)

In this scenario, contraceptive prevalence increases by 1 percent per year from 1998 to 2007 as in Scenario 1. Changes in method mix and source mix, however, continue the trends observed from 1993 to 2001. CMS did not analyze the trends by SLI or residency status. Instead, the total trends were applied to the individual SLI/residency groups. Graphs 8 and 9 show the approximate trends that were applied.

Graphs 10 and 11 show the projections for changes in source mix used in developing Scenario 2. In all areas, use of the private sector for obtaining pills and condoms is expected to increase, with condoms showing the largest increase, especially in rural areas. Private-sector use for IUDs, injectables, and sterilizations is expected to decline slightly.

Scenario 3: Trended method mix and source mix, plus shifting pill users willing to pay social marketing prices to the private sector (trend with pill program)

This scenario is the same as the previous one, except that CMS estimated the potential market made possible by shifting to the private sector those public-sector pill users who report being willing to pay the approximate price of a socially marketed packet of pills. In other words, it is assumed that policy changes and programmatic support will prompt every woman who is willing to pay 25 pesos or more for a packet of pills to switch from the public sector to the private sector. As such, this is a high-end estimate of the potential market for the private sector.

Graphs 12 and 13 show the changes in source mix derived from Table 11.

FINDINGS AND OBSERVATIONS

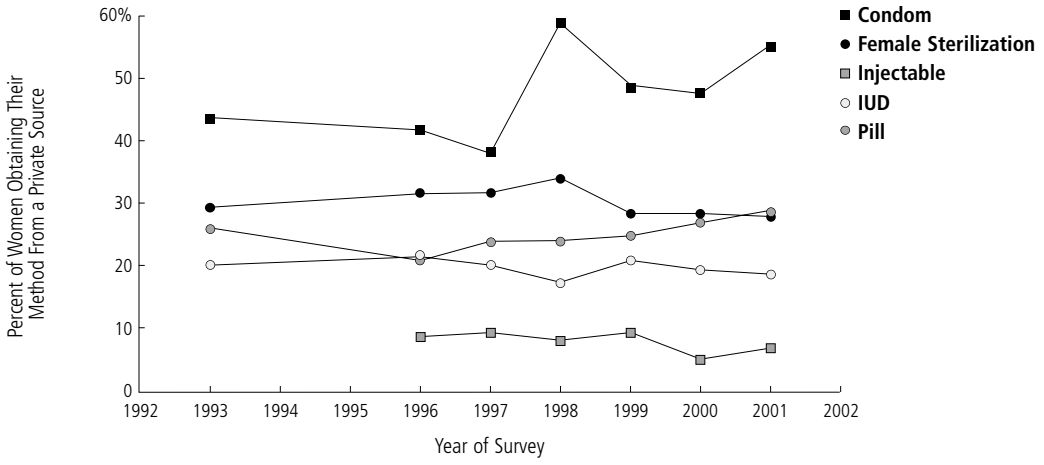
This section presents observations and results based on the scenarios outlined above.[12] As the number of women of reproductive age in the Philippines is increasing, and the percentage of women who use modern family planning methods is increasing,

10 CMS projects increases in contraceptive prevalence in terms of all women. If increases in contraceptive prevalence in terms of married women were projected, CMS would have been forced to speculate on trends in rates of marriage and marital separations. Among the many secular changes currently occurring in the Philippines is a delay in the age at marriage and increased rates of marital separations, leading to declining percents of married women. Projection of this secular change in marriage is beyond the scope of this report.

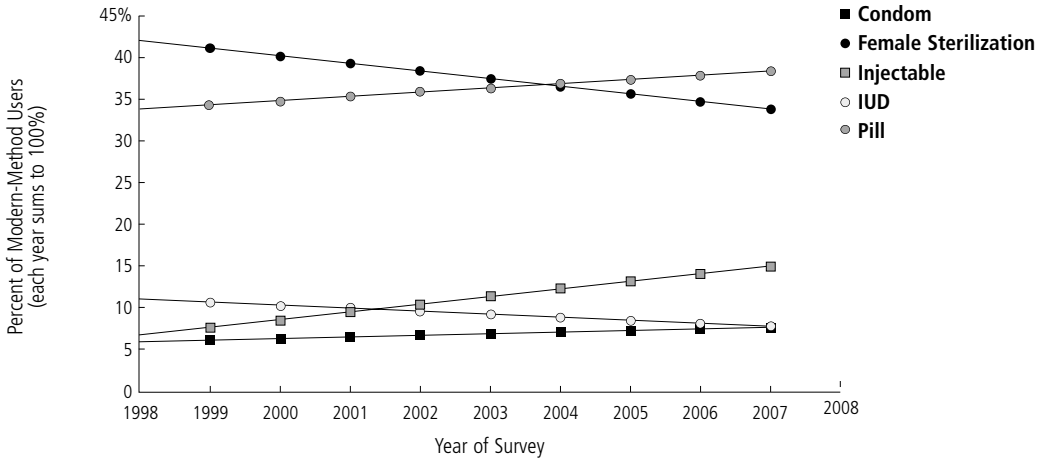
11 CMS is aware that the Philippines is in the process of large structural and economic changes. Per capita income is increasing. The population is moving to larger urban areas, while smaller urban aggregates are becoming larger, and areas that were once rural are becoming urban. Predictions of these changes, however, go beyond the scope of this report.

12 A complete tabulation of the results is available from CMS/Washington.

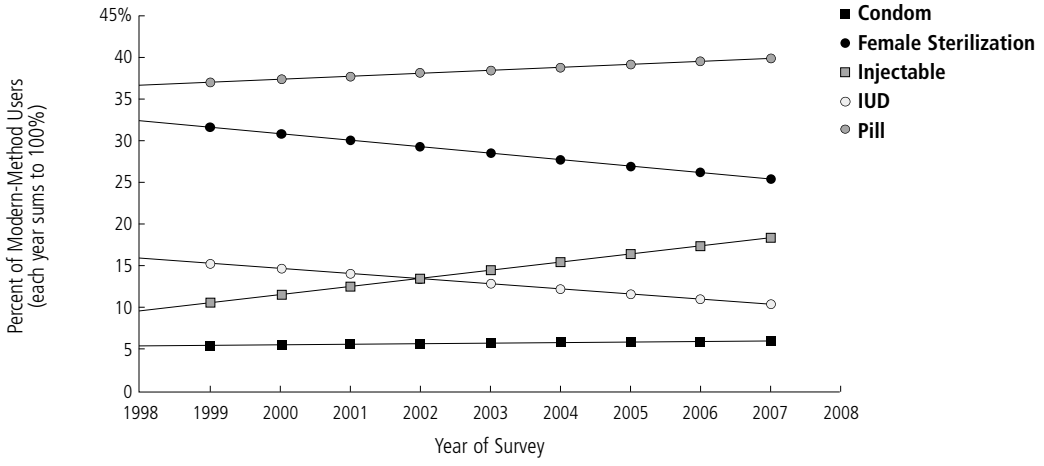
Graph 7. Evolution of source mix for family planning methods by the percent of women getting their method from the private sector, 1993 to 2003



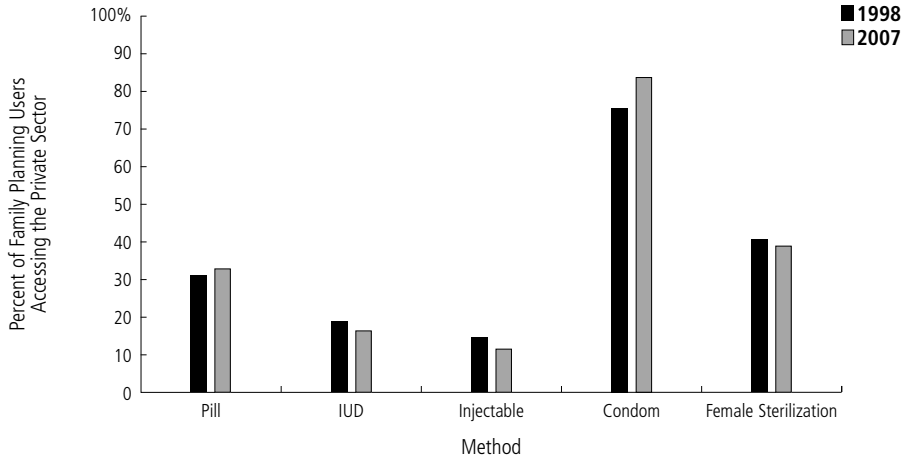
Graph 8. Projection of family planning method mix in urban areas from 1998 to 2007 based on extrapolation of trends, percent



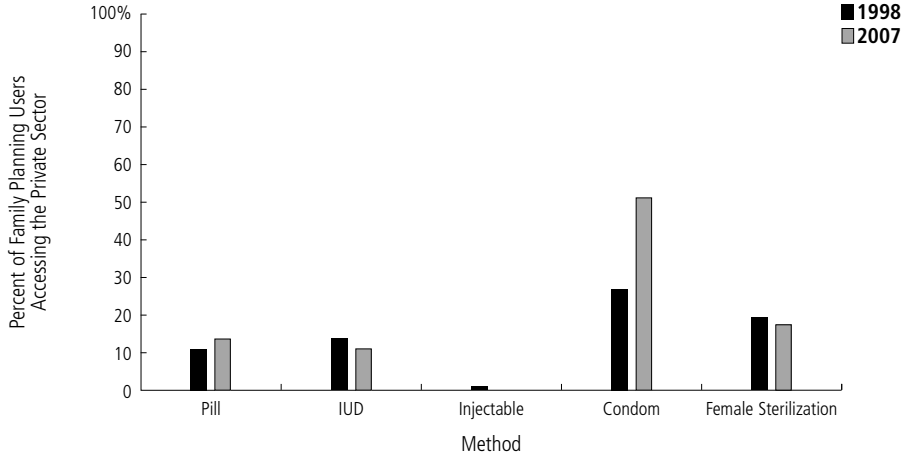
Graph 9. Projection of family planning method mix in rural areas from 1998 to 2007 based on extrapolation of trends, percent



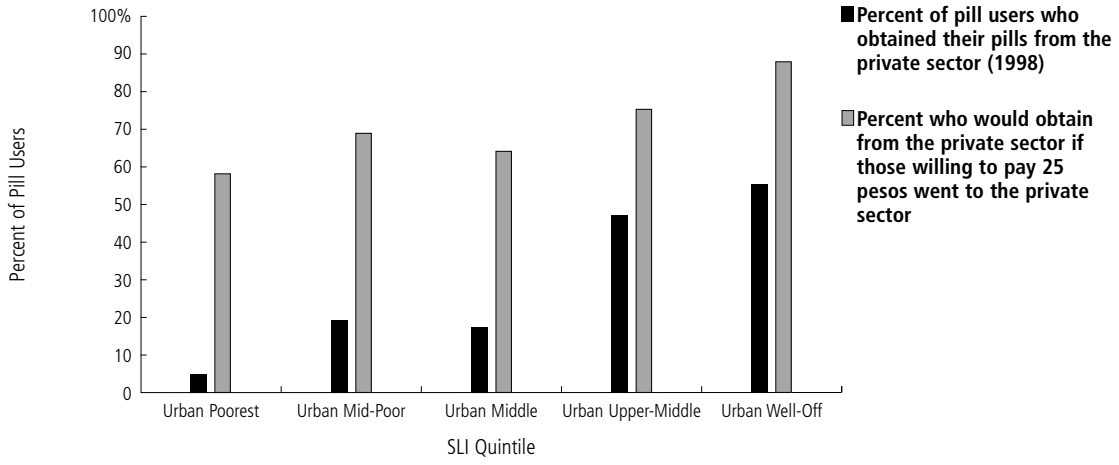
Graph 10. Projection of private-sector use from 1998 to 2007 in urban areas based on extrapolation of method mix and source mix trends, percent



Graph 11. Projection of private-sector use from 1998 to 2007 in rural areas based on extrapolation of trends, percent



Graph 12. Estimates of oral contraceptive users in urban areas who would obtain their method from the private sector if women willing to pay a low price (25 pesos) for oral contraceptives were switched to the private sector, percent



Graph 13. Estimates of oral contraceptive users in rural areas who would obtain their method from the private sector if women willing to pay a low price (25 pesos) for oral contraceptives were switched to the private sector, percent

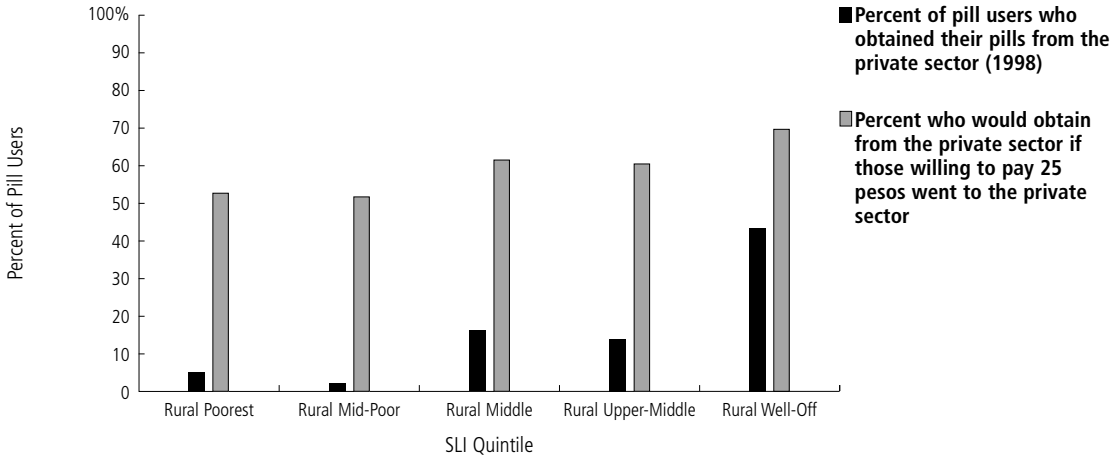


Table 13. Projections of modern-method family planning users for the steady-state increase and trend-increase scenarios, in thousands

Method	1998	2007[a]	
		Steady-State Increase	Trend Increase
All Methods	**3,214.1**	**5,776.8**	**5,787.6**
Pill	1,122.8	2,004.9	2,214.0
IUD	418.8	744.7	495.1
Injectable	266.0	483.5	928.5
Condom	188.2	345.6	396.4
Sterilization	1,218.3	2,198.2	1,753.7

a The differences in the totals for all methods derive from rounding errors in applying the trends.

Graph 14. Projections of modern-method family planning users for the steady-state increase and trend-increase scenarios, in thousands

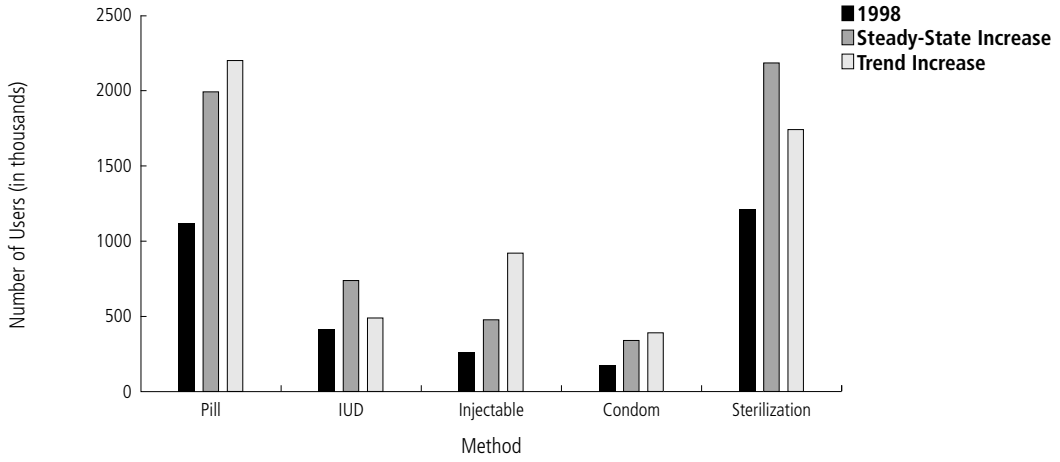


Table 14. Projections of service-delivery sources for modern-method family planning users for the steady-state increase and trend-increase scenarios, in thousands

Source	1998	2007[a]	
		Steady-State Increase	Trend Increase
All Sources	**3,214.1**	**5,776.8**	**5,787.6**
Public	2,363.3	4,202.5	4,210.7
Total private	850.8	1,574.2	1,576.9
Private providers	565.3	1,049.2	901.6
Pharmacy	285.5	525.0	675.3

a The differences in the totals for all methods derive from rounding errors in applying the trends.

Graph 15. Projections of service-delivery sources for modern-method family planning users for the steady-state and trend-increase scenarios, in thousands

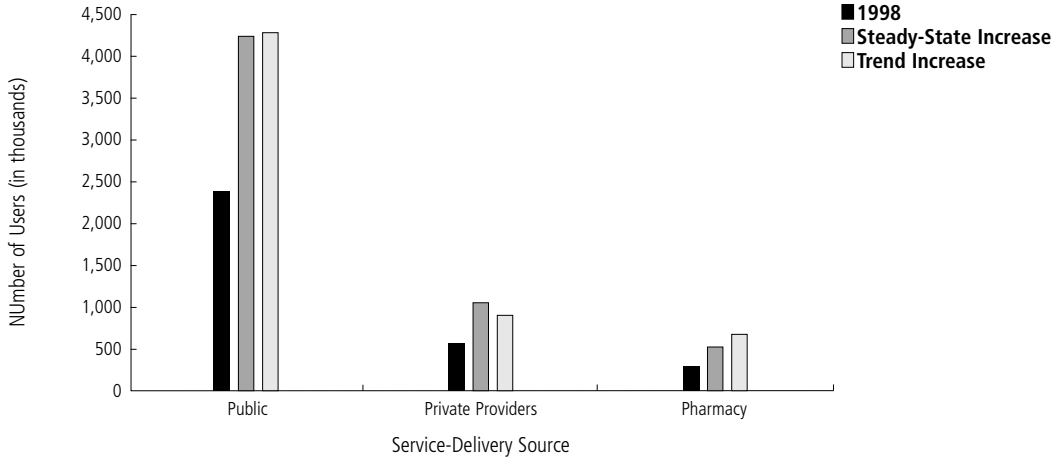


Table 15. Projection of urban oral contraceptive users in the trend-increase scenario, by source and SLI quintile, in thousands

Source	Urban Total	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off
2001						
Public	519.1	30.3	99.5	187.8	130.7	70.8
Private	65.2	0.0	1.7	9.1	24.7	29.6
Pharmacy	194.7	1.9	24.5	34.4	67.1	66.6
Total	778.9	32.3	125.8	231.3	222.6	167.0
2007						
Public	785.0	40.0	144.6	281.0	200.4	119.0
Private	109.7	0.0	2.8	15.2	40.0	51.7
Pharmacy	325.8	3.5	39.5	57.8	108.6	116.4
Total	1,220.5	43.6	186.9	354.0	349.0	287.0

Table 16. Projection of rural oral contraceptive users in the trend-increase scenario, by source and SLI quintile, in thousands

Source	Rural Total	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off
2001						
Public	576.7	206.5	147.8	102.9	92.3	27.1
Private	29.2	8.2	2.6	9.1	4.1	5.2
Pharmacy	51.3	6.1	2.6	12.8	12.4	17.4
Total	657.3	220.8	153.0	124.8	108.9	49.7
2007						
Public	851.4	307.4	228.6	156.4	115.0	44.0
Private	53.6	16.4	6.7	15.7	5.9	8.9
Pharmacy	88.4	12.3	6.7	22.0	17.8	29.6
Total	993.4	336.1	242.0	194.1	138.8	82.4

even if CMS projects a decrease in *share* for a given method, there is still likely to be an increase in the total number of users for that method.

1. The number of contraceptive users will expand greatly; there will be significant variance in the growth of individual methods.

Table 13 and Graph 14 show the estimated number of contraceptive users, in total and by method, in 1998 and projected to 2007. The first column is the baseline of 1998. The second column shows the number if there is a constant 1 percent increase in prevalence, but no change in method mix (steady-state increase). The third column shows the number if prevalence increases by 1 percent and there is a change in the method mix (trend increase).[13]

In both scenarios, the number of users will almost double over 10 years. Comparing the first and third columns, however, it is evident that the increase probably will not be shared equally across methods. The following is likely to occur if trends continue:

- injectable use will triple; injectables probably will replace IUDs before 2007 as the second-most-important temporary method in the program
- condom use will double
- pill use will almost double
- IUD use and sterilization use will not grow as quickly as the other methods

2. Growth in contraceptive use will be somewhat greater in the private sector than the public sector.

Table 14 and Graph 15 show the estimated number of contraceptive users, in total and by source, in 1998 and projected to 2007. In both scenarios, the private sector is projected to grow by 85 percent, versus 78 percent for the public sector. In the steady-state increase scenario, most of the private-sector growth is among private providers. In the trend-increase scenario, however, pharmacy use is projected to increase more than two-fold.

3. The number of oral contraceptive users will increase significantly, although the share who use the private sector will depend on a number of factors, including targeting public-sector commodities.

Tables 15 and 16 show projections for the oral contraceptive market in 2001 and 2007 (urban and rural areas, respectively) using the trend-increase scenario. These projections are broken out by the five SLI groups and show the private/public split that would occur.

An estimated 390,000 (75 percent) of the approximately 500,000 users of public-sector pills in urban areas belong to the middle, upper-middle, and well-off SLI groups. These people probably can afford to buy existing private brands, though the middle-income group may only be able to afford the socially marketed products. This number is projected to increase to 600,000 in 2007.

Rural users in the middle, upper-middle, and well-off SLI quintiles may be able to afford private-sector products. Supply, however, remains a challenge as these products may be poorly distributed in rural areas. Rural users can be switched if they have adequate access.

At least 350,000 people in rural areas and 130,000 in urban areas are in the two poorest SLI groups and use the public sector. These women probably would be difficult targets for private-sector products because they cannot afford private pills, or because the private infrastructure is not sufficiently developed. These numbers are expected to increase to 535,000 and 185,000, respectively, by the year 2007.

Targeting public-sector commodities to this latter group — women without access or ability to pay — is a critical intervention for switching women who can pay to the private sector. Making women who can pay ineligible for free commodities will force them to buy their pills in the private sector. Private-sector marketing activities may encourage some women to switch, but will not affect substantial numbers of clients in the absence of changes to the public-sector program that make free pills unavailable, at least to some women. An added benefit of a public-sector targeting strategy is that it allows the public sector to focus its limited resources on clients most in need.

13 The results of the third column are also valid for the third scenario mentioned above as the only difference between the second scenario (trend increase) and the third scenario (trend increase with pill program) is the source mix for pills.

4. Taking advantage of expressed willingness to pay for oral contraceptives would expand the private-sector contraceptive market.

Table 17 and Graph 16 present the aggregate results of the third scenario, trend increase plus shifting pill users willing to pay a low price to the private sector. This scenario combines the second scenario (trend increase) with the assumption that all women who say that they are willing to pay 25 pesos or more for a cycle of pills switch to the private sector. The results of the trend-increase scenario are included in the table for comparison.

In this scenario, the number of users in the private-sector market would almost quintuple by 2007, from 251,700 in 1998 to 1,468,000, with about 40 percent of users in rural areas. To reach this potential market, however, there will need to be policy and programmatic changes in the public sector that push clients to the private sector, as well as initiatives to create demand and pull clients into the private sector.

Reductions in USAID donations could make oral contraceptives scarce in public facilities, so product stock-outs are one means of pushing clients out of the public sector. Targeting mechanisms that direct public-sector resources to the neediest clients, such as means testing, user fees, or geographic targeting, can also push clients with an ability or willingness to pay to the private sector.

The private sector can implement demand-creation activities to pull in family planning clients, which will be most successful in conjunction with efforts to push clients out. Such pull activities could include method-specific mass media campaigns that direct consumers to private-sector products and outlets; intensified detailing activities by pharmaceutical companies to promote the prescription of private-sector contraceptive brands; and, most important, social marketing interventions that increase access to affordable brands. It is important to note that the social marketing price for oral contraceptives is 25 pesos, and currently, the lowest-priced private-sector brand is *Micropil* for about 40 pesos.[14] People's willingness to pay, however, may have increased over the past four years.

5. The private-sector market for IUDs is comparatively small, and its potential for growth will depend on the availability of affordable services.

Current users of IUDs are spread across income and geographic categories. In 2001, CMS estimates that about 70,000 people obtained IUDs from the private sector (the sum of 39.6 and 33.7 in Tables 18 and 19). In urban areas, three-quarters of IUD users are in the middle, upper-middle, and well-off SLI groups, but 80 percent of these clients go to the public sector for their IUDs. The number of IUD users from these three quintiles is expected to grow from 163,000 in 2001 to about 183,000 by 2007.

Forty-five percent of private-sector IUD clients are in rural areas. In rural areas, however, IUD clients tend to be in poorer quintiles — 55 percent are found in the two lowest income quintiles. Rural women IUD users in the top three quintiles are estimated to be 110,000 in 2001, growing only slightly to 114,000 in 2007. Fewer than 20 percent of these women obtain their services from the private sector.

Getting the private sector interested in launching an IUD or promoting IUD services may require the public sector to discontinue all free product distribution, thereby forcing large numbers of people to look for alternatives in the private sector. The availability of affordable private-sector services, however, is probably more important than product availability. IUDs are inexpensive and last several years, but the up-front cost of the insertion presents a greater barrier for potential clients. Even if affordable IUDs were available in the private sector, the cost of private-sector IUD insertions might put this method beyond the reach of the poor and mid-poor in rural and urban areas.

To shift current users or attract future ones to the private sector, IUD insertions should become more affordable and available. Further analysis of people's ability to pay current prices is needed. Interventions to increase the availability of low-priced services could focus on midwives, who are likely to offer the lowest prices and cater to users living in low-income neighborhoods. It is unlikely that private-sector gynecologists or general practitioners will be interested in lowering their prices for a service that is already in low demand. So again, private-sector activity must follow, not precede, a better targeting of free public

14 For average retail prices of best-selling oral contraceptives, please refer to Table A10.

Table 17. Comparison of private-sector oral contraceptive users in the trend-increase scenario and the trend increase with pill program, in thousands

	Grand Total		Urban Total		Rural Total	
Year	Trend Increase	Trend Increase With Pill Program	Trend Increase	Trend Increase With Pill Program	Trend Increase	Trend Increase With Pill Program
1998	251.7	251.7	193.2	193.2	58.6	58.6
2001	340.4	534.4	259.8	358.5	80.6	175.8
2007	577.5	1,467.9	435.5	895.3	142.0	572.6

Graph 16. Private-sector oral contraceptive users, according to the trend-increase scenario and the trend increase with pill program, in thousands

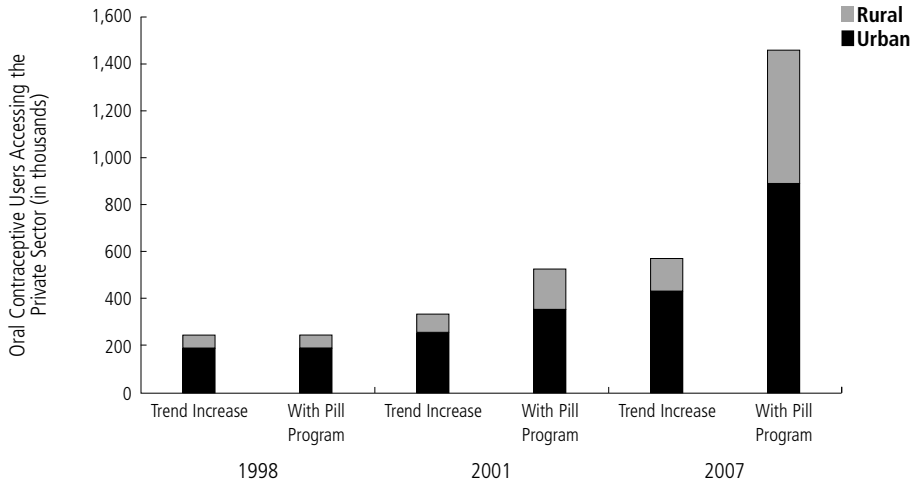


Table 18. Projection of urban IUD users in the trend-increase scenario, by source and SLI quintile, in thousands

Source	Urban Total	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off
2001						
Public	173.3	9.8	31.2	46.6	50.7	34.9
Private	39.6	1.3	7.4	4.0	14.7	12.2
Pharmacy	0.0	0.0	0.0	0.0	0.0	0.0
Total	212.9	11.1	38.6	50.6	65.4	47.2
2007						
Public	193.3	9.4	33.0	51.0	56.9	43.0
Private	40.2	1.0	7.0	3.3	15.0	13.9
Pharmacy	0.0	0.0	0.0	0.0	0.0	0.0
Total	233.6	10.4	40.0	54.2	72.0	56.9

Table 19. Projection of rural IUD users in the trend-increase scenario, by source and SLI quintile, in thousands

Source	Rural Total	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off
2001						
Public	212.5	51.7	72.1	51.7	26.3	10.7
Private	32.0	5.3	6.7	3.9	10.2	5.9
Pharmacy	1.7	0.0	0.0	0.0	1.7	0.0
Total	246.2	57.1	78.8	55.6	38.1	16.6
2007						
Public	231.4	55.7	81.5	57.5	24.0	12.7
Private	28.7	4.5	5.8	3.1	8.7	6.7
Pharmacy	1.5	0.0	0.0	0.0	1.5	0.0
Total	261.5	60.2	87.3	60.5	34.1	19.4

Table 20. Projection of urban injectable users in the trend-increase scenario, by source and SLI quintile, in thousands

Source	Urban Total	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off
2001						
Public	183.8	14.2	37.9	34.7	56.8	40.1
Private	32.0	0.0	1.6	3.9	3.7	22.9
Pharmacy	0.0	0.0	0.0	0.0	0.0	0.0
Total	215.8	14.2	39.6	38.6	60.5	63.0
2007						
Public	404.6	26.7	80.2	74.9	125.6	97.1
Private	64.8	0.0	1.5	6.5	5.0	51.8
Pharmacy	0.0	0.0	0.0	0.0	0.0	0.0
Total	469.4	26.7	81.7	81.4	130.6	148.9

Table 21. Projection of rural injectable users in the trend-increase scenario, by source and SLI quintile, in thousands

Source	Rural Total	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off
2001						
Public	215.7	85.1	53.3	43.3	22.5	11.4
Private	1.4	1.4	0.0	0.0	0.0	0.0
Pharmacy	0.0	0.0	0.0	0.0	0.0	0.0
Total	217.1	86.6	53.3	43.3	22.5	11.4
2007						
Public	459.1	184.5	116.2	93.0	39.4	25.9
Private	0.0	0.0	0.0	0.0	0.0	0.0
Pharmacy	0.0	0.0	0.0	0.0	0.0	0.0
Total	459.1	184.5	116.2	93.0	39.4	25.9

services. Covering insertion costs through PhilHealth, the Philippines' national health insurance program, might be an option.

Making an IUD available on the private market could be done through DKT or another supplier. In rural areas, expanding access to affordable private-sector services most likely implies working through midwives. As there is not an IUD on the market, and it is unlikely that a newly launched product would reach rural outlets, some kind of direct distribution to midwives might be considered. This effort might be done through the local International Planned Parenthood Federation affiliate or DKT.

6. Though comparatively small, current private-sector sales of injectables could increase with significant demand-creation and training interventions.

The trend-increase scenario shows substantial growth in the projected number of injectable users (see Tables 20 and 21), from 266,000 in 1998 to 928,500 in 2007 (based on the continued domination of public-sector supply). At present, only 33,000 people, or 8 percent of total users, get their injectables from private sources, and virtually all of these users are in urban areas. Even if injections were completely phased out in the public sector, this market may not be substantial enough for the private sector. As the existing market is small, new potential users may be a better market than current public-sector users. However, a large effort would be needed to change the perception of injectables. Essential interventions include demand creation and training and detailing of providers. If providers become more comfortable with the method, they will prescribe it more frequently, and demand will grow.

As with IUDs, even if injectables are inexpensive, injections need to be affordable. This problem is less substantial for injectables than for IUDS. Midwives, in particular, can tailor their prices to their clients' ability to pay. Training is an issue, as more midwives and doctors need to be trained on injectables, especially on side-effects management.

4 Private Market Segmentation

PRIVATE MARKET SEGMENTATION

This of section of the report provides greater detail on various groups of potential private-sector clients, which, in addition to women using the public sector, includes women not using modern family planning methods. Potential private-sector clients include the following:

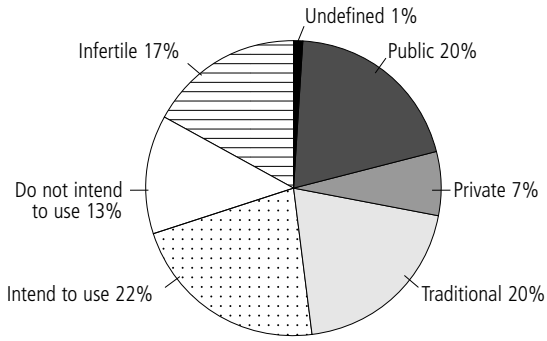
- Public-sector family planning users: These women already have demonstrated a willingness to use family planning services. Public-sector users, however, must have access, including financial access, to private services and must consider the private sector to be the more appropriate provider for their needs.

- Traditional family planning users: These women have shown that they would like to space or limit births. However, in terms of marketing, traditional-method users must be convinced that there is a better way to contracept. The private sector also must be affordable and accessible to them, and they must be convinced that it would best serve their needs. While this task may seem more difficult than convincing public-sector users to switch sources, many traditional-method users are wealthy and live in urban areas. In addition, they are not conditioned to receiving contraceptive services and supplies from the public sector.

- Women who intend to use: These women have stated an intention to use family planning in the near future. Women who intend to use must have quality, affordable services available when they make the decision to use contraception. Sometimes they need information about method choices, and they will need to be convinced of the relative quality of services offered by the private sector.

- Women who do not intend to use: These women have said that they do not intend to use family planning at any time. Among potential clients, they are the least likely clients for the private sector. First, they must be convinced of the need to use family planning; then they must be convinced of the benefits of modern family planning as opposed to traditional methods; finally, they must be convinced that the private sector will best meet those needs. Limited data on these women will be presented.[15]

Graph 17. Distribution of married women by family planning status, 1998



Rounding out the universe of married women of reproductive age are women who are infertile and therefore not in need of family planning.

Graph 17 shows that nearly 70 percent of married Filipino women are using family planning or are potential users of family planning (infertile women and women who do not intend to use family planning are the only groups of unlikely candidates). The private sector serves about 7 percent of married women. Public-sector users, traditional-method users, and those who intend to use in the future each constitute about 20 percent of the population of married women, or 62 percent in total.

Table 22 contains brief profiles of each of these three groups. Private-sector clients have been broken into two groups: users of private providers (medical professionals) and users of private suppliers (pharmacies/shops).

Not surprising, the private-sector clients are concentrated in urban areas, wealthier on average, better educated, and more likely to access television and print media. The non-private segments are not as accessible or attractive to the private sector. Women who intend to use family planning in the future are significantly younger than the other groups and often

15 This report is presented in the context of family planning only. Marketing condom use to the unconvinced for disease prevention can be successful where sexually transmitted diseases are endemic.

Table 22. Profiles of various user groups defining actual and potential clients for the private sector; married women age 15 to 49, 1998

	Public-Sector Users	Users of Private Providers	Users of Private Suppliers	Traditional Method Users	Intend to Use	Do Not Intend to Use	Total
Total Market (%)							
	20.4	4.9	2.4	19.6	21.3	13.4	
Residency (%)							
Urban	48.6	73.7	80.8	52.5	45.5	42.6	50.6
Rural	51.4	26.3	19.2	47.5	54.5	57.4	49.4
SLI (%)							
Poorest	17.7	5.4	2.0	17.9	25.6	31.3	20.2
Mid-Poor	22.8	9.3	8.5	20.6	23.6	22.2	20.6
Middle	25.6	14.5	18.1	19.7	18.0	16.2	19.7
Upper-Middle	21.6	28.2	33.2	22.5	17.2	15.2	20.5
Well-Off	12.4	42.6	38.2	19.3	15.5	15.1	19.0
Age (%)							
15 to 24	11.4	5.7	18.1	11.2	30.3	18.0	14.5
25 to 34	46.6	27.3	52.3	42.4	50.7	42.2	39.8
35 plus	42.1	67.1	29.6	46.4	19.0	39.7	45.7
Method (%)							
Pill	37.0	12.6	65.7	–	–	–	–
IUD	14.8	11.7	0.5	–	–	–	–
Injectable	10.6	3.6	0.0	–	–	–	–
Female sterilization	34.3	71.1	0.0	–	–	–	–
Condom	3.3	1.0	33.8	–	–	–	–
Education (%)							
None	0.8	0.2	0.5	0.8	1.8	4.8	2.0
Primary	35.1	18.4	10.6	28.7	32.0	38.4	33.1
Secondary	41.4	31.4	36.4	39.4	38.9	33.0	36.6
More than secondary	22.7	49.9	52.5	31.2	27.3	23.9	28.3
Number of Children (%)							
No kids	0.1	0.2	1.0	0.7	14.5	12.2	6.4
Low (1 to 3)	54.1	55.5	74.2	57.1	56.6	48.6	53.6
High (4 or more)	45.9	44.2	24.7	42.2	28.8	39.2	40.0
Media Use (%)							
Newspaper	56.8	70.8	77.4	57.8	54.5	47.3	56.2
TV	78.0	89.9	94.5	79.0	69.4	64.7	74.9
Radio	78.3	79.6	76.4	75.4	77.5	72.9	76.9

have not had children. Traditional-method users and public-sector users have similar profiles, although traditional-method users are probably more attractive in terms of accessibility (more than half are urban) and standard of living (42 percent upper-middle or well-off versus 34 percent of the public-sector users).

DEFINING MARKET SEGMENTS BY THE PRIVATE SECTOR'S ABILITY TO REACH CLIENTS

Table 22 provides an overview of potential user groups. In the Philippines, family planning users are almost exclusively married women between the age of 15 and 49.[16] Potential clients for the private sector are women who are accessible to private-sector family planning services, which are described on two axes: geography and ability to pay.

At least three market factors play into the attractiveness of a family planning market segment to the private sector:

- Urban status usually determines whether private infrastructure exists to support sales activities. Unfortunately, CMS does not have a good list of potential sales points categorized by geographic location. In the Philippines, however, urban areas generally have a much larger density of pharmacies, and conditions for profitable non-governmental health care facilities exist.

- Ability to pay is a principal determinant of whether a person is likely to use the private sector. Wealthier women are better able to the pay private-sector prices. Here, CMS categorized women into five groups based on their standard of living, which should correspond to their ability to pay.

- Number of women and, therefore, the potential for a large volume of sales is key for the private sector to make products and services widely available.

Tables 23 and 24 show the family planning behavior of married women separated by standard of living and residency status. The first two rows of each table give an indication of the numbers of women in each group. Not surprising, the number of poor and mid-poor women in urban areas is small, and there are few upper-middle and well-off in rural areas.

For the sake of analysis, CMS classified the residency/SLI niches based on the percent of women already using the private sector, under the assumption that if a certain threshold of private-sector use has been achieved, it can be assumed that access and ability to pay are more or less adequate for the entire quintile.

CMS divided the women of the Philippines into following three market segments:[17]

- Very attractive (3.6 million women): urban well-off and urban upper-middle women. More than 10 percent of these women obtain family planning from the private sector, which indicates that these women are willing and able to access the private sector.

- Moderately attractive (4.4 million women): urban middle, urban mid-poor, rural well-off, rural upper-middle, and rural middle women. Although more than 10 percent of women in the rural well-off category obtain their contraceptives from the private sector, they represent a relatively small market (less than 500,000 women) and may be more difficult for the private sector to reach. Therefore, they are classified as moderately attractive as they can be combined with other rural women to constitute a larger market. The urban mid-poor, the urban middle, the rural upper-middle, and the rural middle also are moderately attractive, as 4 percent or more of the women in each of these categories already are accessing family planning services through the private sector.

- Least attractive (4.0 million women): urban poor, rural mid-poor, and rural poor women. The two poorest categories of rural residents and the poorest category of urban women are the least attractive to the private sector.

16 The Young Adult Fertility and Sexuality Study (2002) indicates that 31 percent of men and 15 percent of women age 15 to 24 have engaged in premarital sex. Of those young adults, 68 percent of men and 70 percent of women did not use contraception during their last sexual episode. Despite these high rates of unprotected sexual contact, only 15 percent of youth consider pregnancy acceptable outside of marriage, and approval for abortion is just 5 percent. These figures indicate an unmet need for family planning among unmarried young adults.

17 CMS uses the terms very attractive, moderately attractive, and least attractive. Reproductive health public policy people might want to think of these in terms of a segmentation along these lines: women who are targets for the pure, unsubsidized commercial sector; women who are targets for subsidized or social marketing efforts; and women who are targets for the public sector (or safety net population).

Table 23. Family planning use status by SLI, urban areas

	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off
% All married women 15 to 49 years old	2.7	7.1	11.0	14.1	15.6
Number of married women (in thousands)	323.5	854.9	1,319.8	1,687.6	1,869.7
% Public-sector users	19.0	22.8	26.7	20.7	12.1
% Private-sector users	2.2	5.5	7.1	12.0	16.6
% Traditional-method users	17.3	19.6	20.2	21.9	19.9
% Intend to use	26.1	22.3	19.8	17.7	17.3
% Do not intend to use	20.4	15.4	10.3	9.3	10.2
% Infertile	13.7	13.3	14.7	17.2	23.4
% Supply not attributable	0.4	0.8	1.1	1.2	0.5
% Intention missing	0.9	0.2	0.2	0.1	0.1

Table 24. Family planning use status by SLI, rural areas

	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off
% All married women 15 to 49 years old	17.5	13.4	8.6	6.4	3.4
Number of married women (in thousands)	2,089.6	1,607.4	1,034.0	769.4	401.5
% Public-sector users	17.7	22.4	26.3	23.1	18.6
% Private-sector users	1.4	1.9	4.0	7.3	12.1
% Traditional-method users	17.5	19.6	18.9	20.7	20.0
% Intend to use	27.1	25.5	19.2	18.2	17.5
% Do not intend to use	20.8	13.9	11.9	11.0	12.5
% Infertile	15.0	16.3	19.0	18.8	18.9
% Supply not attributable	0.2	0.3	0.3	0.7	–
% Intention missing	0.3	0.1	0.4	0.2	0.4

The following three tables profile married women in the very attractive, moderately attractive, and least-attractive categories, respectively. Individual profiles are described for various user and potential user groups: public-sector users, private-sector users, traditional-method users, women who intend to use family planning, and women who do not intend to use family planning. The category of women who are not able to get pregnant is not shown.

FEATURES OF THE VERY ATTRACTIVE GROUP

The public-sector family planning user is one target segment of the very attractive group. It is difficult, however, for the private sector to compete with free products in the public sector. These clients will be an attractive market only if subsidies are phased out or better targeted to the most needy clients. As these clients live in urban areas, limiting access to free products will help direct them to private outlets and providers. Training and detailing providers to encourage them to offer family planning counseling and services also will help expand the private market, as more people use the private sector for curative care than for preventive services such as family planning.[18] Brand-specific advertising can help increase the perceived value of private-sector products.

Table 25 shows that private-sector users and public-sector users have approximately the same age profile and similar media habits. On the other hand, private-sector users are much more likely to be well-off and better educated. Successful marketing to public-sector clients may require adjustments in marketing strategy, including lower prices, effective distribution to upper-middle neighborhoods, and more advertising in electronic media than in print. In addition, as public-sector users have more children than private-sector users, this may indicate a larger niche for private providers who can supply methods popular with women who have several children, such as IUDs, injectables, or female sterilization.

Women who use a traditional method are the second segment of women in this very attractive group. The profile of these women is closer to private-sector users than to public-sector users. They are somewhat poorer and less educated on average, but the differences are not as large as with the public sector. The most challenging aspect of marketing to these women is convincing them both to use modern methods and to get them from the private sector.

Women who intend to use family planning, but are not currently using it, are the third group in this market segment. These women are young — almost 85 percent are younger than 35, and about 20 percent are younger than 25. They are well educated, with more than 90 percent having attended at least one year of secondary school. Also, the vast majority are probably interested in using spacing methods available from pharmacies and drugstores.

Traditional users and women who intend to use contraception are likely to respond to a combination of consumer communication, such as mass media advertising, increased provider counseling and services, and better targeting of public supplies. However, traditional-method users may have concerns about religious issues or side effects, so training, pharmaceutical detailing, and consumer messages should focus on these issues. Research, including focus groups, can be used to identify specific issues and develop appropriate messages.

The final group of women in the table includes those who do not intend to use family planning. They are by far the smallest group of women. The profile of these women is similar to the profile of women who intend to use family planning.

FEATURES OF THE MODERATELY ATTRACTIVE GROUP

Table 26 profiles women in the moderately attractive category. Public-sector users and traditional users in this category are seven times more numerous than private-sector users, but their profiles are not drastically different. The public-sector and traditional users are younger and tend to be in the poorer segments of the population.

On the other hand, women who intend to use, but are not currently using, are considerably different from the other three segments. Their socioeconomic and education status mirrors that of public-sector and traditional-method users, but they are much younger and have far fewer children.

18 PROFIT Project, Consumer Survey on Preferred Source of Basic Health Care and Family Planning Services, March 1996.

Table 25. Profiles of women very attractive to the private sector; married women age 15 to 49 in the urban upper-middle and urban well-off categories

	Public-Sector Users	Private-Sector Users	Traditional-Method Users	Intend to Use	Do Not Intend to Use	Total
% Women in the "very attractive" group	24.4	14.4	20.8	17.5	9.8	
Total number of women (in thousands)	868.0	512.3	739.9	622.5	348.6	3,557.3
SLI/Residency (%)						
Urban upper-middle	60.6	39.5	49.8	47.9	45.0	47.4
Urban well-off	39.4	60.5	50.2	52.1	55.0	52.6
Method (%)						
Pill	27.9	27.8	–	–	–	–
IUD	13.3	4.8	–	–	–	–
Injectable	10.4	3.2	–	–	–	–
Female sterilization	46.1	49.7	–	–	–	–
Condom	2.2	13.1	–	–	–	–
Age (%)						
15 to 24	9.2	10.6	10.3	21.7	10.7	10.2
25 to 34	37.7	33.3	39.7	61.8	51.7	38.4
35 plus	53.1	56.0	50.0	16.6	37.6	51.4
Education (%)						
None	0.5	–	–	–	–	0.2
Primary	18.2	7.3	7.9	7.4	9.5	11.1
Secondary	39.1	26.1	36.0	35.3	33.2	33.9
More than secondary	42.3	66.7	56.0	57.4	57.3	54.8
Number of Children (%)						
No kids	–	0.8	1.6	17.5	17.4	6.5
Low (1 to 3)	55.1	67.5	68.4	69.1	63.6	65.0
High (4 or more)	44.9	31.7	30.0	13.4	19.0	28.5
Media Use (%)						
Newspaper	76.3	83.0	76.0	75.8	76.4	78.1
TV	97.7	97.8	97.1	97.2	97.5	97.4
Radio	79.9	81.3	76.7	80.2	83.1	80.6

Table 26. Profiles of women moderately attractive to the private sector; married women age 15 to 49 in the urban mid-poor, urban middle, rural middle, rural upper-middle, and rural well-off categories

	Public-Sector Users	Private-Sector Users	Traditional-Method Users	Intend to Use	Do Not Intend to Use	Total
% Women in the "moderately attractive" group	24.4	6.6	19.8	19.7	12.1	100.0
Total number of women (in thousands)	1,068.6	289.1	867.2	862.8	529.9	4,379.6
SLI/Residency (%)						
Urban mid-poor	18.2	16.5	19.3	22.2	25.1	19.5
Urban middle	32.9	32.5	30.7	30.3	25.9	30.2
Rural middle	25.3	14.5	22.4	23.0	23.4	23.6
Rural upper-middle	16.6	19.5	18.3	16.3	16.1	17.6
Rural well-off	7.0	17.0	9.2	8.2	9.5	9.2
Method (%)						
Pill	38.5	34.8	–	–	–	–
IUD	14.3	10.6	–	–	–	–
Injectable	8.9	1.4	–	–	–	–
Female sterilization	34.4	40.1	–	–	–	–
Condom	3.0	10.6	–	–	–	–
Age (%)						
15 to 24	10.7	9.5	8.7	31.8	18.8	14.0
25 to 34	48.8	38.3	44.4	51.0	40.5	40.9
35 plus	40.5	52.2	46.9	17.2	40.8	45.1
Education (%)						
None	0.5	0.5	–	0.3	0.3	0.4
Primary	29.8	23.9	24.6	21.5	27.0	28.5
Secondary	45.0	44.3	45.4	47.3	45.0	44.0
More than secondary	24.7	31.3	30.0	30.8	27.8	27.1
Number of Children (%)						
No kids	0.1	–	0.5	17.5	17.1	7.4
Low (1 to 3)	58.2	56.5	58.1	58.2	51.4	54.3
High (4 or more)	41.7	43.5	41.4	24.3	31.5	38.3
Media Use (%)						
Newspaper	59.5	64.7	62.9	62.3	56.0	59.4
TV	87.8	90.5	90.2	84.3	85.0	86.9
Radio	79.0	73.0	75.8	79.0	80.2	78.3

Table 27. Profiles of women least attractive to the private sector; married women age 15 to 49 in the urban poorest, rural poorest and rural mid-poor categories

	Public-Sector Users	Private-Sector Users	Traditional-Method Users	Intend to Use	Do Not Intend to Use	Total
% Women in the "least-attractive" group	19.7	1.7	18.3	26.4	18.1	100.0
Total number of women (in thousands)	792.0	68.3	735.8	1,061.4	727.7	4,020.5
SLI/Residency (%)						
Urban poorest	7.8	10.6	7.6	8.0	9.1	8.1
Rural poorest	46.6	44.7	49.6	53.4	60.0	51.9
Rural mid-poor	45.6	44.7	42.8	38.6	30.9	40.0
Method (%)						
Pill	40.8	20.8	–	–	–	–
IUD	16.4	18.8	–	–	–	–
Injectable	12.8	2.1	–	–	–	–
Female sterilization	24.6	50.0	–	–	–	–
Condom	4.7	4.2	–	–	–	–
Age (%)						
15 to 24	14.0	2.1	15.0	34.0	20.9	18.9
25 to 34	49.9	40.4	42.8	44.0	39.1	39.6
35 plus	36.1	57.4	42.2	22.0	39.9	41.4
Education						
None	1.4	2.1	2.5	4.1	10.3	5.4
Primary	54.7	45.8	54.3	55.0	60.5	57.5
Secondary	38.0	37.5	35.5	34.1	24.3	30.9
More than secondary	5.8	14.6	7.6	6.9	4.9	6.3
Number of Children (%)						
No kids	–	–	–	10.4	6.3	5.2
Low (1 to 3)	47.7	40.4	44.7	48.0	39.4	43.0
High (4 or more)	52.3	59.6	55.3	41.6	54.3	51.8
Media Use (%)						
Newspaper	38.8	31.9	33.5	35.7	26.9	33.3
TV	50.5	47.9	47.2	40.9	34.1	41.8
Radio	76.4	81.3	73.8	74.7	62.9	72.3

The moderately attractive group differs from the very attractive group in two key aspects: their ability to pay and geographic location. Therefore, the marketing strategies highlighted above are applicable to this group, but both products and services need to be affordable and accessible to this group. As a result, social marketing interventions, such as subsidized social marketing brands and alternative distribution systems like direct distribution in rural areas, may need to be utilized to ensure access to affordable products.

FEATURES OF THE LEAST-ATTRACTIVE GROUP

Profiles of the least-attractive women are presented in Table 27. More than 90 percent of these women are in rural areas and in the poorest SLI groups. Overall, they have little education. However, a potentially attractive future market is the large number of young women using traditional methods or intending to use contraception in the future. They may be secondary markets for partially subsidized spacing methods, such as injectables or pills.

5 Conclusion

CONCLUSION

The number of family planning users in the Philippines is growing and will continue to grow. The number of modern family planning method users is projected to grow to 5.8 million women by 2007, from approximately 3.2 million in 1998. In addition, large numbers of young Filipinos are reaching reproductive age, and attitudes about modern family planning methods are becoming more positive, albeit gradually. The result of these trends is a large number of young women who report their intention to use family planning methods in the future.

Large numbers of Filipino women indicate that they are willing to pay for family planning products at prices comparable to or greater than the lowest-priced product on the market (DKT's *Trust* pill at 25 pesos). This bodes well for the private sector. Nevertheless, a majority of women do not currently use the private sector, in part because high-quality family planning products are available from government clinics at little or no cost. USAID's plan to phase out its practice of supplying contraceptives to the Philippine government will reduce the availability of free products in the public sector and may push hundreds of thousands of Filipino women to seek family planning products from the private sector.

CMS's analysis demonstrates that if all women willing to pay a moderate price for oral contraceptives were shifted to the private sector, nearly 1.5 million additional women would become private-sector clients by the year 2007. As a result, pharmacies could become an increasingly important private-sector source for oral contraceptives, especially if they stock an array of products and provide counseling.

For marketing purposes, CMS segmented consumers in two ways. First, consumers were grouped into one of four categories according to their current family planning status:

- obtain a modern family planning method from the private sector
- obtain a modern family planning method from the public sector
- use a traditional method
- intend to use a family planning method in the future

More than 70 percent of married Filipino women are in one of these categories.

Large numbers of public-sector clients likely will be forced to shift to private-sector sources if there is a significant change in the availability of contraceptives in the public sector, such as stock-outs caused by the USAID phase-down or policy and programmatic actions that target public resources to the neediest clients. Following such a change in the public sector, the private sector may respond with efforts to increase consumer demand or expand provider training and pharmaceutical detailing activities.

While converting public-sector clients to the private sector depends, in part, on the availability of low-priced products in the private sector, recruiting traditional-method users and women who intend to use family planning depends more on the availability of private-sector counseling and services. Therefore, attracting traditional-method users and women who intend to use family planning will require activities targeted to private providers to encourage them to provide services and counseling to potential clients.

Second, CMS categorized consumers into three groups based on assumptions about their attractiveness to the private sector:

- very attractive (3.6 million women): urban well-off and urban upper-middle
- moderately attractive (4.4 million women): urban middle, urban mid-poor, rural well-off, rural upper-middle, and rural middle
- least attractive (4.0 million women): urban poor, rural mid-poor, and rural poor

The most desirable market segment for the private sector consists of women who have the ability and willingness to pay for contraceptives and easy access to private-sector brands. Within the group of women who are very attractive to the private sector, there is a dichotomy in market behavior. Women in the well-off quintile are much more likely to use the private sector than women in the upper-middle quintile. Attracting these women who have the ability to pay for unsubsidized family planning products

into the private sector, including traditional-method users and women who intend to use family planning, will require concerted marketing directed at that target audience.

The profiles of women in the moderately attractive category indicate that they are amenable to more aggressive marketing of partially subsidized family planning products and services. Although the least-attractive market segment would be a difficult group for the private sector to market to successfully, CMS sees possibilities for marketing spacing methods to young women, perhaps as a secondary market for subsidized family planning products that are marketed to middle-income women.

Recommended strategies to increase use of private-sector products and services involve a mix of targeted-supply activities (push) and demand-creation activities (pull). Targeted-supply activities include interventions that restrict subsidized contraceptives to underserved populations. This may include means testing, whereby only indigent women are eligible for subsidized products and services, or geographic targeting that directs the subsidized contraceptives to facilities in poor areas or areas lacking private-sector distribution. Activities intended to create demand for family planning may be directed to consumers, such as mass media campaigns, or to providers, such as training and pharmaceutical detailing initiatives that increase provider skills and knowledge about contraceptive methods. Because only the most desirable market segment has both the ability to pay for contraceptives and access to private-sector distribution, other groups offering moderate potential for the private sector may require additional interventions to increase the affordability and availability of products and services. Messages may vary depending on whether targeted segments are made up of modern-method users, traditional-method users, or women who intend to use family planning.

Appendix

APPENDIX

Table A1. Philippine peso–dollar exchange rates, 1996 to 2003

Date	Pesos to US $1.00
1/1/96	26.25
1/1/97	26.30
1/1/98	41.00
1/1/99	39.05
1/1/00	40.40
1/1/01	50.10
1/1/02	51.68
1/1/03	53.54

Table A2. Method mix by SLI, modern-method users in urban areas, percent

Method	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off	Urban Total
Pill	40.8	42.9	41.9	32.3	23.3	33.7
IUD	16.3	15.3	10.7	11.1	7.7	10.7
Injectable	14.3	10.7	5.5	6.9	6.9	7.3
Female sterilization	26.5	28.8	37.3	44.0	51.4	41.9
Condom	2.0	2.3	4.6	5.7	10.7	6.3
Total %	100	100	100	100	100	100
Number of observations	49	177	327	405	391	1,349

Table A3. Method mix by SLI, modern-method users in rural areas, percent

Method	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off	Rural Total
Pill	46.6	32.1	32.9	33.9	32.9	36.6
IUD	13.9	19.3	17.1	13.9	12.9	16.0
Injectable	14.6	8.8	9.0	5.5	5.9	9.6
Female sterilization	19.9	34.7	34.7	40.6	45.9	32.5
Condom	5.0	5.1	6.3	6.1	2.4	5.3
Total %	100	100	100	100	100	100
Number of observations	281	274	222	165	85	1,027

Table A4. Source mix for IUDs by SLI, urban married women, percent

IUD Source	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off	Urban Total
Public	87.5	80	91.2	76.7	73.3	80.7
Private	12.5	20	8.8	23.3	26.7	19.3
Pharmacy	–	–	–	–	–	0.00
Total %	100	100	100	100	100	100
Number of observations	8	25	34	43	30	140

Table A5. Source mix for IUDs by SLI, rural married women, percent

IUD Source	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off	Rural Total
Public	89.7	90.6	92.1	68.2	63.6	85.9
Private	10.6	9.4	7.9	27.3	36.4	13.5
Pharmacy	–	–	–	4.6	–	0.6
Total %	100	100	100	100	100	100
Number of observations	39	53	38	22	11	163

Table A6. Source mix for condoms by SLI, urban married women, percent

Condom Source	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off	Urban Total
Public	100	50	50	21.1	10.5	23.7
Private	0	0	0	0	2.6	1.3
Pharmacy	0	50	50	78.9	86.8	75
Total %	100	100	100	100	100	100
Number of observations	1	4	14	19	38	76

Table A7. Source mix for condoms by SLI, rural married women, percent

Condom Source	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off	Rural Total
Public	92.9	92.3	78.6	30	0	72.2
Private	0	7.7	7.1	10	33.3	7.4
Pharmacy	7.1	0	14.3	60	66.7	20.4
Total %	100	100	100	100	100	100
Number of observations	14	13	14	10	3	54

Table A8. Source mix for injectables by SLI, urban married women, percent

Injectable Source	Urban Poorest	Urban Mid-Poor	Urban Middle	Urban Upper-Middle	Urban Well-Off	Urban Total
Public	100	94.7	88.9	92.8	62.9	84.8
Private	–	5.3	11.1	7.1	37.1	15.2
Pharmacy	–	–	–	–	–	0.00
Total %	100	100	100	100	100	100
Number of observations	7	19	18	28	27	99

Table A9. Source mix for injectables by SLI, rural married women, percent

Injectable Source	Rural Poorest	Rural Mid-Poor	Rural Middle	Rural Upper-Middle	Rural Well-Off	Rural Total
Public	97.6	100	100	100	100	98.9
Private	2.4	–	–	–	–	1.0
Pharmacy	–	–	–	–	–	0.00
Total %	100	100	100	100	100	100
Number of observations	41	23	20	9	5	98

Table A10. Prices (in pesos) of major oral contraceptive brands, 2000

Brand	Company	Price (per packet)	Sales (cycles)
Trust	DKT	25	1,038,000
Femenal	Wyeth	103	415,000
Nordette[a]	Wyeth	89.45	342,000
Trinordiol	Schering	148.80	297,000
Micropil	Pascual	41	204,000
Logynon	Organon	124.30	194,000

a Formerly included in SOMARC Program.

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