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Private Midwife Provision of IUDs: Lessons from the Philippines



BRIEF

SHOPS

Strengthening Health Outcomes
through the Private Sector

Summary: This case study identifies enabling factors that help to ensure viable provision of IUDs by private midwives, based on the experiences of midwives from two major franchises in the Philippines. The study team gathered information from structured and unstructured interviews of midwives, franchise network staff and other stakeholders, and service provision data. The findings can be used to replicate private midwives' provision of IUDs in the Philippines and in similar country contexts. Robin L. Keeley prepared this brief.

Keywords: family planning, reproductive health, IUD, midwives, Philippines

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Cover photo: Robin Keeley

Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in the private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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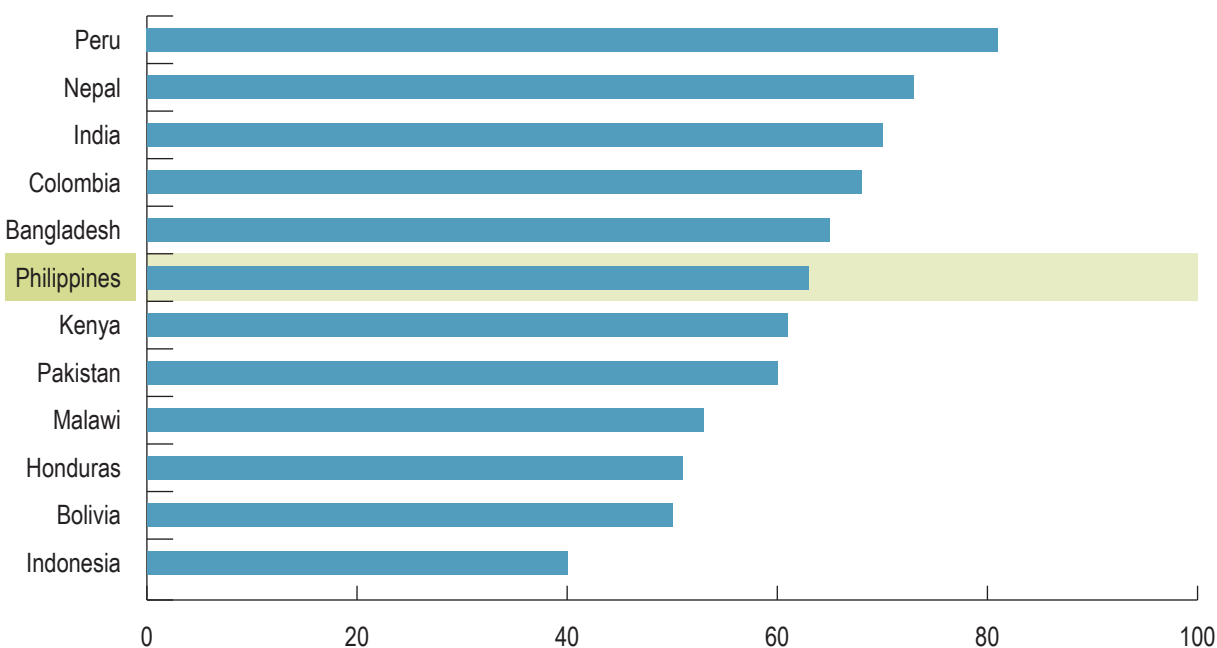
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Private Midwife Provision of IUDs: Lessons from the Philippines

Significant attention has been given in recent years to the use of long-acting reversible contraceptive methods (LARCs) of family planning. However, less attention has been paid to where clients obtain these methods. LARCs are highly cost-effective with low failure rates and high client satisfaction. The effectiveness and ease of use of LARCs may contribute to women who use them having substantially higher continuation rates than women who use short-acting methods (FHI 360, 2008). Inaccessibility to facilities providing such services is purported to be one reason for low use of IUDs in particular (D'Arcangues, 2007).

A recent historical analysis by Ugaz (2014) of source for short-acting methods, LARCs, and permanent methods (PMs) using Demographic and Health Survey (DHS) data showed that although 45 percent of modern contraception is obtained through the private sector in Asia and 33 percent in sub-Saharan Africa, there are wide differences in source by type of method. In Asia, for example, 56 percent of short-acting methods are accessed through the private sector, compared to only 28 percent of LARCs/PMs. In sub-Saharan Africa, 34 percent of short-acting methods are accessed through the private sector compared to only 25 percent of LARCs/PMs. In addition to lower overall use of the private sector for LARCs/PMs, many wealthy women (defined here as women from the top two DHS wealth quintiles) obtain their LARCs/PMs from the public sector, as shown in Figure 1. These data suggest that something prevents access to these methods in the private sector. In the Philippines, 63 percent of women from the top two quintiles obtain their LARCs/PMs from the public sector (Ugaz, 2014).

Figure 1. Percentage of LARC/PM Users from Top Two Wealth Quintiles who Obtained Method from Public Sector



Source: Ugaz (2014)

A review conducted by the United States Agency for International Development (USAID)-funded Private Sector Partnerships-*One* project on the commercial viability of LARCs/PMs looked at the central question of the conditions under which the commercial health sector might feasibly and sustainably provide LARCs/PMs. The review concluded that encouraging private providers, such as doctors and midwives, to enter the LARC/PM service provision market remains extremely challenging because of low demand, high cost of market entry, low perceived revenue from the services, and policy barriers (Ravenholt et al., 2009).

Despite these challenges, there is a growing emphasis on increasing access to LARCs/PMs so that women have more contraceptive options from which to choose. To expand understanding of this issue, the Strengthening Health Outcomes through the Private Sector (SHOPS) project undertook this case study—identifying a country that appears to have viable private provision of LARCs/PMs and examining the provision in more detail to determine why these methods can be viably offered in the commercial private sector. This exercise aimed to identify factors related to successful private sector LARC provision that can be replicated in the Philippines and in other country settings.

After a review of DHS data from multiple countries, the Philippines was selected for the case study because of its relatively high use of LARCs/PMs (8.3 percent), and the significant role of its private health sector in providing the methods (17.3 percent of IUDs and 26.6 percent of female sterilizations) (National Statistics Office [Philippines] and ICF Macro, 2009). The Philippines also has a large number of skilled mid-level health care workers, what appears to be a viable commercial product supply, and a vibrant private sector with high levels of franchising arrangements. A significant amount of groundwork for family planning provision was laid in the Philippines through a history of midwife-focused (including private midwife) projects by the government, USAID, and the United Nations Population Fund. Midwives now play an essential role in providing maternal health services, including family planning, in the Philippines.

This enabling environment was confirmed during a case study pre-data collection trip and led the SHOPS team to focus on private midwives as a large and active provider of family planning services in the country. It is also of global interest as the family planning community continues to look to mid-level providers, such as midwives, as a way to increase availability and use of family planning through task sharing and task shifting (Jacobstein et al., 2013).

The case study* summarized in this brief examines the experience of midwives in the Philippines who belong to two large midwife franchises (Well-Family Midwife Clinic and BlueStar) in providing family planning services, particularly the midwives' effectiveness as providers of LARCs, specifically IUDs. (Implants are not yet widely available in the Philippines, and midwives are not authorized to provide them.)

This study aims to answer the following broad questions: Is it feasible to provide IUDs through the private sector on a commercially viable basis, and what are the factors that make it feasible?

To answer these questions, the case study examines the following issues:

Are private midwives viably providing IUDs? Commercial viability is an important issue for private sector family planning provision. If private providers are not making sufficient income to pay their clinic costs and a profit on which to live, then they will not stay in business. For the purposes of this case study, viability is a self-reported definition that was personal for each midwife. As long as the midwife was earning enough to pay for her clinic costs and support herself, and she was actively offering IUDs, she was considered to be viably providing IUDs.

Why are some private midwives providing a higher number of IUDs more successfully than others? After meeting with franchise NGO staff and private midwives during a planning visit, it was clear that some midwives were able to provide larger numbers of IUDs than others. SHOPS intended to identify what is behind this higher IUD provision

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at a personal, clinic, franchise, and even regional level. The sample of midwives included those with higher IUD provision numbers and those with lower IUD provision numbers from both networks.

If private midwives are viably providing IUDs, what are the factors that make such provision feasible, and how can these factors be used to improve and expand access to LARCs in the Philippines and in other country settings? Identifying the factors that make midwives viable providers of IUDs will enable the broader global community to consider the applicability of these factors in other settings to improve LARC provision.

To collect primary data to answer these questions, the SHOPS team conducted semi-structured qualitative interviews with selected midwives and with NGO and local government staff. The team also reviewed service provision data on family planning and delivery services.



Robin Keeley

A midwife stands beside a counseling tool on birth spacing methods.

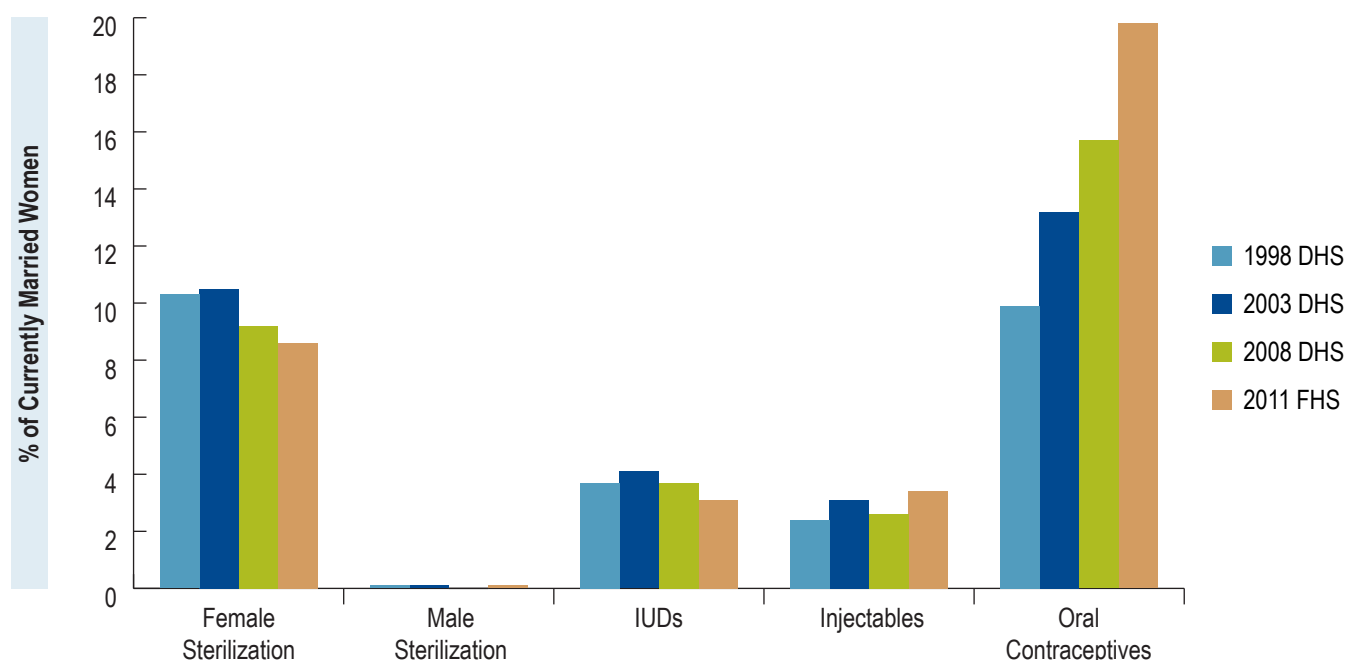
FAMILY PLANNING IN THE PHILIPPINES

Use of modern methods of family planning in the Philippines has increased at a greater rate than use of traditional methods, though use of modern methods is still comparatively low among married women (National Statistics Office [Philippines] and ICF Macro, 2009). This low use is in large part due to fluctuating government policies regarding modern family planning use and the influence of the Catholic Church. Government support for family planning programs has varied with the position of the administration in office. For example, the Ramos administration (1992–1998) favored free choice in the use and type of contraceptives, including modern contraceptives (Youngblood, 1998). In contrast, the Arroyo administration (2001–2010) promoted natural family planning to the exclusion of other methods; in 2002, a National Natural Family Planning Strategic Plan was introduced. Arroyo stated that after the USAID phase-out of contraceptive assistance (in line with the USAID Contraceptive Self-Reliance Initiative aimed at reducing the contraceptive provision burden on the public sector and increasing participation of the private sector, ultimately providing more access and choice to consumers) (USAID, 2003), the funding deficit for modern methods of contraception would not be filled by the government (Ruiz Austria, 2004).

A recent evaluation by USAID showed that a factor affecting the country's family planning program was the 1991 devolution of responsibility for health programs (including family planning budgeting and service delivery) from the federal level to local government units that were unprepared for this task. Challenges include limited capacity (Byrne et al., 2012) and the potential for family planning support to vary by region due to religious influences. As a result, some local government units have more robust family planning programs than others. Currently, an estimated 1,700 local municipalities make funding decisions for family planning programs (Senlet et al., 2012).

Despite these challenges, almost 50 percent of currently married women in the Philippines use some family planning method, and nearly 37 percent use a modern method. Among modern methods, oral contraceptive pills are by far the most popular (nearly 54 percent). LARCs/PMs make up nearly 32 percent of modern contraceptive use (National Statistics Office [Philippines], 2012). LARC/PM use, however, has changed very little since the 1998 DHS, while the use of oral contraceptives has doubled over that period (see Figure 2). Among long-acting methods, female sterilization is the most widely used, especially among poor women. IUD use is slightly over 3 percent—higher than in some other developing countries, but very low compared to countries like Vietnam, where 53.1 percent of currently married women use an IUD (Ministry of Planning and Investment [Vietnam], 2011). IUDs are used more by poor women (at 3.6 percent) than by non-poor women (2.8 percent) in the Philippines.

Figure 2. Use of Selected Family Planning Methods, 1998–2011



Antenatal care visits, delivery, and postnatal care visits are ideal opportunities for introducing family planning options to women. In the Philippines, more than 55 percent of antenatal care is provided by midwives and almost 29 percent of all deliveries are attended by a midwife. Home births constitute almost 45 percent of all deliveries, and midwives attend over 37 percent of these births (National Statistics Office [Philippines], 2012). This highlights the important role that midwives play in the maternal care continuum and their potential for providing access to family planning, particularly in the postpartum period.

As noted previously, the Philippines has a large and vibrant health sector—including an estimated 168,000 registered professional midwives (Fostanes, 2013). The private health sector, including private midwives, provides 19 percent of deliveries and almost 54 percent of modern family planning. However, much of this is short-acting methods obtained from pharmacies (National Statistics Office [Philippines], 2012). This indicates an ideal opportunity for increased provision of modern family planning methods by private midwives. USAID has a long history of supporting private midwives in the Philippines through targeted projects such as the Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Nongovernmental Organizations Project (TANGO) and TANGO II projects (ended in 2004); the Private Sector Mobilization for Family Health Project One (ended in 2009); and the current Private Sector Mobilization for Family Health (PRISM) 2 project. Another USAID project, Banking on Health, worked to improve

private midwives' access to loans for their clinics, and the United Nations Population Fund supported midwives in private practice by providing IUD insertion training.

The Integrated Midwives Association of the Philippines is the main midwife association in the country and the midwife professional organization accredited by the Professional Regulation Commission. According to its management, IMAP has an estimated 70,000 members, 22,000 of whom are active. The association advocates for its members and also runs programs through funding from donors.

Franchise networks are considered to be a private sector model for expanding access to family planning around the world. Models vary depending on the franchisor, the country, and the cadres of qualified health providers available, but they share basic features: providers form a network under a common, branded franchise name and they receive technical assistance from the franchisor. Because the Philippines has a large cadre of qualified midwives, including many already working in private practice, a private midwife franchise is an ideal way to expand family planning services.

This case study focuses on the two major midwife franchise networks in the Philippines: the long-established Well-Family Midwife Clinic network, and the newer BlueStar network.

Well-Family Midwife Clinic was initially established in 1997, under the USAID-funded TANGO project, to provide an affordable private care option so that public sector facilities could focus on serving clients who are unable to pay for services. Since 2005, Well-Family Midwife Clinic Partnerships Foundation Inc. (WFPI) has served as the franchise manager for Well-Family clinics. WFPI's mission is to ensure the effectiveness and sustainability of the Well-Family clinics, manage the brand, and address family planning and maternal and child health concerns at the community level. Under WFPI are seven regional NGOs that supervise the Well-Family franchise clinics in their own geographic areas. At the end of the TANGO project in 2004, there were 220 Well-Family clinics in operation. According to the NGOs interviewed for this case study, there now are fewer than 100.

BlueStar was founded in 2008 by Population Services Pilipinas Incorporated (PSPPI), part of the Marie Stopes International global partnership. Its objective is to increase access to family planning services, especially in peri-urban areas, and it adds family planning services to the maternity services provided by its members. The network is now in a scale-up phase, with a reported 266 existing franchised clinics at the time of data collection and another 45 to be added by the end of 2013 with funding from the World Bank. Ultimately, PSPPI plans to have 500 clinics in the network.

The services provided by the two networks are shown in Table 1.

Table 1. Standard Network Family Planning and Reproductive Health Services

BlueStar	Well-Family
Family planning counseling	Family planning counseling
IUD insertion/removal	IUD insertion/removal
Prenatal care	Prenatal care
Delivery	Delivery
Postnatal care	Postnatal care
Condoms	Condoms
Oral contraceptives	Oral contraceptives
Injectables	Injectables
Tubal ligation referral	Tubal ligation and vasectomy referral
Pap smear Plus	Pap smear
Pregnancy test	Pregnancy test
	Referral for natural family planning
	Breast exam
	Pelvic exam



Robin Keeley

A midwife advertises the services she offers on a sign outside her clinic.

METHODS

Seventeen midwives were selected to be interviewed: eight from BlueStar, and nine from Well-Family. A maximum variation sampling design was adapted to compare the full range of variation for each network. In particular, the networks were asked to provide two lists of midwife clinics: those that report high numbers of IUD provision, and those that report lower numbers of IUD provision. The intent was to better understand the differences, if any, between midwives that provide more IUDs and those who provide less. From those lists, clinics were selected in various geographical regions, ideally where both networks operated. Selected regions were Davao City, the National Capital Region and its surrounding areas, the Caraga region, and Eastern Visayas. Characteristics of the sampled midwives are shown in Table 2.

Table 2. Characteristics of Midwife Sample

Network	Urban ¹	Rural ¹	Income Class ²					Barangay Population ³		
			5	4	3	2	1	Small	Mid-size	Large
BlueStar (n = 8)	4	4	1	1	1	0	5	5	2	1
Well-Family (n = 9)	7	2	0	1	1	0	7	2	4	3

¹ Urban/rural classification sourced from the National Statistics Coordinator Board, http://www.nscb.gov.ph/activestats/psgc/articles/con_urbanrural.asp

² In the Philippines, the wealthiest category is class 1 and the least wealthy is class 5, http://www.nscb.gov.ph/activestats/psgc/articles/con_income.asp

³ Barangay (town) sizes: Small < 5,000 people; Mid-sized = 5,000 to 25,000; Large >25,000

FINDINGS

This case study examines five general areas: provider factors, clinic factors, network factors, family planning provision, and revenue and expenses. The case study team hypothesized that these factors contribute to a private midwife's ability to viably provide IUDs.

This case study is not meant to serve as a direct comparison of the two franchises, but rather aims to find lessons from both networks, with their different histories, structures, and outcomes in IUD provision. As such, most findings are presented in the aggregate; findings are presented by network only when significant differences occur. This case study presents a snapshot of the networks at a time when the networks are at different stages of donor support and maturity. As previously discussed, Well-Family received regular donor financial and technical support for many years; it now receives much less support and the number of its clinics has fallen by more than half since peaking in 2004; BlueStar started much more recently, is receiving some donor support, and is still scaling up.

Provider Factors

Provider factors are those that contribute to a midwife's ability to run a commercially viable business and to provide IUD services. These include intrinsic personal characteristics, such as motivation, previous experience, provider bias, and family support.

Motivation to Become a Midwife

Most of the midwives reported that, from a young age, they had dreamed of being a health care provider and helping people, that they came from a family of midwives, or that they chose the profession because they knew it was reliable work and they could help their families. Most midwives indicated that health care had been in their professional plan from an early age.

"[I became a midwife] because our family is in [a] line of midwives, by medical practitioner. My mother, my aunt, my sister ..."

– Midwife, BlueStar franchise

"When I was little, I [would] always see the RHU [rural health unit] midwives going house to house ... I was interested in the syringe, I wanted to know how to use it. I also learned that they do deliveries. When I went to college, that's what I studied [midwifery]. It's a short course, I can get work immediately, and be of help."

– Midwife, Well-Family franchise

Interestingly, some of the midwives indicated that they had initially been on track, or had desired, to become a nurse or doctor; each had a reason for not reaching this goal, often something family-related.

“I was a full scholar under the UP [University of the Philippines] system. The school’s course was a ladderized program from midwifery to nursing then medicine. But, I got married and was not able to pursue medicine. I only finished up to nursing. Then, I started my midwifery practice after I passed the board exams.”

– Midwife, BlueStar franchise

“I didn’t want to be a midwife. I had no choice because I wanted to become a nurse but my parents didn’t want that. So, I took a different course, but for one semester only because I didn’t like math. My auntie told me to just take midwifery. The other courses had board exam and I didn’t want to take the board. I thought midwifery did not have a board exam. But I enrolled and I tried to enjoy it.”

– Midwife, Well-Family franchise

Previous Midwifery Experience

All the interviewees had been licensed midwives before joining their franchise, with a wide range in length of experience—from three years to 34 years, averaging about 24 years.

Many of the midwives (particularly in the Well-Family franchise) had previously worked in hospitals, in rural health units, with the Commission on Population, or with the Family Planning Organization of the Philippines (the local International Planned Parenthood Federation affiliate). Most of the BlueStar midwives had been doing home deliveries, working in the public sector, or working in a private clinic; some had established reputations and a network of clients. It was more common for a Well-Family midwife to report that she had an established clinic prior to joining the franchise; only half of the BlueStar franchisees had done so.

“They [BlueStar] started this. It was a very big help. If it was just me, it wouldn’t have crossed my mind to have my own clinic. It opened my mind. It was a good idea. I should have thought about it before. I am known here, but it still makes a difference having a clinic of your own, you have signage. It can attract (customers). I wouldn’t be this well known if not for them. It is great that I have a nice clinic and that I can offer services like family planning.”

– Midwife, BlueStar franchise

Provider Bias

All the midwives were committed to their work, including those in rural areas. (In the rural sample, either the midwife or her husband, or both, were originally from that area.) None of the midwives in the sample reported any reluctance to recommend IUDs to their clients, as has been often described in the literature on family planning providers.

Family Support

Many of the clinics operate as a family business, with family members serving as staff. The sense of a family legacy was clearly a driving force for some of the midwives, to ensure that their business is viable and will last.

Families often also serve as a critical source of material support: they may provide financing, or clinic space at reduced or no cost, enabling the midwives to start or to expand their practice. A few of the midwives interviewed had opened a branch clinic, managed by a family member. Particularly important was the support of the midwives' husbands; PSPPI has in fact reevaluated its recruitment strategy, to make sure that a potential midwife has the support of her husband from the beginning.

"With every successful midwife you will find always a sister assisting, or a husband working with her."

– Staff member, BlueStar

Clinic Factors

Aspects of the clinic itself are thought to be very important to the viability and scalability of private sector clinics. These include financing, location, hours of operation and staffing, and other clinical quality factors.

Financing

Financing for renovations and start-up costs can be difficult to secure for entrepreneurs looking to start their own business. However, most of the midwives interviewed had been able to find financing for their clinics. Each network provides a limited amount of support to midwives when they join the network to bring her skills and/or clinic up to the network's standards. In addition to that support, most of the midwives indicated that their financing came from their savings, their family, or the revenue they were earning from their preexisting clients, often for attending home deliveries.

Clinic Location

Many of the midwives had converted a space within their homes to serve clients, thus saving on building rental or land purchase costs; others built a facility next to their homes. This allowed them to be available 24 hours a day for deliveries. However, two BlueStar midwives were hoping to move the clinic or to open a second clinic in a busier area where they would

have more visibility. Well-Family midwives reported that their network recommends locating clinics on busy streets with a lot of traffic. Visibility can have its drawbacks, however, in a country where there is strong religious opposition to family planning, as some women are reluctant to visit a family planning clinic in a highly visible location. The networks should discuss with each midwife whether the clients in her area are more likely to visit a more visible or a more private location.

“Before when I had my clinic there [in a central area], being in a province, when someone came in, people here ask them, ‘Where have you been? What did you do there?’ They don’t want to be seen going here to the clinic. When I transferred here, I have more patients ... even if my clinic is not visible along the road, many people still come here.”

– Midwife, Well-Family franchise

Clinic Hours and Staffing

Most of the midwives stated that they were available to do deliveries 24 hours a day. Some of them noted, however, that this constant availability was a challenge because it cut into their family time; for a very few, it deterred them from wanting to offer delivery services. Most midwives solved the problem by having additional staff, ranging from a part-time, on-call assistant to a multi-person staff. Well-Family midwives were more likely to have other midwives at the clinic. In contrast, just over half of the BlueStar midwives worked alone; the others had only an assistant or an on-call midwife to assist them.

Clinic Services

As was shown previously in Table 1, each network has a standard set of family planning and reproductive health services, with many commonalities that their midwives must follow as a minimum. BlueStar sets fixed maximum prices for their services to ensure affordability, although prices are not subsidized. Well-Family midwives have more liberty to set prices at what they determine will be competitive in their communities.

Most midwives reported operating side businesses or offering additional services in their clinic. Especially in the more urban areas, many of the midwives provide (or planned to provide) additional services such as a convenience store, lab services, or ambulance service. A few provide space for clinical training by midwifery schools or networks, which pay for this service and provide the supplies. Some rent space to doctors, especially pediatricians and obstetricians, for limited office hours. Even in smaller towns, midwives often add simple services such as selling vitamins or over-the-counter medications; the additional income helps them to remain viable and even expand.

“Before to get lab or ultrasound, it was far. You need to pay Php 50 [50 Philippine pesos] for transportation. So, why not provide it in the clinic? The patients can save on transportation cost and time. I was told in our business training that we will be dreaming of a one-stop shop.”

– Midwife, Well-Family franchise

Network Factors

The franchise network is presumed to have an impact on the success and viability of the midwives and their IUD provision. Each network has a unique set of selection criteria for members and then provides a specific set of inputs to their franchisees (e.g., training, marketing, supervision, and physical clinic inputs).

Structure of Networks

As previously noted, BlueStar is in a scale-up phase, with 266 of a planned 500 clinics in place. PSPI is able to cross-subsidize its support to the BlueStar network midwives from its standalone clinics. The PSPI

staff provides senior management, financial and administrative oversight, and clinical service support to BlueStar midwives. Brand associates (franchise coordinators) provide logistical support including managing field team member (FTM) activities; aggregating franchisee weekly reports; supporting training, events, and recruitment of new midwives; and troubleshooting low performance or other issues (Pernito et al., 2010 and interviews with PSPI staff). FTMs are regionally based and provide direct support and supervision to the midwives on a variety of clinic management issues, including meeting and sustaining accreditation standards, ensuring quality standards, marketing, commodity resupply, and other support.



Robin Keeley

A midwife advertises the additional services she offers.

“A key to supporting the midwives is the FTM. Without them, we don’t have a link to the midwives.”

– Staff member, BlueStar franchise

As previously discussed, WFPI is the national umbrella franchisor for Well-Family and its seven regional NGOs support the midwife clinics in their region. This arrangement results in differing levels of support for the midwives, based on the NGO’s expertise and ability to cross-subsidize support to the program from other revenue-generating activities.

Midwives from both networks are expected to offer a core set of family planning and reproductive health services and follow the networks’ standards. BlueStar midwives have frequent check-ins (bi-weekly to monthly depending on their FTM and their level of need) and Well-Family midwives have regular quality assurance check-ins until they “graduate,” which occurs either when the clinic has met all the required standards regularly or after two years of belonging to the network. After graduation, check-ins by the NGO are less frequent and the midwives are expected to proactively identify what they need and request assistance from the NGO.

Membership Requirements

Both networks only accept midwives who are already licensed and providing delivery services and they avoid recruiting government-contracted midwives. The networks also seek midwives with a certain profile: Well-Family looks for established midwives with some business knowledge, good communications skills, and “a personality that can draw people in.” BlueStar makes a commitment to family planning the most important factor. It then trains the midwives to “become popular” and cultivates their personality and business acumen through training.

Support Provided by the Network

Physical Clinic Inputs

The majority of BlueStar midwives have land on which they can build a clinic or an existing structure that can be turned into a clinic. PSPI provides initial financial assistance to help new midwives pay for necessary space improvements, and some midwives reported getting loans from BlueStar for construction and renovation. The standard materials provided to the BlueStar clinics by PSPI include equipment and supplies (for deliveries and family planning provision), as well as a six-month supply of family planning commodities (pills, condoms, injectables, and IUDs). Thereafter, midwives have access to affordable commodities purchased through the Marie Stopes International global purchasing system.

Well-Family currently provides less initial support to its midwives than it did in the past, due to decreased donor funding. Reportedly, this support also depends on the supervising NGO. In the past, when it started under the TANGO projects, Well-Family helped midwives establish a clinic or

renovate an existing one, but many of the Well-Family NGOs now require midwives to have an existing clinic, as they no longer have funds for major renovations. Midwives were also historically provided equipment (now, often secondhand equipment), instruments, delivery tables, and limited family planning supplies. Well-Family midwives are now connected to commercial suppliers for access to affordable commodities.

Marketing

Both networks provide a basic marketing package to their new franchisees. This package includes new signage with the network's branding, flyers and handbills describing services, and support for putting on a "buntis" party (party for pregnant women). Both networks include marketing in their training package. BlueStar specifically includes sponsorship of weekly buntis parties for six months in its start-up package, believing that this is one of the most effective ways of drawing in new clients. Many midwives echoed this sentiment. BlueStar is now looking to help midwives establish links with pharmaceutical companies to continue to support the buntis parties beyond the initial six month period, which is also a method Well-Family has used to keep these key marketing events going.

In the early days of Well-Family, the network, with support from USAID, launched a multimedia marketing campaign that included radio and television advertisements. According to the midwives interviewed, this type of marketing no longer exists, but it helped establish the Well-Family brand. Well-Family also has a website that lists the locations of their midwives. Some of those interviewed mentioned this as a source of clients.



Robin Keeley

A rural midwife clinic displays family planning signage provided by the franchise.

Training

Both networks provide training opportunities for their midwives. BlueStar covers the full cost of trainings, while Well-Family now requires midwives to pay for at least part of the cost.

BlueStar requires a package of trainings, including comprehensive family planning (of which the IUD is a component). IUD training includes a 10-day practicum on IUD insertions with a requirement of performing 50 insertions.

Well-Family midwives are also clinically trained in comprehensive family planning, including IUDs, in line with the standard Department of Health curriculum. The standard Department of Health family planning training requires performing 20 IUD insertions for its practicum.

As noted by the organization that leads the training for Well-Family and BlueStar, BlueStar's training has a greater emphasis on IUD insertion, with very early introduction to and more time spent on this service. This emphasis may be impacting the ability and confidence of BlueStar midwives to counsel on and provide this method in higher numbers.

Supervision and Quality Monitoring

Both networks support their midwives by providing quality monitoring and by assisting them in obtaining PhilHealth accreditation. (PhilHealth is the national health insurance program, created in 1995.) Each network assists the midwives in navigating the requirements and helping them make the necessary improvements—in terms of physical input and business systems—to work toward accreditation.

The BlueStar FTMs are the main point of contact for the midwives for general support and oversight. This monitoring ensures quality services, promotes reporting of service statistics, and ensures that the midwives have what they need to operate successfully.

Well-Family provides similar monitoring, although the level of monitoring appears to vary according to the NGO supporting the clinic and the length of time the clinic has been a part of the network, with more frequent visits occurring at startup. One NGO noted it holds monthly meetings for the midwives in its region to discuss issues, announce upcoming trainings, and address other items that might affect the clinics. The Well-Family NGOs noted that the varying levels of support they are able to provide has been an ongoing challenge for the network—some NGOs are better financed to provide ongoing monitoring or technical expertise to the midwives than others. One NGO representative noted that the NGO no longer had funds to provide the same level of marketing or monitoring visits that it had in the past.

Both networks also engage in important advocacy to promote enabling policies, primarily concerning regulations for clinics, licensure, and PhilHealth accreditation. The Well-Family network played a major role in developing the criteria for midwife clinics to become eligible for PhilHealth accreditation, and the supporting NGOs continue to raise midwifery issues with local authorities. PSPI, on behalf of BlueStar midwives, has been performing similar advocacy on the local level, to encourage fast tracking accreditation of clinics.

Family Planning Provision

Demand and supply are both important aspects of successful family planning provision. To ensure demand, myths and misconceptions about family planning that discourage clients from seeking services or particular methods need to be dispelled. A steady supply of affordable family planning commodities is also critical—if commodities are expensive or not available, providers either cannot obtain them or have to increase prices, which in turn might restrict client access.

Community Attitudes, Myths, and Misconceptions

Nearly all of the midwives interviewed reported that their communities understand family planning and are generally supportive of family planning methods. This is reflected in the family planning services provided by the interviewed midwives, as shown in Table 3.

Table 3: Delivery and Family Planning Methods Provided by Network, 2012

	Deliveries*	Total FP Methods	Total IUDs	Total Injectables	Total OC
Well-Family Total Provision (n=9)	1,326	2,319	513	989	817
BlueStar Total Provision (n=8)	790	2,495	1,372	369	754

Note: FP = family planning, OC = oral contraceptives

*BlueStar reported only deliveries financed by PhilHealth's maternity care package (MCP) of benefits. One Well-Family midwife reported only MCP deliveries. These numbers likely underrepresent true delivery statistics.

BlueStar and Well-Family midwives from the sample provide almost equal quantities of family planning services. The main difference is that BlueStar midwives provide more IUDs, while Well-Family midwives provide more injectables. Interestingly, nearly all of the midwives from both franchises consistently reported that IUDs are the least popular method in their community and that it is very challenging (though possible) to overcome misconceptions about and biases toward this method. In the face of such reportedly strong beliefs against IUDs, it is clear that the ability to effectively counsel women and men regarding use of IUDs is important for midwives. Although some skill in this can be taught, the midwife's personality, ability, and motivation to counsel, and commitment to overcome misconceptions about IUDs, are a key to increased uptake of IUDs.

“ ... when she got home, the mother-in-law talked to her that the IUD is [causing] cancer... and then at the back of her mind, she come back and telling you that experience. ‘Why, why do you want to remove the IUD?’ ‘Because my mother told me, my grandmother told me, my mother-in-law told me that the IUD causing me cancer.’ So I battle the misinformation that she got. So I ... assure her that her IUD is not harmful to her body.”

– Midwife, Well-Family franchise

Commodity Supply

Thanks in part to USAID's ongoing work in partnership with the pharmaceutical industry through PRISM2 and previous projects, family planning commodity supply, including IUDs, is reportedly no longer an issue. Table 4 highlights the IUD purchasing options in the country and the wide range of affordable, fully sustainable supply options. BlueStar midwives can order IUDs through their network's global purchasing system at the lowest price available in the country. Well-Family midwives can purchase affordable IUDs through one of the major distributors. Because these are unsubsidized commodities, there is no concern that the prices will rise when donor funding is removed, or that the commodities will disappear altogether.

Table 4. Suppliers and Prices of IUDs in the Philippines

Supplier	Brand	Purchaser	Price to midwife (Php)	Price to midwife (USD*)
DKT	Pregna	Well-Family midwives	Php 85	\$1.96
DKT	Securi-T	Well-Family midwives	Php 120	\$2.77
Alphamed	T-Care	Well-Family midwives	Php 90	\$2.08
PSPI/MSI	Eve's	BlueStar midwives	Php 23	\$0.53

Note: Php = Philippine peso, MSI = Marie Stopes International

*Php to USD exchange rate: 43.22

With BlueStar midwives charging 100 Philippine pesos, or Php 100 (US \$2.28) for an IUD insertion and the majority of Well-Family midwives charging Php 500 (US \$11), there is significant mark-up over the commodity cost, showing that it is possible to realize a profit from these procedures while keeping prices relatively low.

Revenue and Expenses

This section highlights an individual clinic's financial viability, including its ability to collect payments, pay expenses, and offer enough financial value for the midwife to keep the business open. For the purposes of this case study, these factors are self-reported. Clinic financial records were not assessed.

Delivery

As one of the main services midwives provide, delivery is a key revenue generator for the clinics. Almost all of the midwives from both networks, even those who did not yet have PhilHealth accreditation, stated that delivery was their most profitable service.

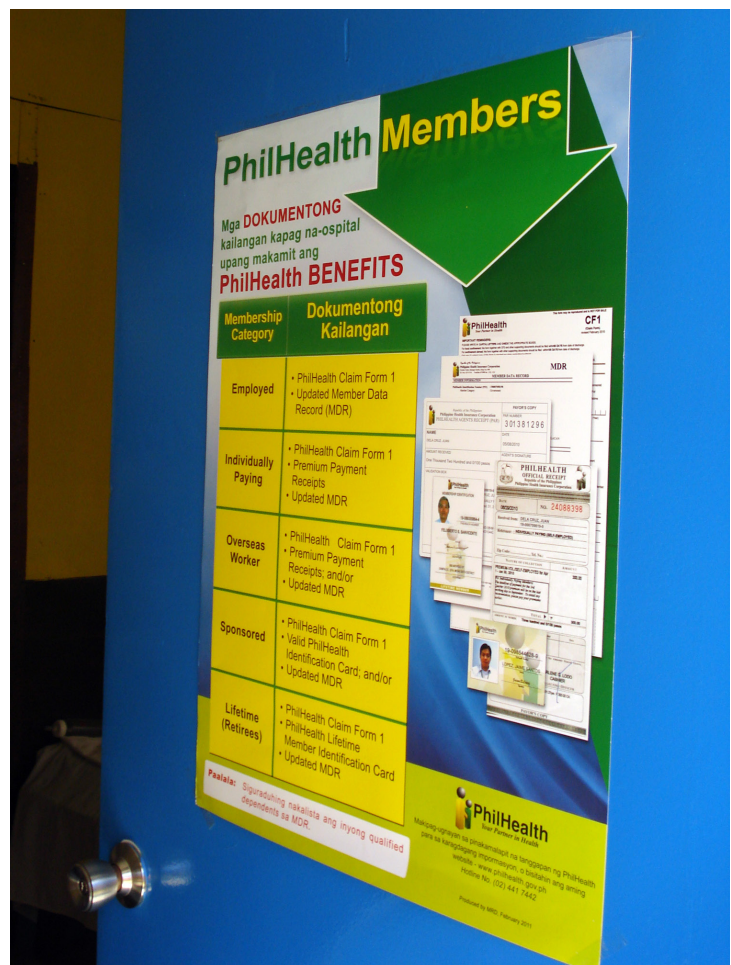
[Responding to which services are most profitable] "Deliveries. Because this month, we had 45 deliveries. This is not peak season. I thought this is the weakest month for deliveries. Last year, during summer, we only had 20 deliveries. It is shocking that this month, we had 45... I have 3 (maternity) packages."

– Midwife, BlueStar franchise

PhilHealth Accreditation

PhilHealth accreditation and reimbursements for its maternity care package (MCP) appear to enhance a clinic's financial viability. MCP reimbursements can be more than double the amount that a midwife would normally charge for delivery. The MCP package also allows midwives to offer more comprehensive services for the package price, including ante- and postnatal care and newborn screenings. Of those midwives who do not have PhilHealth accreditation, many responded that this accreditation would make their clinic more profitable.

In addition to the higher reimbursement it offers, PhilHealth accreditation is also seen as a confirmation of the quality of the midwife's services.



Robin Keeley

A poster on the door of a clinic serves to inform clients about PhilHealth eligibility and benefits.

Most midwives interviewed had PhilHealth-accredited clinics, although some had just received accreditation and no payment yet. To help with their cash flow while waiting for reimbursements, BlueStar midwives can take a loan from PSPI as an advance on their claims. This option can help them keep their cash flow available to purchase commodities and other items they need for the running of their clinic.

For the two midwives interviewed who only offer family planning and reproductive health services, not deliveries, their most profitable services were Pap smears and IUD insertions. Despite not offering delivery services, both of these midwives appear to be very successful and to be operating viable businesses. Prior to opening Well-Family clinics, both midwives were established family planning providers in their communities; they had worked with government offices offering family planning services (Commission on Population or rural health units) and with the Family Planning Organization of the Philippines. This combination of factors may help in their marketing of their family planning and reproductive health services.

Competition

Most of the midwives reported some level of direct competition within their catchment areas, either with other private midwives, doctor-run clinics, or public facilities. This is particularly true in urban and peri-urban areas where there are more providers. However, many midwives reported that the closest government facilities often do not provide the same range of services. Provision of family planning through the public sector is dependent on the local government unit, so if the LGU does not purchase family planning commodities, they are not available in public sector facilities. Many of the midwives also believe that patients come to them because they offer better customer service. Some midwives noted that clients did not want IUDs from the government at discounted prices because they thought the IUDs might not be of equal quality. Midwives also noted that public facilities are often very crowded so women do not find the privacy they want.

“Number 1 is (this is a) private clinic. The public midwife reprimands them. There is no privacy there. That’s what they say. It’s different in private clinics because they get privacy. They get scolded and screamed at [in the public clinics] if they cannot bear it down. Here, we wipe their sweat, comfort them. We pamper them so they will endorse us. That is how it is with private clinics, the charisma. TLC, tender loving care.”

– Midwife, Well-Family franchise

Some midwives also reported that they anticipate and are concerned about more competition from the government clinics as the government sets up more lying-in clinics (maternity clinics) to benefit from PhilHealth’s MCP reimbursement.

Profit

Of all the midwives interviewed, only two indicated that they were not regularly earning a profit. One of these was still in a start-up phase and optimistic about a future increase in clients, while the other was more pessimistic. Generally, the Well-Family midwives interviewed have had their clinics for a longer time and had a better sense of their expenses. Overall, the clinics appeared to be viable in the view of the midwives.

“We have savings every month. There are really savings. That’s what I want. We can’t spend everything for expenses. That’s not a good business.”

– Midwife, Well-Family franchise

“Somehow, I never run out of money since I became part of BlueStar. Not like before, I always ran out of money. But now, it is very rare that I would have zero income in a week.”

– Midwife, BlueStar franchise

To get a sense of monthly clinic expenses, the midwives were asked to report specific categories of expenses in terms of the percentage of total monthly expenditure they represent. On average, the midwives reported salaries, family planning products and other consumables, and utilities (electricity and water) as their major expenses. However, when looking at midwives individually, all of the Well-Family midwives reported family planning products and other consumables as their second highest monthly expense, compared to only half of the BlueStar midwives who reported family planning products and consumables among their top two expenses. This difference can be linked to the low-priced commodities that BlueStar offers to its midwives.

Royalties and franchise fees were not commonly reported among their higher costs. Rent, for those who did not own their own space, is a major expense. Renting space can also make PhilHealth accreditation more challenging to obtain as landlords sometimes do not allow required renovations. One midwife reported being unable to get PhilHealth accreditation without presenting a copy of the lease agreement, which the landlord refused to provide as he did not want the government to know he was renting out the space.

Variety of Payment Mechanisms

Only a few of the midwives, mostly those in small and medium-sized “barangays” (towns), reported having difficulty with clients not being able to make payments for services. BlueStar midwives reported issues more often than the Well-Family midwives, but the BlueStar midwives interviewed were also more commonly located in small or medium-sized barangays than were the interviewees from Well-Family.

“If they only eat one meal a day how can you ask them to pay? For those who can’t afford it, I use it as a promotion to [attract] those who can afford.”

– Midwife, BlueStar franchise

Most of the midwives offer a variety of payment mechanisms to clients who have difficulty paying their full bill at the time of service, in particular for deliveries. These methods included advance payment, incremental payments, accepting other types of collateral, and reduced pricing for clients they know cannot make the payments. They may also refer clients to public facilities if they cannot pay at all.

PhilHealth reimbursement is also accepted at the accredited facilities and is an encouraged method of payment by the midwives, who try to make sure clients know when they can use this insurance. The variety of payment methods allows midwives to accept a wider range of clientele.

Marketing

After network-assisted marketing ends, the midwives from both networks have to find ways to continue marketing their business. One midwife reported stuffing clinic fliers into the paper bags for customers who shop at her adjacent convenience store. Many still go door-to-door to promote the clinic, and they reported this as one of the best ways of getting clients. Most midwives try to find ways to keep buntis parties going, including through accepting donations and financial support from pharmaceutical representatives, because they know what an effective marketing tool the parties are.

“Buntis party. Pregnant parties. Because the pregnant women come here and they can see that my facility is nice and clean. They can see that the clinic looks good. I treat them well. I can explain if they have questions.”

– Midwife, BlueStar franchise

Most of the midwives reported that a large portion of their clientele is driven by word of mouth from satisfied customers, so providing good services is a key marketing strategy. Many of the midwives also offer special discounts to bring in clients or reward existing customers for referring clients to them. Some even provide free services. BlueStar midwives often reported offering free services during buntis parties, which helped them attract more clients.

“Today it’s summer now. I do summer promos. For Mother’s day, I have [a] Mother’s Day Special Promo. It’s exclusive for the moms, the women. This summer, I have circumcision for males. It’s 50 percent off. So, I mark down my services.”

– Midwife, BlueStar franchise

“Volunteering at [a] health center [is the most effective marketing for the clinic]. I help in prenatal, so I can talk to the pregnant women. [I] invite [them] to come visit my clinic, she [pregnant woman] can give birth here if she likes. We also have free prenatal every Saturday. We invite the pregnant women to visit here on Saturdays, free.”

– Midwife, Well-Family franchise



A sign outside a clinic offers free prenatal check-ups on Sunday mornings.

Robin Keeley

CONCLUSION

Midwives from the Well-Family Midwife Clinic and BlueStar franchise networks are important providers of family planning in the Philippines and they have viable businesses, defined as a midwife earning enough to pay her clinic costs and living expenses using revenue from services and actively offering IUDs. Nearly all of the sampled midwives reported earning enough money to support themselves and their businesses. Many were earning enough to also invest in improvements to the infrastructure or services of their clinics. Midwives from both networks provided almost equal amounts of family planning services, varying only in the predominant method that they provided (BlueStar provided more IUDs, Well-Family more injectables). This difference may be due in part to BlueStar's stated objective of increasing access to family planning through new clinic-based midwives, their strong support of IUDs in the method mix, and expanded training on this method.

Below are key factors associated with the viable provision of IUDs by the midwives interviewed and recommendations for applying these factors more broadly.

Training

Focused clinical training on IUD provision can help increase midwife skill and confidence in offering and providing IUDs. Both networks ensure that their midwives are trained in IUD provision. BlueStar's training, however, requires a greater number of IUD insertions (50) during the practicum session. With a clinical skill like IUD insertion, practice is important to gain and maintain confidence in service provision. An increased emphasis on insertion during the training practicum can help providers build their confidence in performing the procedure and in using it with their clients.

Recommendation: Clinical trainings on IUD insertion should include a significant emphasis on IUD insertion during the practicum. The more insertions a trainee performs, the more proficient and confident she will become in the skill. This will make her confident in recommending IUDs to her clients, when appropriate, and help maintain her skill.

Midwife Selection

Certain criteria for midwife selection may help to increase IUD provision and have implications for increased viability. Both networks have criteria for selecting the midwives they bring into their network. However, BlueStar appears to have more overt requirements for the personal characteristics of their midwives. Their goal is to intentionally increase access to facility-based services by selecting midwives who are active providers of delivery services in their communities but do not yet have a clinic. This seems to generate a sense of gratitude in the midwives for the "opportunity" (a word used by many BlueStar midwives) to open

a business. Thus, they may be more dedicated to the mission of their NGO and motivated to counsel clients and overcome their misconceptions related to IUDs.

Many midwives from both networks indicated that they believe their clients come to them for services because of their positive personality or kind care. These traits that both networks value plus an engaging personality (whether a selection criteria as it is for Well-Family or a taught skill as with BlueStar) appear to enhance clinic viability.

Both networks select midwives who have been working in their communities. As reported by many midwives, such community work appears to be a benefit for viability and uptake of IUDs since people know these women and not only come to them for services, but also may trust them more when it comes to counseling on family planning in general and on IUDs in particular.

Finally, having the support of family members and especially of their spouse was critical to the success of most midwives.

Recommendation: Where feasible, the franchise networks should consider the personal characteristics of potential midwives, including personality, experience in the community, motivation, and family support, when selecting midwives for the network.

Access to Commodities

Easy access to affordable commodities keeps prices low and services accessible. Midwives in the Philippines have easy access to a sustainable and consistent supply of IUDs and other family planning methods. This access is vital to their viable provision of IUDs. Also important is commodity affordability—midwives must be able to buy commodities from suppliers at a price they can pass on to clients, with something added to make a profit on each service. BlueStar midwives have access to low-priced IUDs through the Marie Stopes International global commodity purchasing system. Well-Family midwives pay more than twice as much, but also have relatively low-priced options to purchase IUDs (85–120 Php versus 23 Php).

The low-priced commodities that the BlueStar midwives have available to them, in addition to a price cap the franchise puts on IUD services (100 Php), results in a large price difference for IUD services between franchises. Though this was not a factor mentioned by the midwives interviewed for this case study, this price difference may contribute to the increased number of IUDs provided by the BlueStar network midwives.

Recommendation: In recognition of the fact that not all contraceptive commodity markets are as developed as those in the Philippines, more investment should be made in developing or strengthening local markets

for family planning commodities, including IUDs, when possible. This strategy includes ensuring the existence of competing suppliers to keep prices low and access to supplies high. A network also can coordinate bulk purchases of family planning commodities for network members, similar to the BlueStar approach. Since small providers use fewer commodities, they are at a disadvantage in being able to use bulk purchase discounts. These pooled purchases enable the small midwife businesses to take advantage of bulk discounts.

Location and Marketing

Creative low-cost marketing can be highly effective in improving client flow and promoting viability. Marketing is an important component of clinic viability, whether it is networked or independent. People cannot come for services if they do not know that the clinic or the services are available. For many midwives, one of the most effective marketing tools was the least expensive—going from house to house in their communities and talking to women about family planning. Also effective were slightly more expensive approaches such as outreach events in nearby towns (especially those without a midwife) and providing certain free services. Women who receive these free services often come to the clinic for additional services.

Location is also critical to success. Clinics are often built in or near the midwife's home, but the network may also target preferred locations for new clinics. Both networks examined in this case study do some mapping to determine catchment area, client potential, and competition, and Well-Family has the right of approval of clinic location. However, the network may not always know best, and a midwife's knowledge of her community is important. A key decision relates to the benefits of clinic visibility versus client privacy.

Recommendation: Midwife training for those intending to go into private practice should include information on marketing a business. Creative and low-cost marketing solutions can draw in new clients, whether it is a franchise or an independent midwife clinic, especially at the start of a business, before revenues are adequate to support more costly marketing efforts. However, not all midwives are naturally inclined toward marketing.

Regarding location, both the network mapping and the midwife's perspective are valuable sources of information, especially in balancing the need for visibility and local preferences for privacy.

Flexibility in Payment Mechanisms

Flexible payment terms can increase access to services, including IUDs, and potentially have positive implications for business viability.

The fact that many midwives understand that not all of their clients can immediately pay their bill in full may in the long run contribute to the viability of their business. Although many accept partial or even non-payment from clients they know are truly unable to pay, most offer payment plans for the entire amount over time. While this can be detrimental to cash flow in the short term, it generates goodwill among clients; over the long term, the clients are more likely to patronize the midwife and refer other paying clients to her. The benefits of this flexibility would apply regardless of whether a midwife is in a franchise or is independent.

Recommendation: Organizations, projects, and donors can include discussions of flexible payment mechanisms in trainings for both networked and independent midwives. Although insurance mechanisms like PhilHealth may provide generous payments for some services, providers may also have clients who lack insurance. In these cases, it is important for providers to develop payment mechanisms that serve both the midwife and her client, such as sliding-scale payments, deferred payments or pre-payments, and installment payments. Creative financing arrangements can help to extend the midwife's services to those with less ability to pay at one time, yet fulfill her need to receive payment and keep cash flow available.

LOOKING AHEAD

Much can be learned from the Philippines' efforts to increase the provision and uptake of family planning. This case study shows that private midwives can provide IUDs on a viable basis and serve the broader community. Key conditions include consistent access to an affordable supply of commodities, and the availability of services provided through a carefully selected and properly trained mid-level cadre, such as midwives. Providers should have a history of administering services, whether clinic-based or home-based, in their community as well as the motivation to run their own business and to provide quality services.

Developments in the Philippines since data collection for this case study was completed, as well as global research findings and recommendations, suggest some further directions for programming and policy, as outlined below.

In terms of programming, in June 2013 PhilHealth began to reimburse for IUD services provided by accredited private midwife clinics, thus allowing women who cannot afford the service to receive it for free. For BlueStar, the Php 350 (US \$8) reimbursement rate (Senlet et al., 2012) is higher than the Php 100 (US \$2.28) charged by network clinics. The rate is lower than the Php 500 (US \$11) or more charged by most Well-Family clinics. Nevertheless, it will allow these clinics to grow their client base by providing services to women who are not able to pay the normal service fee.

On the policy front, in 2014 PhilHealth will expand subsidized coverage of health insurance to people in the second lowest wealth quintile. Increasing the pool of people with insurance who can take advantage of the MCP has the potential to increase business and PhilHealth reimbursements for private midwives and thus increase the viability of their businesses.

Considering the success that private midwives are having in IUD provision in the Philippines, as implants are introduced into the market, it might make sense to reassess the legal restriction on midwife provision of implants. Globally, the literature shows that midwives and other lower-level cadres of health care workers can provide services, including implants, at a level of quality equal to that of higher-level providers, and often with more comprehensive counseling (Janowitz et al., 2012). The World Health Organization OptimizeMNH guidance recommends task sharing of implant insertion and removal to include midwives (World Health Organization, 2013). Implementing this guidance could help to increase access to LARCs for women, especially in locations with easier access to midwives than doctors.

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Abt Associates Inc.
4550 Montgomery Avenue, Suite 800 North
Bethesda, MD 20814 USA
Telephone: 301.347.5000 • Fax: 301.913.6019
www.abtassociates.com