PRIVATE MIDWIFE PROVISION OF IUDS: LESSONS FROM THE PHILIPPINES

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ACRONYMS

BTL	Bilateral tubal ligation
CHD	Council for Health Development
CPR	Contraceptive prevalence rate
DHS	Demographic and health survey
DKT	DKT International
DMPA	Depot medroxyprogesterone acetate
DOH	Department of Health
FHS	Family health survey
FP	Family planning
FTM	Field team members
IMAP	Integrated Midwives Association of the Philippines
IMCH	Institute of Maternal and Child Health
IUD	Intrauterine device
IV	Intravenous
JSI	John Snow International, Inc.
LARC	Long-acting reversible contraceptive
LGU	Local government unit
MCH	Maternal and child health
MCP	Maternity care package
MNCHN	Maternal newborn child health and nutrition
MSI	Marie Stopes International
NCR	National Capital Region
NGO	Nongovernmental organization
NHIP	National Health Insurance Program
OC	Oral contraceptive
PM	Permanent method
POPCOM	Commission of Population
PRISM2	Private Sector Mobilization of Family Health Project – Phase 2
PSPI	Population Services Pilipinas Incorporated
PSP-*One*	Private Sector Partnerships – *One*
RH	Reproductive health
RHU	Rural health units
SHOPS	Strengthening Health Outcomes through the Private Sector
TANGO	Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Nongovernmental Organizations
UHC	Universal Health Care Act
UNFPA	United National Population Fund
USAID	United States Agency for International Development
WFPI	Well Family Midwife Clinic Partnerships Foundations, Inc.
WHO	World Health Organization

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EXECUTIVE SUMMARY

Although significant attention has been given in recent years to the use of long-acting reversible contraceptive (LARC) methods of family planning (FP), less attention has been paid to where clients go to obtain these methods. A recent historical source analysis using DHS data for both short-acting methods and LARCs/permanent methods (PM) showed that although 45 percent of modern contraception is obtained from 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 obtained from the private sector, compared to only 28 percent of LARC/PMs. Many wealthy women (defined as women from the top two DHS wealth quintiles) obtain their LARC/PMs from the public sector, suggesting a possible access issue to these methods in the private sector.

In the Philippines, 63 percent of women from the top two wealth quintiles receive their LARC/PM methods from the public sector (Ugaz, 2014). A review conducted by the USAID-funded Private Sector Partnerships-*One* (PSP-One) project on the commercial viability of LARC/PMs looked at the conditions under which the commercial health sector might feasibly and sustainably provide LARC/PMs. The authors concluded that encouraging commercial providers to enter this market and succeed remains extremely challenging because of factors such as low demand, high cost of market entry, low perceived revenue from the services, and policy barriers, among others (Ravenholt et al., 2009). The SHOPS project is examining this topic through a case study in the Philippines, a country that appears to have viable commercial provision of LARC/PMs. The intent of this exercise is to identify factors related to successful private sector LARC provision that can be replicated both in the Philippines and in other country settings.

This case study highlights some of the enabling factors that help facilitate viable commercial provision of LARCs, not only in the Philippines, but potentially in the developing world more generally. The case study employed semi-structured qualitative interviews of 17 midwives from the Population Services Pilipinas Incorporated/BlueStar network (BlueStar) and the Well Family Midwife Clinic network (Well Family), and network NGO staff. In tandem, the design analyzed service provision statistics from these networks, focusing on the provision of IUDs as the only LARC that midwives are able to provide in the Philippines.

Five general areas were identified that, based on the literature and on the data collected, appeared to affect the ability of a private midwife to viably provide IUDs. These areas are:

- **Provider factors**: those that influence a midwife's ability to run a commercially viable business and to provide IUD services. These factors include training on clinical skills, counseling, and business skills; provider bias; and innate intrinsic factors such as motivation;
- **Clinic factors**: aspects of the clinic itself are important to the viability and scalability of private sector clinics. These factors include financing, location and hours of operation, staffing and other clinical quality factors;
- **Network factors**: inputs provided by the network to their franchisees (e.g., training, marketing, supervision, physical clinic inputs) and selection criteria for midwives;
- **Family planning provision**: these factors include both demand (myths and misconceptions) and supply (commodity price and availability); and,

- **Revenue and expenses**: a clinic's 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.

Overall, franchised midwives from both networks appear to have viable businesses and are important providers of FP in the Philippines. Viable provision of IUDs is defined as a midwife clinic owner earning enough revenue to pay for her clinic costs and maintain an adequate standard of living while actively offering IUDs in her package of health services. Midwives from both networks provided similar quantities of FP, only varying in the methods that their clients chose to receive more often (BlueStar clinic records showed more IUDs and Well Family clinic records showed more injectables). This difference may be in part due to BlueStar's stated objective of increasing access to FP through new clinic-based midwives and their strong support of and expanded training on IUDs in the method mix.

Based on the data collected and analyzed through this case study, the below key factors emerge as associated with the viable provision of IUDs:

- ***Focused clinical training on IUD provision can help to increase midwife skill and confidence in offering and providing IUDs.***
- ***Certain criteria for midwife selection may help to increase IUD provision and have implications for increased viability.***
- ***Easy access to affordable commodities keeps prices low and services accessible.***
- ***Creative low-cost marketing can be highly effective in improving client flow and promoting viability.***
- ***Flexible payment terms can increase access to services, including IUDs, and potentially have positive implications for business viability.***

Despite its somewhat unique context, there is much that can be learned from the Philippines to support efforts to increase the viable provision and uptake of LARCs worldwide. We have found that it is possible to provide IUDs on a viable basis in certain contexts and serve the broader community. Some of the key conditions include consistent access to an affordable supply of commodities, and the availability of services provided through a properly trained mid-level cadre, such as midwives. Effective providers typically have a history of providing services in their community, whether clinic-based or home-based, as well as the intrinsic motivation to run their own business and to provide quality services. Finally, a reinforcement system for providers can help them remain viable and support them in providing IUDs, as long as the network provides defined benefits for its members.

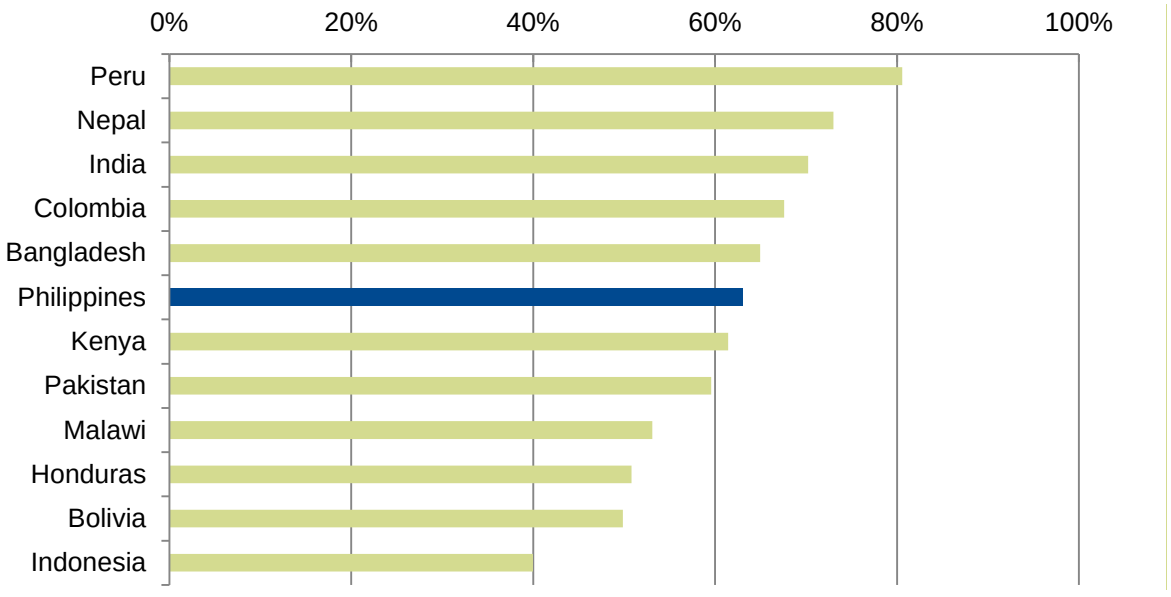
1. INTRODUCTION

1.1 BACKGROUND

Although significant attention has been given in recent years to the use of long-acting reversible contraceptive (LARC) methods of family planning (FP), less attention has been paid to where clients go to obtain these methods. Free and informed choice of a broad mix of contraceptive methods has long been a hallmark of FP programs. When women have more contraceptive choices and comprehensive counseling, they are more likely to find a method that suits their needs, adopt it, and continue using it (FHI 360, 2008). LARCs are one subset of FP methods that tend to be underutilized in many developing countries, yet are highly cost-effective with low failure rates and high client satisfaction. The effectiveness and ease of use of LARCs may contribute to the fact that women who use them appear to have substantially higher continuation rates than women who use short-acting methods (FHI 360, 2008). Some reasons purported for low use of intrauterine devices (IUDs), in particular, include lack of knowledge of the method, misinformation, provider bias, lack of training, cost of the device and procedure, and inaccessibility to facilities providing such services (D'Arcangues, 2007).

As the data show, this last point, access to facilities providing IUD services, is particularly relevant. A recent historical analysis of source for both short-acting methods and LARC/PMs using Demographic and Health Survey (DHS) data showed that although 45 percent of modern contraception is accessed through the private sector in Asia and 33 percent in sub-Saharan Africa, there are wide differences 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 LARC/PMs. In sub-Saharan Africa, 34 percent of short-acting methods are accessed through the private sector compared to only 25 percent of LARC/PMs.

FIGURE 1: PERCENTAGE OF LARC/PM USERS FROM TOP TWO WEALTH QUINTILES WHO OBTAINED METHOD FROM PUBLIC SECTOR



In addition to lower overall usage of the private sector for LARC/PMs, many wealthy women

(defined as women from the top two DHS wealth quintiles) obtain their LARC/PMs from the public sector, showing a possible access issue to these methods in the private sector. In the Philippines, 63 percent of women from the top two quintiles obtain their LARC/PM methods from the public sector (Ugaz, 2014).

A review conducted by the United States Agency for International Development (USAID)-funded Private Sector Partnerships-*One* (PSP-One) project on the commercial viability of LARCs and PMs looked at the central question of the conditions under which the commercial health sector might feasibly and sustainably provide these methods. 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 this provision in more detail to determine if these methods can viably be 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.

1.2 COUNTRY SELECTION

After a review of DHS data from multiple countries, the Philippines was selected for this case study because of its relatively high use of LARC/PMs (8.3 percent), with a significant percentage of that use coming from the private health sector (17.3 percent IUDs, 26.6 percent female sterilization). 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. Finally, the USAID mission in the Philippines believed that if private sector provision of LARC/PMs could be successful anywhere, it would be the Philippines. This belief is due in large part to the groundwork that had been laid through a history of midwife-focused (including private midwife) projects by the government, USAID, and the United Nations Population Fund (UNFPA) (in the post-Cairo International Conference on Population and Development period) and their key role in FP provision.

During a planning trip in January 2013, the SHOPS team identified private midwives as a large and active provider of FP services in the country. Looking at mid- to lower-level providers of FP, such as midwives, is also of global interest as the FP community continues to look for ways to increase availability and use of FP methods (Jacobstein et al., 2013). Midwives are also a key provider of maternal health services worldwide, and of delivery services in the Philippines, specifically, where midwives attend 25 percent of all deliveries (DHS, 2009). The postpartum period is an opportune time to make FP available to women as the World Health Organization (WHO) cites that “65 percent of women who are 0-12 months postpartum want to avoid a pregnancy in the next 12 months but are not using contraception (World Health Organization, 2013).” The WHO also states that more than 30 percent of maternal deaths could be averted by the use of FP to space pregnancies more than two years apart (2013). Based on these findings from the initial visit, together with the links between FP and maternal health, the authors determined that midwives were an ideal focus for this case study.

Because of this focus on midwives, the case study was narrowed from LARC/PMs more broadly to IUDs, as midwives do not provide PMs and implants are currently not widely available in the

Philippines. According to the UNFPA in the Philippines, an implant acceptability study was in the advanced implementation phase in January 2013. However, midwives will not be allowed to legally provide implants when they are available without a change to the midwifery law.

This case study focus on midwives from the two large midwife franchises (Well Family and BlueStar) came after discussions with many stakeholders, including private midwives themselves, and the appearance that some of the franchised midwives were providing large numbers of FP services, particularly IUD services. This trend appeared to be particularly true of the BlueStar network. The franchised midwives also appeared to run viable business models with, after limited initial inputs by the franchise, little to no external financial support from the franchise or other donors. As such, the case study sought to learn lessons from both network models and to identify factors that would help these midwives succeed in the sustainable provision of IUDs and in the provision of higher volumes of IUDs.

1.3 OVERARCHING GOAL

Overall, this case study looks to answer the question:

Is it feasible to provide IUDs in the private sector on a commercially viable basis and what are the factors that make it feasible?

To answer this question, three sub-questions are examined.

Are private midwives viably providing IUDs? Commercial viability is an important issue when it comes to private sector FP provision. If private providers are not making sufficient income to sustain 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 self-reported and self-defined and 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. However, to supplement this self-perception, some quantitative information was gathered to better assess income versus costs.

Why are some private midwives providing a higher number of IUDs more successfully than others? After an initial meeting with network NGOs and private midwives, it was clear that some midwives were able to provide larger volumes of IUDs than others. This case study intended to understand what is behind this higher IUD provision at a personal, clinic, franchise, and even regional level.

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 LARC/PMs in the Philippines and in other country settings?

The case study considered a variety of factors that were thought to impact the commercially viable provision of IUDs. The factors were broken into five categories: provider factors, clinic factors, network factors, financial factors (revenue and expenses), and FP-related factors. Justification for the selection of these factors is presented below.

Provider factors: These are the factors that influence a midwife's ability to run a commercially viable business and to provide IUD services. Midwives provide a range of services, largely revolving around delivery and FP, including IUDs. Training is a clear factor for both viability and IUD provision as, without knowledge of IUD insertion, a provider cannot provide this service in a quality fashion. Sub-standard services could impact her clinic viability. However, the literature supports that though training is necessary, it is not sufficient for viable IUD provision. A study from Pakistan showed that providers who were well-trained and considered themselves experts in IUD provision faced other barriers that prevented their provision of IUDs (Agha et al., 2011).

Provider bias is one of these barriers. Many providers incorrectly believe that there are age or other restrictions for IUD use. Another factor that this study noted, in particular for private providers, is concern related to IUD safety, side effects, and client dissatisfaction. Such concern could cause providers to not recommend the method since their business viability is linked closely to client satisfaction.

This concept also includes intrinsic factors, those that are innate within a person such as motivation and cannot be overtly replicated. Some of these personality traits can be taken into account, however, during the franchisee recruitment process, and can be fostered and encouraged in midwives. Motivation is a major intrinsic factor discussed here. Though there is little literature on private health provider motivation, there is a great deal of literature from the public sector and from other private industries concerning provider motivation. The literature points to the idea that motivation to serve as a midwife may impact the success of the services provided (Prytherch et al., 2013).

Clinic factors: Aspects of the clinic itself are thought to be very important to the viability and scalability of private sector clinics. One such factor is initial financing. Since most midwives are not given all, or in some cases any, of the start-up money needed for their clinic from their network, it is important to look at how midwives obtain start-up capital. Location and hours of operation are important as well in clinic start-up. If providers choose a poor location, it can impact their client flow, and inconvenient hours of operation could encourage clients to choose another provider. Staffing and other clinical quality factors are also elements important to consider as insufficient staffing can impact a midwife's ability to provide expanded services or the hours she can operate, and poor quality or service provision of a clinic can negatively impact client perception, hence affecting the midwife's revenue.

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

Family planning provision: Demand for FP services is often discussed as a barrier to successful IUD provision. However, many myths and misconceptions exist in relation to FP methods. The most common reason why women with a desire to space or limit children did not use FP was health-related concerns, specifically adverse reactions to FP methods or general health concerns. Other reasons include that the women were postpartum or breastfeeding or faced opposition to FP from their husband or their religion (Jacobstein et al., 2013). Beyond demand, supply of FP commodities is also a critical aspect in successful FP service delivery. If commodities are expensive or not available, providers either cannot obtain them or have to increase prices to accommodate the higher cost, which in turn might restrict client access.

Clinic revenue and expenses: This information highlights an individual clinic's 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.

1.4 METHODS

This case study used semi-structured qualitative interviews to gather information on the network's midwives, clinic history and structure, and the policy environment in which the midwives work. Quantitative data were also collected on FP and delivery services from the supporting networks. To provide more context to the midwives' responses, structured interviews were conducted with the nongovernmental organizations (NGOs) that support the networked midwives, and with the local government Community Health and Development units in which the

interviewed midwives work. Verbal consent was obtained for all interviews. All interviews were tape recorded with permission and written transcripts were produced. The transcripts were analyzed with thematic coding using Nvivo 10, a software package for qualitative data analysis.

1.4.1 SAMPLE SELECTION

The two networks selected for this case study were determined during an initial trip to the Philippines in January 2013. BlueStar was purposively selected for the case study because of the high volume of IUDs its midwives provide. Well Family was selected as a comparator network because it is the only other midwife franchise in the country of similar size, scope, geographical distribution, and structure to BlueStar.

Within the networks, 17 midwives were selected to be interviewed, eight from BlueStar and nine from Well Family. A maximum variation sampling design was used to understand the full range of possible experiences from within each network and also to allow for comparison of characteristics that may affect service provision. To learn more about the level of distribution of IUDs, the networks were asked to provide a list of midwife clinics in two categories: those who report high numbers of IUD provision and those who report lower numbers of IUD provision. From the lists, clinics were selected in different geographical regions, in an attempt to select regions that would include midwives from both networks. Selected regions were Davao City, the National Capital Region (NCR), areas around the NCR, the Caraga region, and Eastern Visayas. Midwives in both networks were interviewed for all regions except Eastern Visayas and Caraga, where it was not possible to coordinate with the supporting NGO. Regions were specifically selected to reflect urban areas, like the NCR, as well as peri-urban and rural areas. Eastern Visayas represented an area known to be more rural, which guaranteed that clinics outside the Class 1 income category would be interviewed.[1] Table 1 shows the variety of characteristics within our sample.

TABLE 1: CHARACTERISTICS OF CLINIC SAMPLE

Network	Urban[a]	Rural[a]	Income Class[b]					Barangay Population[c]		
			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

[a] Urban/rural classification comes from the National Statistics Coordinator Board, http://www.nscb.gov.ph/activestats/psgc/articles/con_urbanrural.asp

[b] 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

[c] Barangay (town) sizes are as follows: Small <5,000 people; Mid-sized = 5,000 to 25,000; Large > 25,000.

[1] In the Philippines, the class rankings indicate the level of income within the city or municipality. The wealthiest class is 1 and the least wealthy is class 5. For further details on the class definitions, please visit: http://www.nscb.gov.ph/activestats/psgc/articles/con_income.asp

1.4.2 LIMITATIONS

In some interviews, midwives asked NGO representatives to be present, citing a preferred comfort level. This network influence may have caused bias in the midwives' responses for these interviews. To minimize this bias, interviewers asked the NGO representatives to wait outside or in another room, or attempted to position the midwife so that she was not facing the NGO representative during the interview. There were limited instances where a midwife looked to her NGO representative for an answer or where the NGO representative offered an answer to a question, but was noted in the interview notes when it did occur. Recall issues may surface, since some of the midwives had joined the networks many years ago and had some difficulty remembering the details of benefits they initially received from their network.

Sampling of geographical regions was limited by travel restrictions to volatile areas. These restrictions prevented data collection in certain areas of Mindanao. Most interviews were conducted in English with limited translation needed by the note takers/translators. In a few cases, however, midwives were not comfortable responding in English, so translators were used. Questions were asked in English, translated for the midwife, and responses were translated back for the interviewers and note takers.

1.4.3 REPORT STRUCTURE

This report is broken into four major sections including an introduction, the FP situation in the Philippines, findings from the case study, and conclusions. The findings are broken into thematic sections as outlined in section II.C. Quotes from midwives and the network NGO staff are in italics. The conclusion section then has a summary of findings and recommendations for each section.

2. FAMILY PLANNING SITUATION IN THE PHILIPPINES

2.1 BACKGROUND

The contraceptive prevalence rate (CPR) of currently married women in the Philippines has increased over the years, from a low of 15.4 percent in 1968 (2.9 percent modern methods; 12.5 percent traditional methods) to 50.7 percent in 2008 (34 percent modern methods; 16.7 percent traditional methods). Modern methods have increased at a greater rate than traditional methods, but use of modern methods is still comparatively low among married women (DHS, 2009). This low usage is in large part due to the historically complex and varied position of the government on modern FP use in the Philippines.

When the Philippines signed the United Nations Declaration on Population in 1967, this moment was acknowledged as the point at which the government officially recognized that rapid population growth was a problem. In 1972 a national population policy was developed, out of which grew a national FP program involving both the public and private sectors. However, government support for FP programs through current times has been inconsistent, depending on the position of the administration in office. For example, the Ramos administration (1992-1998) was in favor of free choice in regard to use of and choice of contraceptives, including modern contraceptives (Youngblood, 1998). In contrast, the Arroyo administration (2001-2010) promoted natural FP to the exclusion of other methods; in 2002, a National Natural Family

Planning Strategic Plan was introduced. Arroyo also 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 (Ruis Austria, 2004).

The decentralization of FP planning, budgeting, and service delivery to the local government unit (LGU) level in 1991 created additional challenges to FP usage, including limited capacity (Byrne et al., 2012) and the potential issue for more variable attitudes at the regional level towards FP due to religious influences, leaving some LGUs with more robust FP programs than others. In fact, an evaluation by USAID showed that a contributing factor to the weakening of the country's FP program was this devolution of responsibility for health programs to the unprepared LGUs. Currently, an estimated 1,700 local municipalities make funding decisions for FP programs (Senlet et al., 2012).

A recent success in the country was the passage of the reproductive health (RH) law, called the "Responsible Parenthood and Reproductive Health Act of 2012," signed by President Benigno Aquino III in December 2012, after more than 10 years of debate. However, after passage the bill was mired in Supreme Court battles. In April 2014, the Philippines Supreme Court made the decision to uphold the act, increasing access to reproductive health information and services, including FP, in the country (UNFPA, 2014).

2.2 FAMILY PLANNING AND THE CATHOLIC CHURCH

The Catholic Church has been involved in population growth policy since 1969 when the Catholic bishops issued their first statement in which they cast doubt on the government's assessment that there were demographic concerns related to population growth. The Church also argued that if population growth was a problem, it should be addressed through other ways than FP, such as increasing the legal age for marriage. Some of the historical variation in government support for FP also seems to be linked to church leaders. For example, some of the waning support for FP by the Ferdinand Marcos administration in the late 1970s and early 1980s is thought to be partly related to changing political power of the leaders of the Church. The Church also led the call to repeal the RH law that was in limbo waiting a Supreme Court decision until April 2014.

2.3 HEALTH INSURANCE

The Philippines started a government health insurance program in 1969, but the program was mandatory only for formally employed salaried workers and their dependents and had limited coverage and high out-of-pocket payments. The program eventually failed for numerous reasons, but in 1995 a national health insurance scheme was created. This National Health Insurance Program (NHIP) was mandatory for all public and private employees as well as those independently employed in the private sector. Filipino workers overseas, their dependents, and some pensioners and retirees could enroll on a voluntary basis. In addition, subsidies were offered to indigent enrollees. The new scheme, called PhilHealth, also developed health facility accreditation standards and regulations (Deutsche Gesellschaft für Technische Zusammenarbeit, 2007). In 2010, the Department of Health (DOH) signed the Universal Health Care Act (UHC), aimed at addressing gaps to help attain equitable access to health care, including access to maternal health services and family planning (USAID/RTI, 2012). In June 2013, the National Health Insurance Act of 1995 was amended to provide NHIP coverage for all citizens, and the act is compulsory in all provinces, cities, and municipalities in the country.

Indigent members are to be fully subsidized by the national government (Government of the Philippines, 2013).

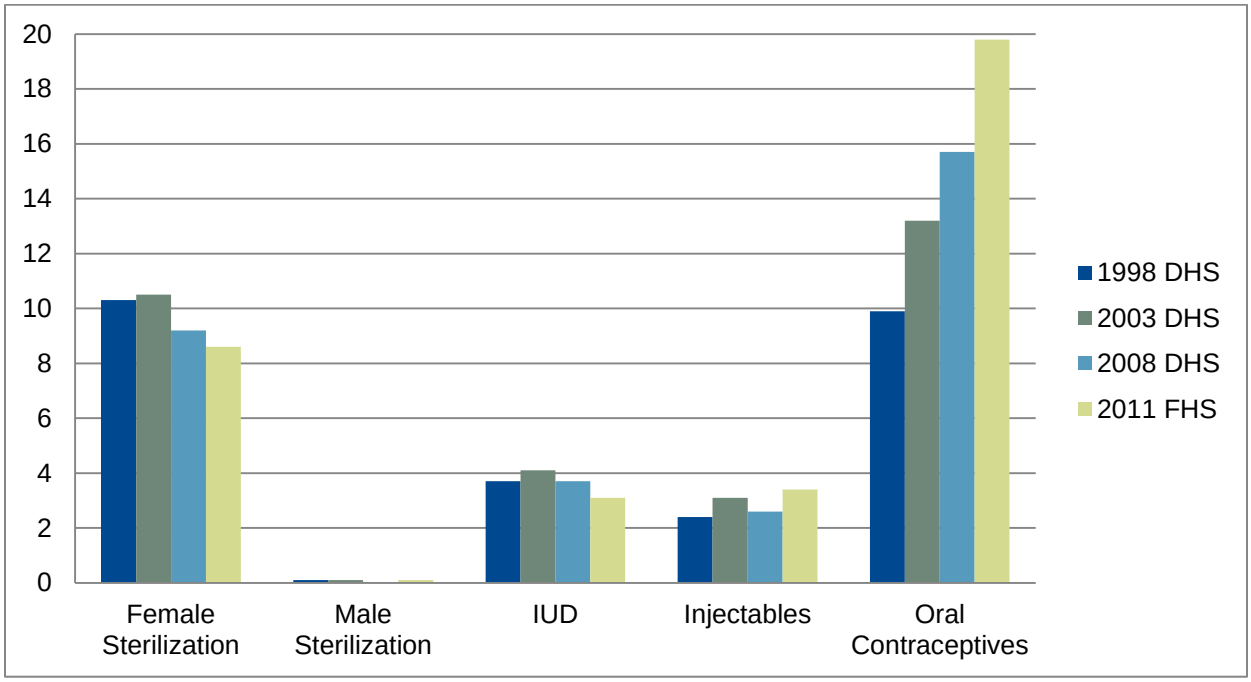
To encourage delivery by qualified providers, PhilHealth allows accredited private midwife clinics to receive reimbursement for the Maternity Care Package (MCP) for normal deliveries. As of the time this report data was collected, this package reimbursed US$149 for MCP services, including prenatal services, delivery, postnatal care, FP counseling, and newborn care and screening (Philippine Health Insurance Corporation, 2012). However the reimbursement has now increased to US$181 according to a PhilHealth Circular (Philippine Health Insurance Corporation, 2013).

2.4 FAMILY PLANNING USAGE

Almost 50 percent of currently married women in the Philippines use some FP method, and nearly 37 percent use a modern method. Among modern methods, oral contraceptive pills are by far the most used (nearly 54 percent). LARC/PMs make up nearly 32 percent of modern contraceptive usage (FHS, 2011). LARC/PM usage, however, has changed very little since the 1998 DHS, while the use of oral contraceptives (OC) has doubled over that period (Figure 1).

Among LARC/PMs, female sterilization is the most widely used, especially among poor women. IUD use, though low at slightly over three percent, is 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 more popular with poor women (3.6 percent) than with non-poor women (2.8 percent) in the Philippines. Midwives are not legally permitted to perform female or male sterilizations in the Philippines; however, in 1972, Presidential Decree 79 gave them permission to insert IUDs and to provide direct FP services and not only provide FP education and demand generation (Cerdinio, 1978).

FIGURE 2: USE OF SELECTED FAMILY PLANNING METHODS 1998 TO 2011



Antenatal care visits, delivery, and postnatal care visits are ideal opportunities for introducing FP 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 trend highlights the important role that midwives play in the maternal care continuum and their potential for providing access to FP, particularly in the postpartum period.

2.5 PRIVATE MIDWIVES

The Philippines has a large and vibrant health sector – including an estimated 168,000 registered professional midwives (Fostanes, 2013). However, it is difficult to estimate the exact number of private midwives in the country. In addition to the purely private midwives, there are also public sector midwives who run a private practice in their off hours. Though this practice would appear to fall under the conflict of interest section of the Code of Conduct and Ethical Standards for Public Officials and Employees (Philippine Civil Service Commission, 1989), the permissibility of dual practice depends on the LGU in which the midwives work. The USAID-funded Private Sector Mobilization for Family Health Project – Phase 2 (PRISM2) project, which works with the government of the Philippines to strengthen the role of the private sector in its delivery of FP and maternal and child health (MCH) products and services through technical assistance (PRISM2, 2013), works with nearly 1,000 private midwives in 36 regions.

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 PRISM 2 project. Another USAID project, Banking on Health, worked to improve private midwives' access to loans for their clinics, and the UNFPA supported midwives in private practice by providing IUD insertion training.

2.5.1 INTEGRATED MIDWIVES ASSOCIATION OF THE PHILIPPINES

The Integrated Midwives Association of the Philippines (IMAP) is the main midwife association in the country and is the registered midwife professional organization accredited by the Professional Regulation Commission. IMAP has an estimated 70,000 members, 22,000 of whom are active, according to their management. The association advocates for its members and also runs programs through funding from donors. For example, IMAP leads the $1.5 million USAID-funded Sustainable Community Action and Leadership Enhancement towards Universal Health Care through Clinical and Organizational Capacity-Strengthening of Midwives for Maternal, Neonatal, Child Health and Nutrition project. This project works with both public and private midwives to improve their clinical skills in FP and maternal newborn child health and nutrition (MNCHN) services, expand their service delivery capacity, and strengthen the association's organizational and management capacities.

2.6 PRIVATE NETWORKED MIDWIVES

Franchise networks are considered to be a private sector model for expanding access to FP around the world. Models vary depending on the franchisor, the country, and the cadres of qualified health providers available, but some general commonalities exist. Members form a network of providers 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 FP services.

There are two major midwife franchise networks in the country: the Well Family network and the BlueStar network.

2.6.1 WELL FAMILY MIDWIFE CLINICS

The Well Family franchise has had a long history, which has allowed it to evolve into its current state. Since 2005, Well Family clinics have been managed by Well Family Midwife Clinic Partnerships Foundations, Inc. (WFPI) as the franchisor. WFPI's mission is to ensure the effectiveness and sustainability of the Well Family clinics, manage the brand, and address FP and MCH concerns at the community level. WFPI was formed by Well Family midwives and the NGOs that support them. The Well Family clinics themselves were initially established in 1997 under the USAID-funded TANGO project. One of the goals of the TANGO project was to address the gap between the demand for FP and MCH services among those who were able to pay and the lack of supply of qualified providers outside of the free public health care system. By providing an affordable private care option, Well Family clinics enable public sector facilities to cater to those who cannot pay for services. John Snow International, Inc. (JSI) served as the initial franchisor until the project ended and a new local entity (WFPI) was formed to step into this role.

Prior to Well Family, JSI supported a project called the NGO Strengthening Project, in collaboration with the Institute of Maternal and Child Health (IMCH) and the Integrated Maternal Child Care Services and Development, Inc., both of which had existing clinic networks. Under this USAID project, the existing clinics were converted to franchises, and the service providers, including some midwives, became the owners. The clinics became more focused on FP and on improving quality of services and obtaining financial sustainability. The project provided business plans and loans for the NGO franchisors to help them renovate their clinics, purchase equipment, and obtain extensive training in FP service delivery. This project ran from 1993-1995, at which time the funding was reduced due to challenges in the model. During the course of this project, it was discovered that initially the NGOs did not have the business orientation to support these types of franchises, the franchisees were not repaying loans, the franchisees needed more business training, franchisees were resisting paying royalty fees to the NGOs for the limited technical support they were receiving, and the communities were too poor to pay the fees for services.

JSI and USAID drew lessons from the NGO Strengthening Project in the development of Well Family. The Well Family Midwife Clinic franchise created one brand for all NGO franchisors to follow and increased the number of supporting NGOs who would support clinics in their areas. There are currently seven NGOs overseeing Well Family franchise clinics in their respective geographic areas. All franchises were owned and operated by midwife franchisees. JSI served as the national franchisor until it was replaced by WFPI. The targets for franchise services were lower middle and middle-income categories. At the end of the TANGO II project, 220 clinics were in operation (JSI). Today, as reported by NGOs interviewed for this case study, fewer than 100 Well Family clinics exist.

2.6.2 BLUESTAR PILIPINAS

Launched in 2008, BlueStar franchise clinics are a relatively new arrival in the Philippines. Population Services Pilipinas Incorporated (PSPI), part of the Marie Stopes International (MSI) global partnership, serves as the franchisor and the manager of the BlueStar Pilipinas network. PSPI's mission is to provide a full range of sexual and reproductive health services, especially to the underserved, and BlueStar was founded in 2008 to increase access to FP services for Filipina women, especially in peri-urban areas. In addition to the BlueStar network, PSPI

provides reproductive health services through 11 regional clinics in urban centers and 55 mobile outreach teams that provide services to rural areas.

BlueStar Pilipinas is a network of private sector maternity clinics owned and operated by community midwives, over half of whom have been successfully supported through the rigorous PhilHealth accreditation process, which allows franchised midwives to provide PhilHealth members with free comprehensive maternity care. A partial franchise model, BlueStar adds FP services to the existing maternity services provided by its members. The network is in a scale-up phase, with a reported 266 existing franchised clinics at the time of data collection in May 2013 and another 45 to be added by the end of 2013 with funding from the World Bank. Ultimately PSPI plans to have 500 clinics in the network.

3. FINDINGS

As discussed previously, the data collected for this case study corresponded to five general areas: provider factors, clinic factors, network factors, FP provision and revenue and expenses. These are the factors that are hypothesized to impact a private midwife's ability to viably provide IUDs.

This case study is not meant to be a direct comparison of the two franchises, but rather seeks to find lessons from both networks that have different histories, structures, and outcomes in viability and 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-funded 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 operations much more recently, is receiving some donor support, and is still scaling up.

3.1 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 factors include intrinsic personal characteristics, such as motivation, previous experience, provider bias, and family support.

3.1.1 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.

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

"When I was little, I always see the RHU midwives going house to house in [name of town]. 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; however, each had a reason for not reaching this goal and eventually becoming a midwife. Often the reasons were 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***

As might be expected from midwives who are working at the community level, many mentioned the desire to help the women in their communities deliver safely. However, whether they entered midwifery because it was their dream to help people, or because they knew it was a good profession with a solid income or a family legacy, there is a clear trend that health care was their first choice profession. Even for those who want (or wanted) to go on to become a nurse or a doctor, health care was their calling. Interestingly, one midwife in the sample had a career before she became a midwife. She changed to midwifery because she saw that others were earning from this business rather than from an intrinsic motivation to serve her community; however, her business was not as viable as the others, and sometimes did not earn a profit. Overall, the data suggest that viable franchise owners deliberately chose to enter the midwifery profession from an early age.

3.1.2 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. As can be seen in Table 2, the average experience level of the midwives is about 24 years. Well Family midwives average more years of experience than BlueStar midwives, at 26.4 years compared to 20.5 years of experience. When number of years of experience in the private sector is factored in, however, the differential among the midwives disappears.

TABLE 2: WORK EXPERIENCE OF THE SAMPLE POPULATION

Midwife	Years of Midwifery Experience	Total Private Sector Experience	Years with Franchise	Other Private Experience	Public Sector Experience
BlueStar 1	26	26	4	Midwife clinical instructor, own clinic	0
BlueStar 2	22	22	3	Midwife clinical instructor, caregiver, own clinic	0
BlueStar 3	3	17	3	Med Tech, family planning promoter, manager	0
BlueStar 4	17	17	3	Home deliveries	0
BlueStar 5	16	16	4	No official work, some home deliveries	0
BlueStar 6	39	39	5	Home deliveries (30 years), owned small clinic (4 years)	0
BlueStar 7	9	9	3	On call in a lying-in clinic, owned small clinic (6 years)	0
BlueStar 8	32	Yes*	5	Home deliveries	Yes*
Well Family 1	34	34	16	semi-private puericulture center (7 years), own clinic	0
Well Family 2	21	17	14	Midwife in a lying-in clinic	4
Well Family 3	13	13	13	None	0

Well Family 4	38	36	13	Home delivery	2
Well Family 5	approx. 28	*	13	Private hospital, abroad	Yes*
Well Family 6	10	10	10	Midwife assistant before owned clinic	0
Well Family 7	36	22	17	Midwife clinical instructor	14**
Well Family 8	30	25	16	Family Planning Organization of the Philippines (FPOP)	5
Well Family 9	28***	18	15	FPOP	5
Overall Average	23.6	21.4			
BlueStar Average	20.5	20.9			
Well Family Average	26.4	21.9			

* Unclear how long
** 5 years in public sector abroad
***Took some time away from midwifery

It was more common for a Well Family midwife to report that she had an established clinic prior to joining the franchise, while only half of the BlueStar franchisees had such experience. This lack of clinic ownership by BlueStar midwives is in line with PSPI's goal to increase access to high-quality clinic-based services by establishing new midwife clinics. However, according to an interview with leadership at PSPI, they have expanded their acceptance of new midwives to include some who already had an existing facility in order to widen the pool from which they identify new midwives. A 2010 case study on PSPI reported that recruiting qualified midwives who could manage to complete the franchising qualifications and then set up their own clinic was a challenge, so PSPI began looking at the possibility of expanding membership to midwives "already offering FP services, those with less previous experience, or those with more than two beds in their clinics (Pernito et al., 2010)." This shift in requirements has evidently occurred. Still, more BlueStar midwives were working in their communities doing home deliveries before joining the franchise than were Well Family midwives.

"My clients, some of my friends are clients. They ask about health problems and some deliveries. Since it's difficult for me to do house-to-house delivery, I put up a small clinic, so they will be the ones to come here." ***-Midwife, BlueStar Franchise***

Many of the midwives, particularly those in the Well Family franchise, had previously worked in Rural Health Units (RHU), in hospitals, for the Commission on Population (POPCOM), or with FPOP. Similarly, most of the BlueStar respondents had been working as a midwife in some fashion before joining BlueStar, doing home deliveries, working in the public sector, or working in a private clinic. As mentioned previously, this experience also helped them with their clinics, *as some had an established reputation and clients.*

"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***

"When I graduated [from midwifery school], I really wanted to work, I went house to house. Not at a hospital. I applied in the region as rural health midwife. [Later] I practiced here in [name of city where her husband is from]. I don't want to work in a hospital; I have my mind set to work like the RHU midwives. I wanted to have patient contact. I did house to house for my services like home deliveries, postpartum, family planning counseling, because I don't have a clinic. Then I learned about Well Family. I applied and they asked me to attend seminars. They helped me put up a clinic. I did not have difficulty getting patients then because I already invested in house to house before. I had more patients through word-of-mouth of clients." -***Midwife, Well Family Franchise***

"[When asked why she joined BlueStar] Because I have no organization yet that time and then I was interested in family planning services. Because I have not yet experienced, I have no experience in family planning so I grab the opportunity. Opportunity comes only once." -***Midwife, BlueStar Franchise***

3.1.3 PROVIDER BIAS

Provider bias towards specific FP methods, including IUDs, can be a strong deterrent to client uptake. Though discussed in the literature as a persistent issue (Jacobstein et al., 2013), none of the midwives in the sample mentioned an aversion to recommending IUDs to their clients. Though there were varying degrees of motivation expressed towards educating women on IUDs for initial uptake and the prevention of discontinuation, none of the midwives expressed any overt biases towards the method.

3.1.4 FAMILY SUPPORT

It appears that family support also affects the viability and success of the midwife clinics. Some families provided financial support to assist the midwives with their capital costs and the midwives, in turn, also had to sacrifice time with their families to go to training and be available to the clinic 24 hours a day. As mentioned earlier, one midwife noted how the required 24 hours of operation for clinics was particularly challenging for her because she was not able to spend enough time with her family and she did not have an assistant. She was considering giving up the delivery aspect of her business to provide only FP and spend more time with her family. Balancing family responsibilities during trainings was difficult for some midwives, especially as they were also facing reduced income during that time. PSPI also reported that some of their midwives were unable to continue their contracts due to lack of support from their husbands. As a result, PSPI began to require the midwife's husband to sign a document confirming his support of her clinic.

"Running the clinic is hard enough so changes are hard. They enlist their family's support. Part of the initial support from BlueStar is determining whether their families support them. With every successful midwife you will find always a sister assistance, a husband working with her." **– *Staff member, BlueStar Franchise***

"Planning the time, manage time. With my husband, asking permission [from him], so there is harmony in living. Sometimes, the husband is the one who is very strict in terms of planning." **– *Midwife, BlueStar Franchise***

Many family members serve as staff in the clinics. The clinics often were seen as a legacy to leave to the midwives' children. Many midwives were investing in their children's or other family member's education so that they could eventually come to work at the clinic and add additional

services to the clinic or fill midwife positions. Husbands were sometimes reported to be drivers or office managers at the clinics, and one of the NGOs reported recognizing the importance of family support as well in viable clinics.

Family support is clearly an important aspect to the viability of a network midwife clinic. This message was clear from the midwives when they talked about having their family work for them in their clinics and their desire to create a business legacy for the family that will be passed on. This family legacy was clearly a driving motivation for some of the midwives and may contribute to their attention to ensuring that the business is viable and lasting. Families are also a source of financing for many midwives, or a source of clinic space at a reduced or no cost, which also helps midwives to start up their clinic and continue to make improvements and expand their clinics. Again, without this support, many of the midwives may not be in the financial position they are now with a viable clinic. However, family can also be a detriment if family members are not supportive. PSPI noted that they had cases where midwives had to close their clinics because their husbands did not approve or support them. This lack of spousal support caused PSPI to reevaluate its recruitment strategy and make sure from the beginning that potential midwives had the support of their husbands.

"With every successful midwife you will find always a sister assisting, or a husband working with her." ***– Staff member, BlueStar***

3.2 CLINIC FACTORS

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

3.2.1 FINANCING

Financing for start-up and ongoing renovations can be challenging for entrepreneurs looking to start their own business. However, most of the midwives interviewed did not have difficulties finding financing for their clinics. Each network provides a limited amount of support to midwives to join the network and bring it up to the network's standards. Outside of that support, most of the midwives indicated that their financing came from their savings, family, or the revenue they were earning from their preexisting clients, often times through home delivery. Many of the midwives had converted space within their homes to offer their services, which saved on rental or land purchase costs. During an initial visit by the SHOPS team, key informants noted that most midwives avoided institutional loans. Four of the midwives interviewed for the case study, however, took loans from more formal sources: one through a USAID project that helped midwives finance clinics, one from a bank through a spouse who is employed in the government sector, one through a local medical school, and one through a local cooperative union. Once the clinics were established, most of the midwives reported they earned enough through their own revenue or family support to make new investments.

Initial start-up money for the clinics was often found through savings or from family. This level of personal financing made the input from the network seem important, especially for BlueStar whose midwives were starting with no clinic at all. Many of the BlueStar midwives interviewed, especially those in more rural locations, were making improvements piece by piece with their income once they had received the initial NGO investment. However, it was also clear that they understood and valued the impact that the improvements could have on their business. As anecdotal evidence shows, in general, midwives do not like to take institutional loans, and the networks may want to look into alternative mechanisms for borrowing or saving for the midwives.

3.2.2 CLINIC LOCATION

Nearly all the midwives interviewed reported that they were living and working in their hometown or that of their husband. The majority of midwives had built their clinic in or next to their home. Reasons for this selection of location included convenience (needing to be available for deliveries 24 hours a day) and available space. Most midwives only had one clinic location. Two midwives from each network, however, reported having opened branch locations, most often run by another family member. Meanwhile, a third Well Family midwife reported planning to have a branch location.

The midwives appeared to understand the importance of clinic location to their business. Two BlueStar midwives spoke of hoping to open branch clinics or move their clinic to another area where they knew the traffic would be busier and they would have more visibility. More Well Family midwives reported that their network emphasizes that the clinics should be located on a busy street where there is a lot of traffic in order to be successful and they had final approval over their clinic location. Based on the experience of the midwife quoted below, who had to move her clinic due to problems with her landlord, this idea of a well-trafficked location may not always be the best decision for a midwife clinic.

"Before when I had my clinic there, 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. I was afraid at first, because [name of NGO] said that my clinic should be visible, if not I won't earn. In contrary, even if my clinic is not visible along the road, many people still come here. And I am open 24 hours." ***- Midwife, Well Family Franchise***

Another aspect of location is urban versus rural. An April 2013 article reporting on health worker motivation in three African countries noted that, among public providers posted to rural posts in the study group, those who were originally from the area or had decided to settle in the rural area demonstrated more commitment to their work (Prytherch et al., 2013). Though from a different global context, this finding is an interesting point about motivation to provide services in rural areas. This case study found that all of the midwives were committed to their work, even those in the rural settings. Those working in the rural settings, however, were either from that area originally or had moved there to settle in their husband's town.

Location is often discussed as key to a successful business. This factor is a principle that Well Family especially has taken to heart. The majority of the BlueStar franchisees have clinics in or next to their homes. This fact minimizes the need for selection of an external location. Well Family midwives, however, reported that the network has the final approval over the location of the clinic. The natural assumption would be that this approval is to ensure that midwives locate their clinics in busy areas where they will attract attention and clients. It is interesting to note the previously mentioned case of the Well Family midwife whose clientele increased when she moved from her initially approved location to a more out of the way location in her home. In a country with strong religious opposition to FP, some women may not want to go to a clinic that is in a highly visible location for what is often a very private, potentially even secret, service. Though this factor was indicated by only one midwife interviewed, it suggests that the networks should have a dialogue with the midwife (who knows the community in which she works) as to whether more clients are likely to come to a visible or more private location.

The rural midwives' commitment to their work and their clients may demonstrate that the key to reaching rural women is to identify providers in their local area or those who are willing to settle in a rural area and make that their home.

3.2.3 CLINIC HOURS AND STAFFING

Although all of the clinics had posted specific hours of operation, most of the midwives stated that they were available to their clients 24 hours a day because of the nature of delivering babies. For some, this constant availability was noted as a challenge because it cut into their time with their families, and for a very few, this sacrifice deterred them from wanting to perform deliveries.

"My family, my children. I don't have time for them anymore. I just want to focus on family planning, not on deliveries. There are complications, bleeding, it's tiring, you have no sleep and sometimes, you don't get paid… Even if I say that I will only provide FP, I am known here for delivering so they would still go to me for deliveries. I no longer aim to have higher earnings. It is not about earning anymore, I just want to help. Earning a little is fine." ***-Midwife, Well Family Franchise***

Others, however, learned to capitalize on the after-hours work.

"I have a store here…Sari-sari store. Like a small store. So if clients will buy napkin [sanitary pads], I have. Adult diapers, I have. Especially midnight…If we have patients in labor [we are open after hours]." ***-Midwife, BlueStar Franchise***

Most midwives, however, referenced the after-hours and work load as why they have additional staff, from part-time on-call assistants to full-time employees. Well Family midwives were more likely to mention having other midwives at the clinic versus an assistant, while nearly half of the BlueStar midwives had only an assistant or on-call midwife to assist them. A commonality among many of the midwives was that their staff included family members including husbands, sons, aunts, and nieces. Some midwives view their clinics as long-term investments for their families.

"The reason I let him (son) get midwifery course so that he can help me. That is one of my conditions." ***-Midwife, BlueStar Franchise***

"I established my clinic with a purpose. I think this is one way of giving back and retuning the blessings… I have no worries especially now that my niece has graduated. I can rest now. I plan when I reach 35 and I am now [age] years old, I will just sit and travel. I save a lot for the future and for the family. I know this clinic will earn income even if I am not here in the clinic. I even plan to cover the tuition fees of nephews and nieces as long as it's a medical course or any health related course." ***-Midwife, BlueStar Franchise***

Midwives' investment in clinic staff was varied. BlueStar midwives indicated across the board that their staff members were not trained by the network, and few of them indicated that they invested in training for their staff. Many of the Well Family midwives, however, reported providing training opportunities for their staff and noted that Well Family opened training opportunities up to all clinic staff, sometimes even funding the cost. Some of the midwives arranged to cover up to half of the cost of the training for staff members. A few midwives noted concerns about retaining the staff that they had trained. There were concerns that trained staff would move abroad to work or open their own midwife facility.

It is understandable that being a midwife, whose primary function is deliveries, is more than a 9-to-5 job. It is one that demands attention when a baby is ready to be born, any hour of the day or night. This round-the-clock availability is not palatable to everyone, and likely requires a committed personality. Some of the midwives reported that being available constantly was hard and caused them to either stop delivering, want to stop providing deliveries, or challenged their personal lives. Others, however, showed a more entrepreneurial spirit and found ways to

capitalize on working non-traditional hours. The ability to work beyond 9-to-5, or to find ways to work beyond 9-to-5, is an important characteristic of a successful full-service midwife. Staffing appears to be key for helping midwives cope with the hours and workload. It is notable, though, that many of the midwives, especially those with BlueStar, expressed concern that their employed midwives would leave to open their own clinic or go abroad once they gained enough experience. This concern was true even when the staff were family members. This concern about staff attrition may be a reason that a midwife would not see the need to invest in her staff as far as providing them with training opportunities.

3.2.4 CLINIC SERVICES

Each network has a standard set of FP and RH services that their midwives must follow and provide (see Table 3).

TABLE 3: Standard Network Family Planning and Reproductive Health Services

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

BlueStar sets fixed maximum prices for their services to ensure affordability although prices are not subsidized. Well Family midwives have more liberty to set their prices at what they determine will be competitive in their communities.

Most midwives reported having side businesses or offering additional services in their clinic. These range from a few midwives who have multiple clinic locations to those who sell vitamins or over-the-counter medications as a convenience to their clients or because they “don’t want to be left behind.” Some of the larger income-generating side businesses included a Sari-Sari store (convenience store), and midwives who bring in doctors (including pediatricians, lab technicians, and obstetricians) who pay a fee to hold hours in their clinic. A few midwives noted the desire to be a “one-stop shop” for their clients. A number of the clinics were also PopShop franchises, which allowed them to purchase affordable commodities. PopShop franchises are consumer-friendly sources for DKT International’s (DKT) affordable, high quality contraceptives and information and are located in some government health facilities and NGO clinics. PopShops are a way for these clinics to provide sustainable access to FP commodities, and DKT helps them to avoid stock-outs and provides some training (DKT International, 2013). A few of the midwives’ clinics also act as clinical training sites for midwifery schools or network trainings, which draws extra income since the midwives are paid for this service and provided

with all of the required supplies. This training activity can also draw in new clients to the clinic. A few midwives have also opened additional branches of their clinics with family members supporting the management of the other facilities. Many of the midwives also reported getting income from referrals from physicians for complicated deliveries, lab services, and other services. When responding to questions about why they added services, most midwives reported they did it for additional income and for the convenience of the customers, which also draws more clientele, as demonstrated in the quotes below.

"Because some people will inquire, "do you have some?" … 'I have not yet', [then if you don't provide], you will be left behind in the trend." ***– Midwife, BlueStar Franchise***

"To increase income. So that the patient will not go to [closest city] to have urinalysis, pregnancy test, Hep-B. Because I know [how]… for client's convenience." ***– Midwife, BlueStar Franchise***

"Additional income of course. Other than that, before to get lab or ultrasound, it was far. You need to pay P50 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 entrepreneurship, that we will be dreaming of a one-stop shop. You can see some well family clinics have lab or ultrasound." ***– Midwife, Well Family Franchise***

The idea of the "one-stop shop" was popular with many of the midwives, which indicated their understanding of the value of adding services such as a Sari-Sari store, lab services, doctors' hours, ambulances, and other such services to their clinics. This idea was especially true of midwives located in larger areas, where there is more competition. However, even in some of the smaller areas, midwives added simple services like providing some over-the-counter medications. These services all bring in additional income to the clinics, helping them to remain viable and grow.

3.2.5 CLIENT PROFILE

Most of the midwives reported that their clients come from within their town or barangay, or from within a radius of one or two towns away. This catchment area is also dependent on whether the clinic is in an urban or rural area and how many other clinics are in the area. Some midwives have noted, however, that they have clients who come from far away – often seemingly out of loyalty and trust in a provider.

"[Clients] Mostly are from the nearby area... But other than that, we have some from the provinces like [names of provinces]. Because they are my clients before, and when they trust you, they would come back. I have one from [name of province], she used to come for prenatal then 2 weeks before her due, she would stay in the nearby area with brother or sisters or relatives." ***– Midwife, Well Family Franchise***

The range of clients with PhilHealth is also greatly variable for BlueStar clinics, ranging from 4-5 percent of clients who are members of PhilHealth to as much as 70-80 percent of clients who are members, depending on the location of the midwife. However, the majority of midwives who are PhilHealth accredited reported that upwards of 80 percent of people in their communities are PhilHealth members or have a Conditional Cash Transfer card under the 4 P's program,

which automatically enrolls one in PhilHealth as a sponsored member.[2] Of the Well Family clinics that are PhilHealth accredited, from 20 to nearly 90 percent of their clients are members of PhilHealth. It is important to remember, however, that these are not all indigent clients and some hold employer-sponsored PhilHealth. In fact, two Well Family midwives reported that most of their PhilHealth clients have employer-sponsored insurance.

Many of the midwives reported serving clients who could not pay for delivery or who had to pay in installments, which implies that they do not have PhilHealth (which fully covers normal deliveries performed in accredited midwife facilities). This report suggests two possible scenarios for this situation. Either the clients are very poor but not yet enrolled in PhilHealth or do not know their benefits, or the clients are poor, but not so poor as to qualify for fully subsidized PhilHealth paid for by the LGU and they do not have an employer-sponsored or individual subscription. These scenarios point to the possible reason why poorer women go to private midwives for services. A willingness-to-pay study done for the Well Family network reported that their midwife clinics are often located in low-to-moderate income areas (Cabegin et al., 2001). Because most midwives charge relatively low-to-moderate prices (particularly BlueStar), being located in lower income areas could increase client flow, improving income and viability, but it could also challenge viability depending on a midwife's personal motivation to provide free or reduced price services to those in need.

3.3 NETWORK FACTORS

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

3.3.1 STRUCTURE OF NETWORKS

Both BlueStar and Well Family share a franchise model, but the organizational and fee structures of the two networks differ.

3.3.1.1 BLUESTAR

As noted previously, BlueStar is in scale-up phase, with 266 of a planned 500 clinics in place. PSPI is able to cross-subsidize their support to the BlueStar network midwives from its standalone clinics. The PSPI staff provides senior management, financial and administrative oversight, and clinical services support to BlueStar franchisees. Full-time BlueStar staff includes the Brand Associate (franchise coordinator) and the field team members (FTMs) (Pernito et al., 2010).[3] 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. The Brand Associate provides the logistical support to the network, including: managing the FTMs' activities; getting cash advances to the FTMs; aggregating franchisee weekly reports; supporting training, events, and recruitment of new midwives; and troubleshooting low performance or other issues. The FTMs provide direct support and supervision to the midwives on a variety of clinic management issues, including meeting and sustaining accreditation standards, marketing, commodity resupply, and other support.

[2] The 4 P's program is the Pantawid Pamilyang Pilipino Program of the Philippines national government that invests in the health and education of poor households with the objectives of social assistance and social development (http://pantawid.dswd.gov.ph/index.php/about-us)

[3] Also drawn from interviews with PSPI staff

"Also a key to supporting the midwives is the FTM, without them we don't have a link to the midwives." ***– Staff member, BlueStar Franchise***

When midwives join BlueStar, they are given their initial inputs from the network as outlined above, and the midwives pay monthly dues of US$27 and a membership fee of US$27 per year. This fee decreases to US$23 when they renew their contracts after three years.

Under the BlueStar franchise model, each midwife franchisee gets a standardized set of trainings (including FP training), commodities access through a bulk purchasing mechanism, marketing support and franchise branding, and quality monitoring on service provision. The franchisee must provide the full package of BlueStar services, submit weekly service delivery statistics reports, participate in various franchise activities, and pay the annual franchise fees. Midwives receive essential equipment, and they must pay back a portion of the cost of this equipment through monthly fees over the first three years of their contracts. The network also sets pricing for certain services like IUD insertions (US$2.26), but allows for flexibility in the pricing of other services such as pap smears. There is, however, recommended pricing for these services. The required services for BlueStar include prenatal and postnatal care, delivery, FP counseling and methods (pills, condoms, injectables, IUDs, and referral for tubal ligation), pap smear plus (which includes a breast examination), and pregnancy tests.

3.3.1.2 WELL FAMILY

Under Well Family, WFPI serves as the national umbrella franchise while regional NGOs provide support to the midwife clinics in the region assigned to the NGO. This arrangement results in differing levels of support available to the midwives based on their NGO's expertise and ability to cross-subsidize overall franchisor support to the program from other revenue-generating activities.

"The golden years of FP have passed. NGOs are struggling. I think we are one of the few regional NGOs still standing. Some of us (NGOs) are reaching out and diluting our ability to provide support. We are able to sustain because of our training aspect. NGOs should diversify but do so within your original objective. Projects have dried out. The general support for FP is changing. Some new NGOs have come into WPFI. Some do not have any relation to health. They don't last." ***-Staff member, Well Family Franchise***

After USAID support was discontinued at the end of TANGO, royalty fees were instituted in addition to the franchise fee. Monthly royalty fees vary for the midwives according to where they are located. The franchise fee, which must be paid every five years, has decreased since Well Family was first established. In the Davao region, the NGO supporting the Well Family midwives reported that the royalty fee was US$34 and the franchise fee was US$685. According to the network supporting midwives in the NCR and CALABARZON region, for those living in cities, the royalty fee is US$37 in advance or US$46 when paid late; in the provinces, US$15 in advance or US$18 late; and in peri-urban areas, US$27 in advance or US$34 late. For the renewal franchise fee, the rate is US$274 per year paid in advance for most areas and US$160 in Laguna and Rizal. It was noted the franchise fee upon joining used to be US$1,095, but is now only US$274.

Well Family provides training updates (including FP related), monitoring and quality assurance of services, and marketing; facilitates access to credit and low-cost supplies; and distributes information on areas of interest to its franchisees. In return, the franchisees are expected to offer a core set of services that fall within the midwives' legal scope of practice, follow the networks' standards, and 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

joining the network. After graduation, check-ins by the NGO are less frequent and midwives are expected to be able to identify what they need and request assistance from the NGO.

3.3.2 REQUIREMENTS TO JOIN

Both franchises avoid recruiting government-contracted midwives; BlueStar specifically forbids it. Potential franchisees in both networks must be willing to provide FP services, and BlueStar requires a commitment specifically to modern contraceptives, including IUDs. Both networks require their midwives to attend trainings after joining. Both also accept only midwives who are already licensed and providing delivery services. Well Family looks for midwives who already have a clinic space, and a number of the Well Family midwives reported having some type of facility prior to joining. Many of the Well Family NGOs now require midwives to have a space as they do not have funds available to support major renovations as they did under TANGO. BlueStar seeks out midwives who are doing community-based deliveries (though they have begun to consider midwives who already have a clinic) and who have an available space, such as an extra room in their house, which can be converted to a clinic.

"The ideal (midwives) are those who don't have a facility because it's (the facility is) the value-added (for joining BlueStar) and you are adding a new facility so you are addressing the addition of high quality skills and facilities to what's available now. Before we did not want women who had facilities but now we are taking those with facilities." ***– Staff member, BlueStar Franchise***

The networks aim for the spaces to be able to meet PhilHealth accreditation standards as well. Both networks restrict the distance of clinics – Well Family clinics cannot be any closer than 5km to another Well Family clinic, and BlueStar clinics should not be within a 500-meter radius of other BlueStar clinics. Some of the Well Family NGOs also conduct a mapping exercise with the midwives to ensure that the location will have enough clientele and they recommend locations on main roads. Well Family must approve the location for the clinic.

A few of the midwives also clearly endorse the distance requirements and show signs of feeling the competition from other private providers.

"[When asked what advice she would give to new franchise midwives] Don't open a clinic in [name of midwife's city]. Choose an area without a Well Family clinic. The franchisees should not compete. She can put up a clinic in [name of faraway municipality]." ***– Midwife, Well Family Franchise***

"[When asked what advice she would give to new franchise midwives] To those with ambitions to own a clinic, BlueStar is good. Everything is included. They help you improve. They guide you just like a child. Just don't open a clinic here, do it in [name of next town over]." ***– Midwife, BlueStar Franchise***

3.3.3 RECRUITMENT STRATEGIES

Currently, the success of both BlueStar and Well Family has reduced the need for active recruitment strategies as both networks get many referrals from their current network members and potential midwives seek them out. The Well Family NGOs participating in this case study were not actively expanding at the time of the interview, while BlueStar was looking to expand the number of clinics until it reached a target of 500. Well Family has established a close relationship with IMAP and initially got many referrals for new midwife clinic owners through this association. BlueStar is looking to cultivate more referrals through IMAP as well. In its initial start-up phase, Well Family advertised on the radio to describe the program and ask interested

midwives to come to an information meeting for more details. Well Family NGOs have also worked with the PRISM project to identify potential midwives for its network. In addition to referrals, BlueStar works in conjunction with local governments to conduct mapping exercises that identify unemployed midwives working informally in their community.

3.3.4 SUPPORT PROVIDED BY THE NETWORK

The networks provide various types of support to their midwives. This support includes physical inputs to the clinic, marketing support, training, and quality monitoring. The support offered by Well Family in its initial years, when it was funded through USAID, was similar to what BlueStar is able to provide today. One NGO reported that, in comparison to BlueStar, the Well Family midwives now receive far less support and, as a result, potential midwives may choose BlueStar instead. In comparison to the older network members who received greater support from USAID funding and are "loyalists," the newer midwives are "not as committed," one Well Family NGO staff commented.

3.3.4.1 PHYSICAL CLINIC INPUTS

BlueStar provides assistance to improve the clinic's structure, if needed, and to equip the clinic. Though the package of assistance to midwives is reportedly standard, there may be some variation depending on the amount of infrastructure support a new clinic requires. Some midwives reported getting loans from BlueStar for construction and renovation. The standard physical inputs according to PSPI include a package of equipment and supplies for the facility related to delivery and FP provision and a six-month supply of FP commodities (pills, condoms, injectables, and IUDs). After the initial FP stock is exhausted, midwives can reorder supplies through BlueStar at substantially lower rates. For example, PSPI can provide IUDs at a cost of US$0.52 compared to US$1.92 from DKT, which would be the next cheapest provider, according to PSPI. PSPI orders its commodities from the MSI global purchasing system and does not mark up the price of the commodities when selling them to the midwives. PSPI also makes reordering easy through use of a mobile text-based system.

The Well Family NGOs historically provided support by way of equipment (often this is now second-hand equipment), instruments, delivery tables, and limited FP supplies. The equipment and instruments are no longer provided by Well Family as USAID support has ended. Most midwives who joined after this shift from donor support reported that if they already had the necessary equipment to meet the standards when they joined Well Family, they did not receive any additional funds. Much of the investment in the renovations of the building for the midwife's practice comes from the midwife's own earnings, not from Well Family. Well Family no longer provides commodities directly to midwives but assists in establishing linkages between the midwives and DKT and other pharmaceutical suppliers, which often have special discounts for network members. Many of the Well Family midwives interviewed also run a PopShop franchise in their clinic as a way to ensure a sustainable supply of high-quality, affordable FP commodities (DKT International, 2013). DKT offers two tiers of IUDs, the lower cost Pregna for US$1.92 and the Securi T brand for US$2.94. DKT imports its IUDs from an Indian manufacturer. Alphamed is another FP commodity supplier that began carrying FP products, including IUDs, in 2008 when it started working with the PRISM2 project. Alphamed works largely with LGUs and NGOs, including PRISM2 with whom it worked to get FP commodities to underserved areas through what are known as Alternative Distribution Points, aimed at providers such as midwives and doctors.

Since BlueStar now provides more initial support to its midwives than Well Family due to the latter's changing donor support situation, the BlueStar midwives have a clear advantage when it comes to starting up with the network. One main advantage is they have less need to find their own financing for the initial investment. This advantage may also contribute to BlueStar having

the first choice of available midwives and the ability to more easily select those with a commitment to providing modern FP.

The BlueStar internal commodity ordering system may also lessen the chances that its midwives will stock out of commodities, while the onus on the Well Family midwives to source their own commodities, despite the linkages made for them, could increase their chances of not having a commodity in stock when a client needs it. However, with USAID completing withdrawal of support for FP commodities in 2008, and new companies like DKT and Alphamed having moved in, a working commodity market now exists.

3.3.4.2 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 hosting a Buntis party (mother's or pregnancy party). Both networks include marketing as part of their training package. BlueStar specifically includes weekly sponsorship for Buntis parties for six months in its start-up package and believes this is one of the most effective ways of drawing in new clients. Many midwives echoed this sentiment. BlueStar is now looking to help establish links with pharmaceutical companies to continue to support the Buntis parties, which is also a method Well Family has used to keep these key marketing events going. BlueStar also replaces reading materials and government flip charts with materials in the local language and at a lower language level to ensure clients understand the FP and maternal health services offered.

Well Family assists midwives in preparing a marketing strategy, which also includes the mapping of the clinic location to ensure that it is in an easily accessible area and near a main road to attract clients. 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 was enough to establish the Well Family brand.

"Because there was advertisement in TV, they used to know this [the Well Family brand]. With the partnership with the government, they introduced me to the community. I used to partner with the barangay captains. I used to invite them during mother's class, I ask for their messages. And through them, I was introduced to the clients. It is important that higher people (officials) trust me so much that I was a good midwife and Well family is the first in the place. I was endorsed to class C or D [lower income groups] or those who can pay." ***– Midwife, Well Family Franchise***

The Well Family network also maintains a website that lists all of their clinics. A few of the midwives interviewed noted some of their clients found them through searching online and coming across the Well Family website.

All of the midwives interviewed seemed to appreciate and understand the benefit of the marketing support that they received from the networks. Buntis parties were named most often as a key marketing tool to bring in new clients. Interestingly, the Well Family midwives often mentioned the success of the radio promotions that had been produced when the network was still receiving USAID funding. This mass marketing promotion had helped to make the Well Family brand better known. Midwives from both networks understood the importance of effective marketing either promoting high-quality or affordable services in attracting people to their clinics.

3.3.4.3 TRAINING

Both networks offer opportunities for a range of FP and MCH training for their midwives. BlueStar covers the full cost of the trainings, while Well Family now requires midwives to pay for at least part of the cost of the training.

BlueStar requires a comprehensive package of training, which includes a 21-day (not continuous) clinical FP training equivalent to the DOH's FP Competency Based Training levels 1 and 2 (including a 10-day practicum on IUD insertions with a requirement of performing 50 insertions).[4]

Well Family also requires its midwives to have a wide range of training. Well Family midwives are clinically trained in a range of areas including FP Competency Based Training levels 1 and 2, which includes IUDs, in line with the standard DOH curriculum. The standard DOH FP training requires performing 20 IUD insertions for its practicum.

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

"Before I joined BlueStar, I didn't know much about family planning. I had little or slight knowledge on FP. It improved when I was trained in BlueStar. At least now, I personally insert IUD…My skills, my quality of service as a midwife improved." – **Midwife, BlueStar franchise**

3.3.4.4 SUPERVISION AND QUALITY MONITORING

Both networks support their midwives by providing quality monitoring and assisting them in obtaining their DOH/PhilHealth licensing and accreditation. Both networks assist clinics in understanding the requirements for licensing and help them make the necessary arrangements, in terms of physical input and business systems, to work toward accreditation. Both networks provide monitoring that helps ensure the standards of the networks (and licensure and accreditation) are being maintained. They also celebrate the success of their midwives with annual ceremonies.

BlueStar FTMs each support a few midwives in their geographic area. They 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. In addition to the assistance mentioned above, the FTMs also help to follow-up with PhilHealth on reimbursement status and checking of reimbursement forms ready for submission. A few midwives mentioned that beyond this assistance, the FTM visits let them know that someone cares about them and gives them moral support. FTMs are also the ones who often give the midwives one-on-one support during the DOH and PhilHealth application processes.

"Yes, when I was not yet a BlueStar member, so I have no attractive signage, no attractive clinic structure. No one assisting, following-up, caring. It's better that someone follows-up on you, it convinces you to improve your clinic." ***– Midwife, BlueStar Franchise***

"Many changes. Big changes in skills, business, the facility itself improved. The way the

[4] FP Competency Based Training 1 includes counseling and skills training on pill dispensing, injectable, condoms, and cycle beads. FP Competency Based Training 2 includes counseling and skills training on IUD insertions.

monitoring team visits us. Sometimes they are strict, sometimes it's annoying but it's okay. It's part of my improvements… When I am working, they [the FTM] will send a text message: 'Ma'am we are going to visit you tomorrow.' I am pressured to prepare. But I am happy when we talk. I discuss with the monitoring team, they encourage me, unlike when there is no one monitoring, like nobody cares. When there's no one, it's like nothing. It's very important to us." ***– Midwife, BlueStar Franchise***

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 start-up. One NGO noted it holds monthly meetings for the midwives in its region to discuss issues, announce upcoming trainings, and address any 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 kind 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 large role in developing the criteria that would allow for midwife clinics to become eligible for PhilHealth accreditation, and the supporting NGOs continue to raise midwife issues to local authorities. PSPI, on behalf of BlueStar midwives, has been performing similar advocacy on the local level to help fast track accreditation of clinics.

3.4 FAMILY PLANNING PROVISION

Demand and supply are both important aspects of successful FP provision. To ensure demand, myths and misconceptions about FP that discourage clients from seeking services or particular methods need to be dispelled. A steady supply of affordable FP 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.

3.4.1 COMMUNITY ATTITUDES, MYTHS, AND MISPERCEPTIONS TOWARDS FAMILY PLANNING

Nearly all of the midwives interviewed reported that their communities understand FP and are generally supportive of FP methods. This consensus is reflected in the FP services provided by the interviewed midwives in 2012 as shown below in Table 4.

TABLE 4: DELIVERY AND FAMILY PLANNING SERVICES PROVIDED BY NETWORK, 2012

	Barangay Population Small – <5,000 people Mid – 5,000 – 25,000 Large - >25,000	Delivery*	Total FP Methods	Total IUDS	IUDs %	Total DMPA	DMPA %	Total OC	OC %
BlueStar 1	Mid	210	298	212	71%	63	21%	23	8%
BlueStar 2	Mid	78	741	269	36%	99	13%	373	50%
BlueStar 3	Small	189	370	205	55%	40	11%	125	34%
BlueStar 4	Small	-	85	77	91%	6	7%	2	2%
BlueStar 5	Small	13	139	121	87%	0	0%	18	13%
BlueStar 6	Small	48	252	76	30%	62	25%	114	45%
BlueStar 7	Large	252	430	322	75%	50	12%	58	13%
BlueStar 8	Small	-	180	90	50%	49	27%	41	23%
Well Family 1	Mid	546	43	13	30%	22	51%	8	19%
Well Family 2	Mid	121	35	9	26%	26	74%	0	0%
Well Family 3	Mid	122	432	3	1%	302	70%	127	29%
Well Family 4	Large	203	704	74	11%	333	47%	297	42%
Well Family 5	Small	18	189	137	72%	18	10%	34	18%
Well Family 6	Large	15	154	2	1%	64	42%	88	57%
Well Family 7	Large	301	266	137	52%	52	20%	77	29%
Well Family 8	Small	0	100	66	66%	28	28%	6	6%
Well Family 9	Mid	0	396	72	18%	144	36%	180	45%
Well Family Total		1326**	2319	513		989		817	
Well Family Average		189**	258	57		110		91	
BlueStar Total		790	2495	1372		369		754	
BlueStar Average		132***	312	172		46		94	

* BlueStar deliveries are reporting only MCP package and WFMC has one midwife reporting only MCP deliveries. These numbers likely underrepresent true delivery statistics.
** Excluding the two facilities that do not provide delivery services
*** Excluding the two facilities that did not report and MCP deliveries

Both networks are important providers of FP, with similar numbers of FP services provided. BlueStar midwives, however, provided more IUDs while Well Family midwives provided more injectables. Interestingly, nearly all of the midwives from both networks consistently reported that IUDs are the least popular method in their community and that it is very challenging (though possible) to overcome existing misperceptions and biases towards this method. In a few cases, bilateral tubal ligation (BTL) was named as the least popular FP method, but in general, IUDs and BTL have the most myths and fears associated with them. Among some of the myths that women have heard concerning the IUD are that it will prick their husbands, cause cancer, or cause infection or bleeding. In general, midwives reported counseling clients as the best way to counter such misperceptions.

"They are positive on IUD. They just need one-on-one talk, information. Some of my clients will say, 'According to my neighbor…' I'd say 'No, you need to ask a medical practitioner, the midwife'. So they will be informed. Once they are informed, it's okay already. Especially the husband, I'll say, 'Bring your husband here'. I'll talk to the husband to explain, 'don't listen to the neighbors'." ***-Midwife, BlueStar Franchise***

"I explain about the procedure, the method, the advantages, then how it affects the family, the number of children. During the Buntis party, I do health education, information for responsible parenthood. What is responsible parenthood, I also include family planning especially (effects on) financial income. If it's IUD, it's long-term, they are financially safe for 10 years. Not like injectable, after 3 months, they would need money again for it. With pills, it's monthly. After that information, they are the ones who choose." ***-Midwife, BlueStar Franchise***

"…when she got home, the mother-in-law talked to her that the IUD is having cancer, the IUD is having… 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 told her that the assurance, to assure her that her IUD is not harmful to her body." ***-Midwife, Well Family Franchise***

A few midwives, however, did not express that IUDs were challenging to provide.

"Here, IUD has the biggest acceptor. I think it depends on how you explain it because IUD is long lasting. We have many IUD acceptors, In 1 month I have 10 to 15 acceptors. The second is DMPA. When someone asks for advice, I present IUD first then DMPA. For pills, they can get that in the pharmacy." ***-Midwife, Well Family Franchise***

Some Well Family midwives reported that the price of IUDs sometimes deterred women in favor of a cheaper option. However, a few midwives noted that some clients who could not afford an IUD but desired one would wait until the midwife had a special or a promotion for the method. Overall, the preferred methods seemed to be OCs, because they are cheap in the short term and easy to access, or injections, because the women do not have to think about them on a daily basis. Some midwives reported that condoms are not popular because husbands do not like them.

"Husband is not so much satisfied using the condom. Because it's like eating candies with wrapper, they told me and the husband don't want to use condoms as a family planning method." ***-Midwife, Well Family Franchise***

Overall, midwives did not report demand for FP as a large problem. More at issue is the lower levels of demand for IUDs, specifically, as they are linked with the most myths and

misperceptions. In the face of such strong beliefs against IUDs, it is apparent that the ability to effectively counsel women and men regarding use of IUDs is vital for midwives.

3.4.2 ACCESS TO FAMILY PLANNING COMMODITIES

Access to an affordable and consistent supply of quality FP commodities is a key aspect of commercially viable provision of IUDs. As mentioned briefly in section 3.3, access to affordable commodities is reportedly not an issue in the Philippines. This sufficient access is due in part to USAID's ongoing work in partnership with the pharmaceutical industry, currently through the PRISM2 project. The FP market in the Philippines grew in recent years to include Alphamed Pharma Corporation, an importer, marketer, and distributer of retail and wholesale pharmaceutical products, including contraceptives. Prior to 2008 when Alphamed began to work with the USAID PRISM2 project under a Global Development Alliance (Alphamed, 2009), DKT was reportedly the only commercial supplier of FP commodities in the country. One of PRISM2's goals was to develop the contraceptive market and viable mass market brands, including for IUDs (PRISM2, 2013). As stated earlier, MSI has its own global contraceptive procurement network from which PSPI provides access to its BlueStar midwives. Table 5 shows the IUD purchasing options in the country and highlights the wide range of affordable, fully sustainable supply options.

TABLE 5: 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
** Php to USD exchange rate: 43.22*				

With BlueStar midwives charging US$2.28 for an IUD insertion and the majority of Well Family midwives charging US$11, there is significant mark up over the commodity cost, showing opportunity for profit from these procedures.

3.5 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 assessment, these factors are self-reported. Clinic financial records were not assessed.

3.5.1 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**

3.5.2 PHILHEALTH ACCREDITATION

PhilHealth accreditation and reimbursements for the maternity care package (MCP) appears to enhance a clinic's financial viability. MCP reimbursements can be more than double the amount that a midwife would normally charge for delivery. This fact makes it unsurprising that most of the midwives who are PhilHealth accredited and offer delivery reported it as being their most profitable service. Many of the midwives also reported including a FP method of the client's choice (including IUD) in the cost of the MCP reimbursement at the six-week postnatal visit. In general, the MCP package allows midwives to offer more comprehensive services for the package price, including ante- and post-natal 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 high reimbursement it offers, PhilHealth accreditation is also seen as a seal of quality approval for the midwife's services.

"Because it's a… it's not only a trend now, actually proof of your profession that you are capable in the field, so people will trust you and then you have a business, your profession." ***–Midwife, BlueStar Franchise***

Most midwives interviewed were PhilHealth accredited, although some had just received accreditation but not yet received a payment. The reimbursement process can take two to three months. To help midwives with their cash flow, BlueStar midwives have the option of taking a loan from PSPI as an advance on their claims. This option potentially helps keep cash flow available for use in purchasing commodities and other items necessary for the running of their clinic.

For the two midwives interviewed who only offer FP and RH 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 successful and to be operating viable businesses. Prior to opening Well-Family clinics, both midwives were established FP providers in their communities; they had worked with government offices offering FP services (Commission on Population or rural health units) and with the Family Planning Organization of the Philippines. This deep experience and community exposure may help in their marketing of their FP and RH services.

PhilHealth accreditation and reimbursement for deliveries are an important source of income for midwives and appear to increase the viability of clinics. There are, however, examples of midwives who are running viable clinics without PhilHealth. PhilHealth is also not only an income booster, but a sign of quality that people understand. This factor could also increase viability by attracting new clients to the clinic. Beyond viability, PhilHealth is also helping to increase the amount of FP, including IUDs, provided through cross-subsidization of services.

3.5.3 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 competition 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 FP through the public sector is dependent on the local government unit, so if the LGU does not purchase FP 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]... 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.

There was less concern expressed about competition from private doctors. Midwife clinics tend to charge less than doctors. Another factor setting the private midwives apart from private doctors is that doctors tend to be men, and some patients prefer not to go to men for IUD insertions.

"The only clinic near here, the doctor is male. The mothers prefer it here because I am female. It's a private clinic. They are embarrassed to have IUD insertion there, they have it here. There are few clinics here, so they go here. Only two. Then me, it's three." ***–Midwife, Well Family Franchise***

Almost all of the midwives contend with competition in some way, especially those in larger towns and cities. One Well Family midwife in the NCR mentioned that she could not charge as much for her services as could her friend in another part of the city because she had so much more direct competition in her area. However, many midwives also identify factors that set them apart from their competition, including friendly service, privacy, assurance of FP commodities in stock, and the assurance of female providers.

3.5.4 PROFIT

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

"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***

"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***

The profit earned by a clinic is one key to its viability. Based on the interviews, the majority of the midwives considered their clinics to be viable and reported some sort of profit, enough to pay the expenses and live on. The factors leading to profit will be explored more below.

3.5.5 EXPENSES

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, including salaries, consumables/FP commodities, equipment, rent, franchisee fee, maintenance, and loan repayment. Thirteen of the 17 midwives interviewed responded (seven from Well Family and six from BlueStar). However, not all midwives gave responses for every category.

On average, the midwives reported salaries, FP products and other consumables, and utilities (such as electricity and water) as their major expenses. However, when looking at midwives individually, all of the Well Family midwives reported FP products and other consumables as their second highest monthly expense, compared to only half of the BlueStar midwives who reported FP 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 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.

3.5.6 VARIETY OF PAYMENT MECHANISMS

Only a few of the midwives, mostly those in small and medium-sized barangays, 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 compared to those interviewed from Well Family. Those midwives in the larger barangays noted that most of their clientele know coming in that they must pay for services; if not, they get referred to a public facility. In cases where clients cannot pay anything for the services, some midwives do not pursue the payments but expect that this goodwill offering will come back to them through a patient referral. The one commonly reported mechanism for ensuring payment is to withhold the birth certificate from the parents as collateral until they make the payment for their child's delivery. However, most of the midwives offered a variety of payment mechanisms to their clients who have difficulty coming up with the full cost of services, particularly delivery services. These methods included advance payment, incremental payments, accepting other types of collateral, and reducing pricing for clients they know cannot make the payments. 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 in payment methods allows midwives to accept a wider range of clientele.

"They say that when I have a promotion, and they don't have the money; they are the first one I call - those people who cannot afford to pay my services as a package. …Most of the time when they came here having the IUD insertion, they are already prepared for the payment. But sometimes, when my clients don't have enough money, just talk to me and have agreement that you only have only PhP500... " ***–Midwife, Well Family Franchise***

"If they only eat one meal a day how can you ask them to pay? For those who can't afford, I use it as a promotion to [attract] those who can afford." ***– Midwife, BlueStar Franchise***

Ensuring payment for services can be a challenging issue for these midwives, yet receiving payment is vital for a viable business. The midwives are often located closest to the clients, even those who cannot pay or cannot pay in full the prices charged. Because of this proximity, midwives have strategies such as referrals to public facilities for those who cannot pay at all or flexible payment plans for those who simply cannot pay all at once. Some midwives, however, clearly see providing some services for free as their duty to their community. They find ways to offer promotions or subsidize some clients.

3.5.7 MARKETING

As described earlier, the networks provide their midwives with various types of initial marketing support. This support includes marketing training, network branding, fliers, and financially supporting Buntis parties. Once this initial infusion ends, however, the midwives have to find ways to continue marketing their business with less network inputs. One BlueStar midwife reported stuffing clinic fliers into the paper bags for customers who shop at her adjacent Sari-Sari store. Many still go door-to-door to promote the clinic, and they reported this outreach 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 these 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***

As stated earlier, most of the midwives also 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 bringing 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 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 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***

"They [BlueStar] offered me a Buntis Party. We go to the different barangays to promote. For example, we will do free IUD [insertion] in promoting the clinic. Free pap smear. Like that." ***– Midwife, BlueStar Franchise***

In addition to the initial marketing support provided by the network, midwives need to find creative ways to continue marketing their business. All of the midwives recognized this fact and had at least one way of attracting new clients, even if it was the low-cost door-to-door strategy. Some were more sophisticated with their marketing tactics, including finding pharmaceutical company support for Buntis parties or developing promotions for services from time to time to attract new clients. Though the brand of the network is important, it is not sufficient in itself for a clinic to be viable.

4. CONCLUSION

Midwives from the Well-Family Midwife Clinic and BlueStar franchise networks are important providers of FP 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 FP 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 FP 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.

4.1 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 sufficient practice will make her confident in recommending IUDs to her clients, when appropriate, and help maintain her skill.

4.2 MIDWIFE SELECTION

Certain criteria for midwife selection may help to increase IUD provision and have implications for increased viability. Both networks have a set of criteria for selecting midwives they bring into their network. However, BlueStar appears to have more overt requirements for the personal characteristics of the midwives. By working to select midwives who are active in their communities but do not yet have a clinic, BlueStar is intentionally increasing access to facility-based services. This selection criterion may also generate a sense of gratitude in midwives who are supported to open a business and who may be more dedicated to the mission of their NGO.

Both networks also 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 FP in general and on IUDs in particular.

Motivation is another quality that appears to contribute to the success of midwives' businesses, but also to the provision of FP methods. It may also be a contributing factor to the BlueStar

midwives' ability to provide higher levels of IUDs. Many midwives themselves indicated that they believe their clients come to them for services because of their positive personality or kind care. However, their success could also be in combination with the previously stated increased training on IUDs that the network gives its midwives and/or the sense of gratitude that the midwives feel to the network for giving them the opportunity to open their own clinic.

Recommendation: NGOs that run a midwife network, other organizations, projects, and donors can focus on including topics such as marketing and customer service in trainings for franchised and independent midwives. Though not realistic in all countries due to sometimes significant human resources crises, when possible, midwife personality and motivation should be considered in the selection of midwives into networks as this can help her business viability.

4.3 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 FP methods. This access is vital to their viable provision of IUDs. Also, the affordability of the commodities in relation to the price that they charge for the service is vital to viable provision, as they are able to make a profit on each service. In addition, the lowest priced commodity that the BlueStar midwives have available to them appears to contribute to their ability to keep the price of IUD insertion (and other FP methods) intentionally low so as to make FP more accessible to a broader range of women.

Recommendation: More investment should be made in developing or strengthening local markets for FP commodities, including LARCs, when possible. This strengthening approach includes ensuring multiple suppliers to enable competition and keep prices low and access to supplies high. Another role that a network can play is to coordinate the pooling of FP commodity purchases for network members, similar to what BlueStar does. Since small providers use fewer commodities, they are at a disadvantage in being able to use bulk purchase discounts. However, by pooling purchases, they can take advantage of bulk discounts.

4.4 LOCATION AND MARKETING

Creative low-cost marketing can be highly effective in improving client flow and promoting viability. Marketing is an important component of a midwife clinic's 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. Though marketing can be expensive, many midwives reported that one of the most effective ways to market their clinic is to go out into the community house to house and talk to women about FP. With slightly more investment, midwives reported doing things like outreach events in nearby towns, especially those that do not have their own midwife, and providing some free services as a marketing tool. Women who receive these services then reportedly often come to the clinic for additional services.

Location is also a critical aspect of a successful small business. Though some clinics, especially those in the BlueStar network, are built based on the location of the midwife's home, others are subject to the approval of the network. The need for network approval is particularly true for the Well Family midwives. Both networks see the importance of conducting a mapping exercise to determine catchment area, client potential, and competition, and of doing so before committing to a new clinic location. However, it is also evident that a mapping exercise can only tell so much, and network rules for placing clinics may not always be applicable for every location. This fact was made clear by a Well Family midwife who received permission to move her clinic off of the main street in her community and into her home, which was in a more secluded area. She reported that her business increased after this move, largely because women felt more security and privacy going to her clinic in a less trafficked area. This example is a lesson that a one-size-

fits-all model does not work and a midwife's knowledge of her community is highly relevant. There were also, however, midwives who were located on side streets or in more secluded areas who recognized that this location hindered their business as they can be difficult to find. Some of these midwives reported they had plans to improve signage or to open branch clinics in other areas to draw in more clients, which would theoretically increase client flow and improve their viability.

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 to a franchise or independent midwife clinic. However, not all midwives are naturally inclined toward marketing. Low-cost, but effective, methods are especially important at the start of a business, when a midwife might not have as much money to invest.

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.

4.5 FLEXIBILITY IN PAYMENT MECHANISMS

Flexible payment terms can increase access to services, including IUDs, and potentially have positive implications for business viability. The understanding on the part of many midwives that not all of their clients can pay for services immediately, or even in entirety, may in the long run benefit the viability of their business. Though many do subsidize some of their clients who truly cannot pay, most of the midwives offered payment plans so that the whole amount could eventually be paid. In the short term, this gesture could impact cash flow, but at the same time, the midwife may be generating goodwill among her clients who then may refer other paying clients to her business. This flexibility would apply regardless of whether a midwife is in a franchise or is independent.

Recommendation: Organizations, projects, and donors can include topics related to flexible payment mechanisms in trainings for networked and independent midwives. Although insurance mechanisms like PhilHealth can help providers to earn larger payments for some services, providers still have clients who do not benefit from insurance. In these cases, it is important for providers to develop payment mechanisms that are amenable to themselves and their clients. Be they sliding scale payments, deferred or prepayments, or installment payments, creative solutions to financing services can help to extend services to those with less ability to pay higher costs at one time, and provide balance to a private provider's need to receive payment and keep her cash flow available.

4.6 LOOKING AHEAD

Much can be learned from the Philippines' efforts to increase the provision and uptake of FP. 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. This decision allows women who cannot afford the service to receive it for free. For BlueStar, the US $8 reimbursement rate (Senlet et al., 2012) is higher than the US $2.28 charged by network clinics. The rate is lower than the 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.

ANNEX A: MIDWIFE INTERVIEW TOOL

Midwife characteristics

I'd like to start with asking you some questions about your career path, then how you joined the franchise network, and the learn more about how your clinic operates now. So let's start with a little background about you.

1. What made you decide to become a midwife?

2. How long have you worked as a midwife?

3. Where have you worked as a midwife, for example, overseas, in public or private facilities?

4. Do you work as a midwife anywhere else right now?
    i. **[If YES]** Where else do you work?

Clinic start-up and initial network inputs

5. Did you previously run a practice before you joined the Well Family/BlueStar network?

    [If YES probe below. If NO, skip to Question 5]

    a. What influenced you to open a practice?

    b. How long did you run the first practice before joining this network?

    c. How did you finance the start of your practice?

    d. Did you own or rent the building your practice was in?

    e. Was the practice you had accredited by PhilHealth?
        - **[If NO]** Why did you decide not to get accreditation?

    f. Were you licensed by the DOH?
        - **[If NO]** Why did you decide not to get licensed?

    g. What types of infrastructure, supplies, or staff did you bring from your previous practice to help establish and run your Well Family/BlueStar clinic?

    h. What knowledge did you bring from your previous practice to the networked clinic you now run?

    i. What previous relationships did you bring from your previous practice that helped you establish and run this Well Family/BlueStar clinic?

j. What changed about your practice after you joined Well Family/BlueStar network, if anything?
    - *Probe: For example, have any of your services changed, your hours of service, number of clients, or marketing?*

6. How did you learn about the Well Family/BlueStar network?

7. What influenced you to join the Well Family/BlueStar network?

8. How long have you been a part of the network?

9. Did you face any challenges in establishing your own clinic?
    a. **[If YES]** What were they?
        i. *Probe: Did you have any challenges with:*
            1. *Funding,*
            2. *Interactions with the network,*
            3. *Politics,*
            4. *Information,*
            5. *Support,*
            6. *Training,*
            7. *Supplies or equipment,*
            8. *Infrastructure.*

        ii. How did you overcome these challenges?

10. Who provided information and support to you in establishing your practice (both inside and outside the network)?
    a. What kinds of support did those people provide you?

11. Did you have to pay a fee or make other investments to join the network?
    a. **[If YES]** How did you finance joining the network and making those investments?
        i. Probe: Did the network help?

        ii. ***[If YES]:*** *In what ways?*

12. How did you decide where to locate this clinic?
    a. Do you currently live this village or did you grow up here?

13. What types of initial equipment and supplies where provided to you by the network?
    a. What, if anything, did you have to get on your own?

14. Did the network provide marketing support when you started the clinic?
    a. **[If YES]** In what ways?

15. Is your clinic currently licensed with the government?
    a. **[If YES]** How did the network or other organizations help you to get your license, if at all?

16. Is your clinic currently Phil Health accredited?

a. **[If YES]** How did the network or other organizations help you to get your accreditation, if at all?

17. What kinds of investments have you made to improve your clinic?
    a. *Probe: For example, did you:*
        i. *Expand the space*
        ii. *Open an additional clinic,*
        iii. *Add extra services*
        iv. *Purchase other equipment*
        v. *Hire additional staff*

18. Have you had any additional training since joining the network?
    a. **[If YES]** What kind of training?
        i. *Probe: for example in family planning methods or business training?*

        a. Who paid for these trainings?

Services provided at the clinic

19. Do you have additional staff, besides you, working at the clinic?
    a. **[If YES]** How many staff do you have now?

    b. **[If YES]** What does each of them do at the clinic?

    c. **[If YES]** Have the other staff had any additional training since starting at the clinic:
        i. **[If YES]** What kinds of training?

        ii. *Probe: Any training in family planning methods or business skills?*

        iii. **[If YES]** Who paid for these trainings?

    d. **[If YES]** How did you recruit your staff?

20. Do you offer services outside of the network's basic package?
    a. **[If YES]** What are those services?

    b. **[If YES]** What influenced you to offer the additional service?

21. What services make up the majority of your business?

22. Are there any required network services that you would prefer not to offer?
    a. **[If YES]** Why?

23. What types of clients do you see?
    a. *Probe: For example, what are your clients' typical age range, wealth status, religion*

    b. What types of clients make up the majority of your business?

    c. What communities or areas does your clinic serve?

d. What is the longest distance your clients travel to come to the clinic?

e. Where do most of your clients come from?

Marketing

24. How do clients find you?
    a. *Probe: For example, through*
        a. *Word of mouth*
        b. *Marketing*
        c. *Referrals*

    b. How do the majority of your clients find you?

25. How do you market your business?
    a. *Probe: For example, Do you:*
        i. Post signs?
        ii. Advertise?
        iii. Hold special promotion days?
        iv. Get referrals from other providers?

    b. **[If YES to referrals]** What type of arrangement do you have for the referral?
        i. Probe: Do you compensate people who refer clients?
        ii. *Probe: Do you get compensation for referring clients to other providers?*

26. How do you think being a part of the network supports the marketing of your clinic?

27. Which types of marketing do you feel are most effective for your clinic?

Payment for services

28. What payment methods are available to your clients?
    a. *Probes: Do you:*
        i. Accept PhilHealth,
        ii. Offer sliding payment scale
        iii. Allow clients to pay in installments

    b. Are these methods of payment available for all services?

29. How do most clients pay?

30. How do you handle clients who cannot pay?

31. Do you accept PhilHealth?
    a. **[If YES]** Roughly, what percentage of your clients has PhilHealth and uses the benefits?

32. Do you have any difficulties collecting payments for services?
    a. **[If YES]** What are the difficulties?
        i. **[If ACCREDITED]** How is the PhilHealth reimbursement process working for your clinic?

b. **[IF YES]** How have you tried to address these challenges or how would you suggest improving them?

33. How do your clients perceive the prices for the IUD services you offer?

Costs and sustainability

34. Do you think your business is profitable?
    a. Why or why not?

35. What do you think would make your business more profitable?

36. What are your largest costs, in terms of running your business from month-month?

37. What competition for family planning services do you face?
    b. Probe: For example are there public clinics, other private providers, or other free services?

    c. How does this competition vary for the different types of services you offer and specifically for IUDs?

    d. Do you believe your prices are comparable to what your competitors offer?

38. Do you think your business is successful?
    e. Why or why not?

39. What are the biggest challenges you face in keeping your clinic operating successfully?
    f. Probe: For example, some challenges could be
        i. Client demand,
        ii. Low supply,
        iii. Business costs,
        iv. Political dynamics,
        v. Community relations,
        vi. Poor economy

40. From your experience, what factors contribute to the successful operations of your business?

41. Do you have any concerns about the future success of your business?
    a. **[If YES]** What are the concerns?

    b. *Probe: For example, are you concerned about:*
        i. Changes in public support for family planning
        ii. Changes in client demand
        iii. Changes in the cost of supplies
        iv. Changes in your clients population

FAMILY PLANNING SPECIFICS

Family Planning Services

Now I'm going to ask you some specifics about the family planning in your community and with your business. We are specifically interested in knowing more about IUDs so many of our questions will be related to IUDs.

42. How would you describe demand for family planning in your community?
    a. *Probe: a lot of demand, very little demand*
    b. How would you describe IUD demand in your community?

43. How would you describe the LGU's attitude toward family planning and IUDs?
    a. *Probe: Are they supportive? Unsupportive?*

    b. What types of challenges or opportunities do you face as a result of the LGU's attitude towards family planning and IUDs?

44. What family planning methods are most preferred among your clients?
    a. Why do you think these methods preferred?

45. What family planning methods are least preferred among your clients?
    b. Why do you think those methods are least preferred?

46. When a client comes to your clinic, who typically initiates conversations about family planning methods?
    a. *Probe: Do clients typically come in to request family planning services?*

    b. *Probe: Do you recommend family planning when clients come in for other services:*

        i. ***[if YES]*** *With which services do you typically include a discussion about family planning?*

47. What is your process for starting a client on a new family planning method?
    a. *Probe: What do you before they begin using the new method?*

    b. *Probe: What about after they've started?*

48. How do most of your clients feel about IUDs?

49. How do most of your clients feel about sterilization?

50. What do you do if a client is interested in sterilization?

51. What do you do when a client has side effects from a family planning method?

52. What do you do when a client has side effects from an IUD?

53. What is challenging about providing IUDs?

54. How do you address misconceptions related to IUDs?

55. What is the IUD discontinuation rate among your clients?
    a. How does this rate compare to the discontinuation rates among the other family planning methods you offer?

Family Planning supply

56. How do you obtain family planning products and related supplies, including IUDs?
    a. *Probe: Do you ever obtain family planning products and supplies outside the network?*

    b. ***[If YES]*** *What typically causes you to purchase outside the network?*

    c. ***[If YES]*** *How do you get other products?*

57. Do you face any challenges in getting your family planning supplies?
    a. **[If YES]** What are these challenges?

    b. **[If YES]** How do these challenges change for IUDs?

    c. **[If YES]** How would you recommend addressing these challenges?

ANNEX B: BIBLIOGRAPHY

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