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# Philippines Private Health Sector Assessment

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**About SHOPS Plus:** Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is USAID's flagship initiative in private sector health. The project seeks to harness the full potential of the private sector and catalyze public-private engagement to improve health outcomes in family planning, HIV/AIDS, maternal and child health, and other health areas. SHOPS Plus supports the achievement of US government priorities, including preventing child and maternal deaths, an AIDS-free generation, and supporting the goals of FP2020. The project improves the equity and quality of the total health system, accelerating progress toward universal health coverage.

**Cover photo:** Robin Keeley, SHOPS project



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# Acronyms

<b>ADB</b>	Asian Development Bank
<b>AJA</b>	Adolescent Job Aid
<b>AOR</b>	Agreement Officer Representative
<b>BPO</b>	Business process outsourcing
<b>BSP</b>	Bangko Sentral ng Pilipinas
<b>CBHC</b>	Credit for Better Health Care
<b>CPR</b>	Contraceptive prevalence rate
<b>DBP</b>	Development Bank of the Philippines
<b>DCA</b>	Development Credit Authority
<b>DHS</b>	Demographic and Health Survey
<b>DOH</b>	Department of Health
<b>DOTS</b>	Directly Observed Treatment
<b>EMR</b>	Electronic medical record
<b>FDA</b>	Food and Drug Administration
<b>FGD</b>	Focus group discussion
<b>FP</b>	Family planning
<b>GDP</b>	Gross domestic product
<b>HMO</b>	Health maintenance organization
<b>IMAP</b>	Integrated Midwives Association of the Philippines
<b>IUD</b>	Intrauterine device
<b>KII</b>	Key informant interview
<b>LAPM</b>	Long-acting permanent methods
<b>LBP</b>	Land Bank of the Philippines
<b>LGU</b>	Local government units
<b>LTO</b>	License to operate
<b>MFI</b>	Microfinance institution
<b>MMR</b>	Maternal mortality ratio
<b>MOH</b>	Ministry of Health



<b>NCR</b>	National Capital Region
<b>NPL</b>	Non-performing loans
<b>OCP</b>	Oral contraceptive pills
<b>PLCPD</b>	Philippines Legislators' Committee on Population and Development
<b>PPP</b>	Public-Private Partnership
<b>PRISM</b>	Private Sector Mobilization for Family Health Project
<b>PSA</b>	Private Sector Assessment
<b>PSPI</b>	Population Services Pilipinas Incorporate
<b>PSRP</b>	Philippines Society for Responsible Parenthood
<b>RHU</b>	Rural Health Unit
<b>RPRH</b>	Responsible Parenthood and Reproductive Health
<b>SAM</b>	Short-acting methods
<b>SAMPI</b>	Society for Adolescent Medicine of the Philippines, Incorporated
<b>SDN</b>	Service Delivery Network
<b>SME</b>	Small and medium enterprise
<b>TMA</b>	Total market approaches
<b>TRO</b>	Temporary Restraining Order
<b>UHC</b>	Universal health coverage
<b>USAID</b>	United States Agency for International Development

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# Executive Summary

The Republic of the Philippines is home to approximately 104.9 million people in Southeast Asia. A strong history of economic growth throughout the 2010s has resulted in a declining poverty rates across the country, with some regional variation. The Philippines is also home to the youngest working age population in East Asia, which is fueling the growth of the business process outsourcing (BPO) sector. At the same time, health outcomes are similarly improving in the Philippines. Substantial increases in government funding, investments in facilities and human resources for health, and investments in the national health insurance program PhilHealth have all helped more Filipinos access the health care that they need.

Despite remarkable progress, challenges remain in reproductive health. The landmark Responsible Parenthood and Reproductive Health law, passed in 2012, provides a legal guarantee for all women to access family planning (FP) and reproductive health information and services. However, fertility is high for the region at 2.9 children per woman, and modern FP use is low (25 percent of all women use modern contraception). The Philippines also faces a teen pregnancy problem, with high rates of teen pregnancy compared to its neighbors. These trends come in spite of significant investments by donors and the Philippines government and contribute to slow progress at improving maternal health outcomes. Many factors contribute to the low uptake of FP services. One main barrier is opposition from the Catholic Church, which exhibits a great amount of influence in the Philippines and only supports natural FP methods. This opposition helped delay passage of the 2012 Reproductive Health law for 13 years and has led to the greatest current challenge to accessing FP services: temporary restraining orders issued by the Supreme Court that have prevented the full implementation of the 2012 Reproductive Health Law and created confusion about what is and is not allowed regarding the procurement, distribution and provision of contraceptives in both the public and private sectors.

The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS Plus) project conducted this assessment to identify opportunities and provide recommendations for USAID/Philippines to support increased delivery of modern FP services, especially for Filipino youth and adolescents, through the private sector. To achieve this purpose, the PSA team had four specific objectives:

1. Provide an overview of private health care providers and their roles delivering FP services;
2. Assess current constraints to the optimal use of PhilHealth benefits in the private sector, and identify opportunities to strengthen and expand them;
3. Identify barriers and opportunities for private provider to access financing so that they can expand their businesses and the delivery of FP services; and
4. Provide recommendations to USAID/Philippines programming to expand effective public-private engagement.

To achieve these objectives, the SHOPS Plus assessment team implemented a five step process that included a desk-based review of the literature and secondary data analysis, and in-country data collection that consisted of key informant interviews with 60 stakeholders from the public and private sectors, as well as nine focus group discussions with private doctors, nurses, and midwives in Cavite, Davao, and National Capital Region. These data points formed the basis for this report.

The health system in the Philippines is decentralized and composed of both public and private sectors which are regulated by the Department of Health (DOH). Service delivery in the public

sector is decentralized across multiple levels of government, with local government units operating many primary care facilities while the DOH operates a few higher level tertiary hospitals across the country. The private nonprofit and for-profit sectors offer services at every level of care. With the exception of community-based public health outposts, the majority of health facilities at almost every level is found in the private sector. Across these sectors, the Service Delivery Network (SDN) is a key public-private initiative run by the Filipino government to increase lower income populations' access to health services, especially FP and reproductive health.

The Philippines health system has a robust and well-functioning oversight structure. The DoH licenses all health providers, as well as their facilities, to practice in both the public and private sectors within the country. In addition, each cadre is licensed by a body authorized by the Professional Regulations Commission to adopt and maintain standards of practices. The DOH has a strong platform for engaging with the private sector in the policy development process at the national level, including representatives from key private provider associations on its National Implementation Team. However, most of this engagement is with networked providers or larger private hospitals; there has been less engagement with individual independent private providers to solicit their inputs and involve them in policy dialogue. To address the teen pregnancy rate and increase use among youth and adolescents, the 2012 reproductive health law provides legal assurance that reproductive health information and services must be available for these populations. However, the law also codifies the need for parental consent for adolescents (less than 18 years old) to access FP services, imposing a barrier to access.

Since 1995, the Philippines government has operated the Philippines Health Insurance Corporation (PhilHealth), the country's national health insurance scheme, as its primary pathway to achieve universal health coverage. PhilHealth aims to improve access to high quality health care. The scheme now covers nearly all citizens, and has begun to expand service coverage, recently increasing benefits for Indigent members for selected primary care services. PhilHealth has made remarkable progress with respect to the three dimensions of UHC. The implication of this overall progress is that more Filipinos have greater access to FP and other health services covered under the PhilHealth benefit package, with less financial burden. Specific to FP, PhilHealth covers counseling and provision of some—but not all—services.

Based on 2017 data, approximately 6.7 million women of reproductive age (15-49) use a modern contraceptive method, with contraceptive prevalence and method mix varying greatly by age. Women between 30 and 39 are the bulk of the FP market, with much smaller numbers of both older (45-49) and younger (15-24) users. OCPs are the most prevalent choice by a wide margin, with sterilization and IUDs increasing in prevalence among older women. Overall, the private sector is the source for 44 percent, especially private pharmacies due to the predominance of short acting methods. The public sector is the main source of long acting and permanent methods.

The potential FP market is much larger than current use. Approximately 89 percent of women do not want a child soon or at all, regardless of whether or not they currently use a modern method. Secondary analysis of 2017 Demographic Health Survey data reveals that there are approximately 6.0 million non-users who intend to use a modern method later and 2.8 million traditional users who could potentially switch to a more effective modern method. The majority of women who do not use a modern method even though they do not want to become pregnant are motivated by reasons related to their current situations, such as not being married or not having sex. These motivations are situational and can change relatively quickly, turning non-users into users. It therefore is important to ensure that an adequate number of providers are trained and equipped to meet this potential demand.

Focus group participants indicate that private providers offer a range of commodities, although the degree to which they offer specific methods varies by cadre. The main gap for many smaller providers are implant removals and bilateral tubal ligations, as these are considered surgical methods and are required by law to take place in a hospital setting. An important element to FP provision currently is accreditation with PhilHealth so that they can get reimbursed for these services. Partially as a result of these revenue streams, midwives—an important source of post-partum FP—in particular are widely accredited. Other cadres, such as doctors and nurses, play a much more limited role in offering standalone FP services. Nurses in particular play a limited service delivery role, as they are largely regarded as support to doctors. While the law states that properly trained nurses can insert and remove implants and IUDs, PhilHealth has not yet included them as an accredited provider for IUD and implant packages, although it indicates that such guidelines are being developed. In addition, the DOH issued an Administrative Order in February 2017 that provided guidelines to certify new freestanding FP clinics that nurses (and other cadres) could operate. These two developments could help legitimize nurses as independent service providers. Across all cadres, though, the number of providers trained in adolescent-friendly services to meet adolescent and youth FP needs is too low.

PhilHealth is an important factor in determining what services private providers deliver. Private providers tend to view revenue from PhilHealth as the first layer of their cost recovery. Therefore, what PhilHealth covers, how much it reimburses, and how it makes payments, all shape provider willingness to offer certain services. For example, its Maternal Care Package, which includes generous reimbursements to midwives for certain post-partum FP services, has motivated midwives to become accredited with the scheme and trained to deliver those methods. This incentive will be tested as PhilHealth rolls out a new electronic claims system that will require providers to make costly investments and upgrades in its technical infrastructure. In addition to PhilHealth, there are several private health maintenance organizations that offer “top up” benefits. These schemes generally cover services at private hospitals for members who are employed in the formal sector. While these schemes generally do not cover FP, they indicated a willingness to consider it should one of their corporate clients request them to do so.

As private providers look to make upgrades necessary to stay accredited with PhilHealth, they will require access to capital. The Philippines has a robust formal banking and microfinance system that could potentially address these needs. To date, though, there has been limited lending to the private health sector, partially due to the relatively small size of individual loans and the banking industry’s perceptions of risk. Again, participation in PhilHealth offers opportunities to reduce this risk by serving as a verifiable cash flow or collateral. These opportunities can be strengthened by supporting private providers to formalize their financial management practices with banks (e.g., opening bank accounts specific to their practices) or by supporting partnerships between PhilHealth and the financial sector to process provider payments.

Based on these findings, there exist an array of opportunities to strengthen the private sector and family planning services in the Philippines. This assessment provides an actionable plan to utilize the opportunities identified for all of the stakeholders in the country to act on. Potential opportunities for strengthening the private sector provision of family planning services include:

- capitalizing on emerging market opportunities to expand access, by incentivizing nurses to stay in the health sector and leveraging of the business process outsourcing (BPO) industry expansion;
- transitioning midwife assistance to target midwives with entrepreneurial spirit, including addressing financial literacy needs to increase their access to finance for private providers;

- leveraging opportunities presented by PhilHealth expansion by supporting midwives to adopt newly mandated electronic claims submission to PhilHealth, advocating to include family planning services in expanding primary healthcare benefits under PhilHealth, expanding the cadres of accredited providers, and supporting private providers to establish more formal banking practices that will help use their PhilHealth payments to reduce lending risk;
- strengthening public sector engagement with wider range of private providers beyond the larger provider networks, franchises, and hospitals that policymakers traditionally engage in public-private dialogue and planning; and
- breaking the paradigm that only sees adolescents enter health system after becoming pregnant, by developing mass media campaigns that focus on interactions between parents and teens, leveraging social media to provide teens with direct link to providers and other credible sources of family planning information, addressing socioeconomic and behavioral factors that lead to risky sexual behavior, and better integrating private providers into programs focused on educating and serving youth and adolescents.

# Introduction

Located in Southeast Asia, the Republic of the Philippines is an archipelago of over 7,000 islands and home to approximately 104.9 million people.<sup>1</sup> It is also home to the 10<sup>th</sup> fastest growing economy in the world (World Bank 2017a). Outperforming some of its regional peers, the GDP growth rate increased from 5.9 percent in 2015 to 6.8 percent in the first half of 2016. Strong domestic economic policies, public investment, low inflation, and a steady increase in remittances have all contributed to this growth (World Bank 2017b). In addition to impressive economic growth, moderate poverty levels (the percent of Filipinos living on less than \$3.10/day) have considerably declined from 32 percent in 2012 to 23.9 percent in 2016. This rate is projected to fall further to 22.5 percent in 2017 (World Bank 2017b). Contributing to the decline in poverty are low inflation, high employment, and the government's conditional cash transfer program, "Pantawid Pamilyang Pilipino Program ("the 4P's"). The Philippines is also home to the youngest working age population in East Asia. Key to this success has been the growth of the business process outsourcing (BPO) sector. BPOs employed about 1.3 million Filipinos at the end of 2016 – up from 100,000 in 2004 and expected to reach 2.6 million by 2020 (Oxford Business Group 2016). This sector is the fastest growing industry in the Filipino economy and is an especially important source of employment for youth, with workers aged 15-24 accounting for one quarter of the BPO labor force (Philippines Statistics Authority 2016a).

Health outcomes are similarly improving in the Philippines owing to many factors, including a substantial increase in government funding and investments in facilities and human resources for health. The government has also prioritized universal health coverage, and as a result, 92 percent of the population is enrolled in the national health insurance program, PhilHealth (WHO 2017). The landmark Responsible Parenthood and Reproductive Health law, passed in 2012, provides a legal guarantee for all women to access family planning (FP) and reproductive health information and services. All of these factors have helped the Philippines to be the only country in the East Asia and Pacific region to close gender gap in health, meaning there are no gender-based differences in life expectancy (World Economic Forum 2016).

Despite remarkable progress, challenges remain in reproductive health. Fertility is high for the region at 2.9 children per woman (compared to 1.5 in Thailand and 2.0 in Vietnam). Modern FP use is low (25 percent of all women use a modern contraceptive method; 11 percent use traditional methods) and overall use has not changed much in the past decade despite significant investments by donors and the Philippines government. These factors contribute to poor maternal health outcomes, with only a 25 percent decline in MMR between 1990 and 2015 (World Bank 2015). The Philippines Department of Health Adolescent and Youth Health program also identifies preventing teenage pregnancy as a key priority, as it was previously identified as the only country in the region with an increasing rate of teen pregnancy (Simon/PLCPD 2013). Between 2003 and 2013, DHS data indicates that the percentage of women aged 15-19 who had begun childbearing increased from 8.0 to 10.1 (Philippine Statistics Authority and ICF International 2014); by the 2017 DHS, that number had declined to 8.6 percent either pregnant or having had their first child (Philippines Statistics Authority and ICF, 2018). Teens are the only age group in the Philippines that is experiencing an increase in fertility rates (WHO 2015). If the country can reduce its fertility and leverage the young working age population, it has the potential to harness the demographic dividend (World Bank 2017b).

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<sup>1</sup> The World Bank. 2016a. *Philippines Country Page*. <<http://www.worldbank.org/en/country/philippines>>. Accessed 4/5/19.



There are many factors that contribute to the low uptake of FP services. Among them are concerns over side effects and opposition from the Catholic Church. Among non-users who would like to space or limit their births, 16 percent are not using a method due to fear of side effects or health concerns (Philippine Statistics Authority and ICF International 2014). The Catholic Church exhibits a great amount of influence in the Philippines and only supports natural FP methods or abstinence. This influence extends to policy as the FP program under the Arroyo government focused on natural FP (Guttmacher 2010). The Church's opposition to modern "artificial" methods also kept the reproductive health law from coming to a vote for 13 years (Whalley 2013). In addition to opposition on theological grounds, the Church is concerned that a law providing access to contraceptives would lead to other laws in conflict with other doctrine such as the legalization of abortion, euthanasia and same-sex marriage (Hundley 2013). The Catholic Bishops' Conference of the Philippines has issued many statements and lobbied vigorously against the 2012 Reproductive Health Law even though it was supported by 70 percent of the population (Hundley 2013). This opposition has led to the greatest current challenge to accessing FP services: temporary restraining orders issued by the Supreme Court that have prevented the full implementation of the 2012 Reproductive Health Law (Kiesel and Rottach 2014).

## Assessment purpose

SHOPS Plus conducted this private sector assessment (PSA) to identify opportunities and provide recommendations for USAID/Philippines to support increased delivery of FP services through private doctors, nurses and midwives, with the goal of increasing access to and use of modern FP methods. In particular, the assessment sought to identify how the private health sector could help reach Filipino youth and adolescents with FP messages and services.

To achieve this purpose, the PSA team had four specific objectives:

5. Provide an overview of main private health care providers (i.e. private doctors, nurses, and midwives) and their respective roles in delivering FP services;
6. Assess current constraints to the optimal use of PhilHealth benefits in the private sector, and identify opportunities to strengthen and expand them;
7. Identify barriers and opportunities for private doctors, nurses, and midwives to access financing so that they may expand and improve their business and the delivery of FP services; and
8. Provide recommendations to USAID/Philippines programming to expand effective public-private engagement for improved and increased delivery of priority health services in the private health sector.

USAID/Philippines has a long and active history of investing in the private health sector. This assessment sought to build on that experience by identifying new and innovative opportunities that have emerged since the last round of USAID bilateral health projects launched in 2013.

## PSA methodology

SHOPS Plus and its predecessor project, SHOPS, have conducted more than 25 PSAs. Many of these assessments have led to field-based programs designed to engage private sector actors in helping countries address priority health needs. The PSA in the Philippines followed the SHOPS Plus methodology and consisted of five phases:



**Figure 1. Steps in a private sector assessment**



**PLAN:** The PSA process began with a comprehensive review of peer-reviewed and grey literature. This step included an analysis of existing DHS datasets and Track20 models to identify potential market segments that currently access – or potentially could access – FP services through the private sector. This review provided the assessment team with a clear overview of the landscape and context, as well as key challenges and gaps in information. The results of this review informed the development of a list of key stakeholders to interview during the second phase.

**LEARN:** SHOPS Plus convened a multidisciplinary team to conduct the PSA focusing on service delivery, demand for FP methods, health financing, and access to finance. The team consisted of four private sector and FP experts from the SHOPS Plus home office, as well as a local FP technical consultant. The consultant organized a series of focus group discussions with private doctors, nurses, and midwives in National Capital Region (NCR), Davao, and Cavite between June 26 and July 6. Following the focus group discussions, the SHOPS Plus team traveled to Manila, Cavite, and surrounding regions for key informant interviews between July 10<sup>th</sup> and July 21<sup>st</sup>, 2017. The SHOPS Plus team met with over 60 stakeholders in the public and private health sectors.

**ANALYZE:** The analysis began in country, as part of nightly debriefings where the PSA team shared findings, determined whether additional key informants should be added, and began to form actionable recommendations. This process continued past the fieldwork, as the team integrated findings and developed recommendations.

**SHARE:** This step consisted of debriefing with USAID/Philippines during the trip to Manila as well as disseminating the final report both locally and globally.

**ACT:** The final step is to support action and programming based on findings and recommendations from the PSA.

**DISCLAIMER:** The PSA was conducted during the summer of 2017 and reflects findings as of that time. Between the assessment completion and the publication of this report, the Food and Drug Administration announced that 51 contraceptives do not classify as non-abortifacients, thereby lifting the Supreme Court’s temporary restraining order. The authors have added a short addendum to the conclusion offering updates on the family planning market since this update.

# Health systems background and context

## Health system structure

The health system in the Philippines is decentralized and composed of both public and private sectors which are regulated by the Department of Health (DOH) (Romualdez et al 2011). Service delivery in the public sector is decentralized across multiple levels of government. Autonomous local government units (LGU) operate rural health units (RHU) (staffed by doctors, nurses, etc.) and barangay health centers (staffed by barangay health workers, volunteer health workers, and midwives). These outlets focus on primary care needs including FP. Provincial governments operate provincial and district hospitals for secondary, more complicated health services. The DOH, while mainly providing stewardship and guidance for the overall health system, also operates a few higher level tertiary hospitals across the country.

Inconsistent data makes it difficult to determine the exact degree that a lack of human resources for health seems to be a constraint that limits access to health services. The World Health Organization recommends that an average density of 2.28 providers per 1,000 population is needed to ensure adequate coverage of priority health services. As of 2017, the MOH reported overall numbers of physicians (40,775 – or .39/1,000 Filipinos), nurses and midwives (133,352 – or 1.28/1,000 Filipinos), and medical techs (13,413 – or .13/1,000 Filipinos) that are slightly below this estimate (Dayrit et al, 2018). Official statistics indicate that most cadres are slightly skewed toward the private sector; the sole exception is midwives (Table 1) (Ibid). However, this database relies on facilities to self-report the number of staff that they employed and there is no formal process for collecting this information. For example, while the database lists only approximately 21,000 midwives in the country, the Integrated Midwives Association of the Philippines (IMAP) indicated that there are 66,000 practicing midwives – and a further 110,000 registered but not practicing – across the country. IMAP also indicated that the majority of these midwives are operating in the private sector either on an exclusive basis or by moonlighting at a private lying-in clinic after their shift at a public facility.

**Table 1. Distribution of human resources for health across the Philippines public and private sector**

Cadre	Public	Private
Doctor	50%	50%
Nurse	61%	39%
Midwife	90%	10%
Pharmacist	53%	47%

Source: Dayrit et al, 2018

The private sector offers nonprofit and for-profit services at every level of care. In the private sector, primary care services are generally found at free-standing clinics, birthing homes, and clinics operated by trained health care providers (i.e. doctors, nurses or midwives). There are also a significant number of higher level private hospitals that provide secondary and tertiary care. With the exception of community-based public health outposts (i.e. Barangay Health Stations and RHUs), the majority of health facilities are concentrated in the private sector (Table 2). 60 percent of health facilities accredited with PhilHealth are private health hospitals, clinics, and infirmaries (PhilHealth 2017). In addition to the service delivery points listed below, there

are over 3,000 pharmacies across the country; half of which are found in the National Capital Region and the remaining largely concentrated in urban areas. To address drug shortages in rural areas, the Filipino government created a second tier of drug shops – Botika ng Barangay – which operate without a licensed pharmacist (Romualdes, et al 2011). There are also over 16,300 Botika ng Barangay that are more broadly found in rural and underserved areas, offering a limited range of over the counter medicines that includes generic formulations of contraceptive commodities (DOH 2017).

**Table 2. Public and private facilities in the Philippines**

Facility Type		Public	Private	Total
Level 1	Barangay Health Station	20,208	0	20,208
	Rural Health Unit	2,592	0	2,592
	Infirmary/Clinics	322	309	631
	Birthing Home	632	798	1,430
Levels 2 and 3	Hospital	476	961	1,437
Total		24,230	2,068	26,298

Source: [http://nhfr.doh.gov.ph/Philippine\\_health\\_facility\\_statuslist.php](http://nhfr.doh.gov.ph/Philippine_health_facility_statuslist.php)

The Service Delivery Network (SDN) is a key public-private initiative run by the Filipino government to increase lower income populations' access to health services. Authorized by the Responsible Parenthood and Reproductive Health law, SDNs are established by the LGUs in coordination with the DOH specifically to increase access to FP and reproductive health. Specific to FP, LGUs should ensure that there are sufficient providers within their networks to cover the delivery of FP counseling, natural methods, and a comprehensive range of modern methods (i.e. oral contraceptive pills, condoms, injectables, subdermal implants, postpartum and interval IUD insertion, non-surgical vasectomy, and interval and postpartum bilateral tubal ligation). SDNs are created through a memorandum of understanding that stipulates the following arrangements:

- Reproductive health care services to be provided at each facility
- Provision of list of families or individual names to be assigned to the facility
- Total resource requirement needed
- Financing arrangements
- Recording and reporting of cases to the municipal, city, or provincial health officer
- Compliance with PhilHealth accreditation and other standards set by the DOH

USAID has actively supported the development of SDNs through the Private Sector Mobilization for Family Health 2 (PRISM2) project and three USAID regional projects (LuzonHealth, MindanaoHealth and VisayasHealth). PRISM2 helped establish over 50 SDNs in 36 provinces and independent cities, involving over 750 private and 1,200 public providers and facilities. SDNs are considered promising, however, they are fairly new and require more time to be completely rolled out and fully functioning. A key priority moving forward will be establishing strategies to sustain them without donor support.

## Current method mix

The overall contraceptive prevalence rate (CPR) among all women of reproductive age has grown slowly in the Philippines. Between the three most recent DHS surveys, the country saw a steady uptick in modern CPR due to an increase in short acting methods (SAM), mainly oral

contraceptive pills (OCP) and injectable methods. Use of long-acting and permanent methods (LAPM) remained relatively stagnant, and traditional methods declined slightly. Among modern users in 2017, half used OCP, 19 percent sterilization, 12 percent injectables, 9 percent intrauterine device (IUDs) and 4 percent condoms. All other modern methods – including implants – combined to account for approximately 2 percent of modern method users (Table 3) (Philippines Statistics Authority and ICF International 2014; Philippines Statistics Authority and ICF International 2018). 9 percent of women also use a traditional method, mainly withdrawal. Key informant interviews and focus group discussions with private providers indicate that implants quickly gained in popularity following their introduction in 2013 and thus likely currently represent a much larger share of use than the 2013/2014 DHS data shows. However, confusion around the TRO limited the continued growth of this method, especially for women who access their methods in the public sector. Since the 2017 DHS data collection period overlapped with the implementation of the TRO, it will be important to monitor how the method mix changes during the next DHS.

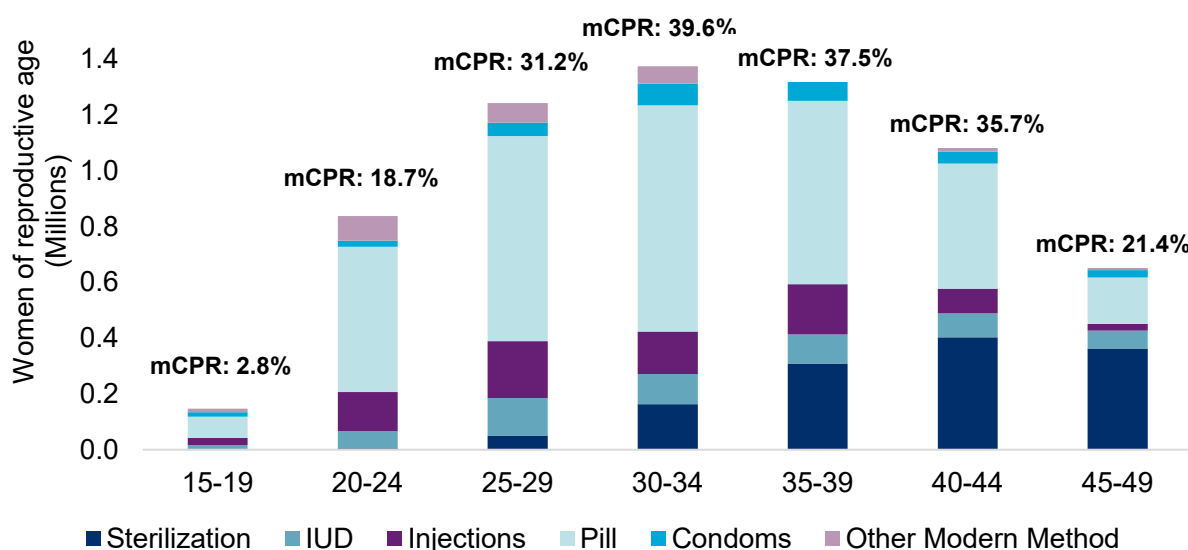
**Table 3. Changes in contraceptive method use among all women**

Method	2008	2013	2017
Any Modern Method	21.8%	23.5%	24.9%
Female sterilization	6.0%	5.4%	4.8%
Pill	9.9%	11.8%	12.7%
IUD	2.3%	2.2%	2.2%
Injections	1.6%	2.3%	3.1%
Implants	0.0%	0.0%	0.7%
Condoms	1.6%	1.4%	1.1%
Other modern method	0.4%	0.4%	0.3%
Any Traditional Method	10.9%	10.4%	8.7%
No Method	67.5%	65.4%	66.4%

Source: DHS 2008, PSA and ICF 2014; PSA and ICF 2018

Based on 2017 data, approximately 6.7 million women of reproductive age (15-49) use a modern contraceptive method. Modern CPR and method mix varies greatly by age (Figure 2). Women between 30 and 39 were most likely to use a modern method, both in absolute and relative terms. While there are more youth and adolescent (15-24) users compared to women aged 45-49 in absolute terms, modern CPR among the former is less than the latter. As expected, method mix shifts from short acting to long acting methods based on age. For all age groups under 39, OCPs are the most prevalent choice by a wide margin; use of sterilization and IUDs increases among older age groups. This corresponds to a shift in motivations for using FP, as well. The majority of women under the age of 29 want to delay pregnancy, while the majority of women older than 30 want to limit their births. As noted previously, this data likely undervalues the potential impact of implants since their introduction was halted due to the TRO; providers interviewed indicated that women, especially youth and adolescents in particular, found implants to be attractive methods during their brief introduction, and so there likely be shifts in this breakdown once the TRO is lifted.

**Figure 2. Method mix and modern CPR by age**



Source: PSA and ICF 2014

Other modern method includes lactational amenorrhea, standard days method, male sterilization, and implants

The 2017 DHS report highlights several issues concerning adolescent use of modern FP methods. Among adolescents (ages 15-19), overall use of any FP method is low (3.6 percent), although it is much higher among sexually active women. 36 percent of married adolescents and 31 percent of sexually active unmarried women use any method. There are significant differences in method mix, though. Married women use modern methods at much higher rates than sexually active unmarried women, who rely more on traditional methods. 83 percent of married adolescents who use any method choose a modern method, while only 41 percent of sexually active unmarried adolescents who use FP do. Married adolescents are most likely to use OCPs (16 percent), injections (6 percent), and IUDs (3 percent). Unmarried sexually active adolescents are most likely to use a condom as their main contraceptive method (6 percent) or an IUD (4 percent) (PSA and ICF, 2018). Similar patterns emerge for youth aged 20-24 as well.

## Policy environment for FP

The Philippines policy environment for FP is mired in a protracted and unresolved legal battle, with lingering uncertainty about contraceptive availability and access. On paper, there is much to support increased investments in FP. Chapter 13 of the National Development Plan is on the Demographic Dividend and sets a contraceptive prevalence rate (CPR) target of 65 percent by 2020. More importantly, the country passed the landmark Responsible Parenthood and Reproductive Health (RPRH) Law in 2012 after more than a decade of trying to do so. This law guarantees access to information and services on all FP methods in both public and private sectors and represents a departure from previous policy that encouraged natural FP in line with the Catholic Church's stance on FP. Since its passing, implementation of the RPRH Law has been delayed due to legal challenges led by religious groups who favor natural FP (summarized in Table 3). A Supreme Court decision in 2015 included a temporary restraining order (TRO) that prevented registration or renewal of all contraceptives in the country, but a court decision on May 26, 2017 interpreted the registration decision to apply only to two brands of implants, alleged to be (illegal) abortifacients.

The legal uncertainties have created confusion about what is and is not allowed regarding the procurement, distribution and provision of contraceptives. President Duterte issued an Executive Order in January 2017 that encourages LGUs to partner with the private sector to reduce unmet need. While LGUs are still required in theory to provide free contraceptives to the poor, they have not been budgeted the funds to do this. In 2016, the legislature cut a \$21m budget item for DOH to purchase FP commodities for the poor. A 2017 budget increase is pending. Even when funds are available, LGUs have great autonomy to decide whether to comply with this order. Stakeholder interviews indicate that many LGUs have refrained from doing so due to either religious opposition or fear of legal challenges from opposition groups.

Although the Supreme Court decisions on implants apply only to public clinics, and not private facilities, the legal rulings have had a chilling effect on reproductive health services throughout the country. Supplies have dwindled as the Food and Drug Administration (FDA) stopped evaluation and registration of contraceptives generally, and sex education is not being provided. In addition, several private providers who participated in focus group discussions as part of this assessment expressed confusion about whether or not the TRO applied directly to them.

**Table 4. Summary of RPRH Law and Ensuing Supreme Court Rulings**

Policy/Ruling	Summary Provisions and Additional Notes
<p><b>December 2012:</b> Responsible Parenthood and Reproductive Health Act of 2012 (RPRH law) or Republic Act No. 10534 signed into law First introduced in 2000, pro-natalist advocates vigorously debated and opposed for more than 12 years. Immediately upon enactment, dozens of lawsuits were filed challenging the law and delaying implementation.</p>	<ul style="list-style-type: none"> <li>● Provides that accredited health facilities shall provide a full range of modern FP methods</li> <li>● Mandates LGUs provide free contraceptives for the poor (estimated at 2 million women) and sex education be taught in schools</li> <li>● Mandates training for all FP service providers (doctors, nurses, midwives) in both public and private sectors through DOH accredited curricula, refreshed at least every 5 years</li> <li>● Maintains that abortion is illegal</li> </ul>
<p><b>2014/2015/2016:</b> Supreme Court strikes down eight provisions of the RPRH law, issues Temporary Restraining Order (TRO) enjoining sale of Implanon and Implanon NXT, directs FDA to adopt rules to screen and evaluate all contraceptive drugs and devices</p>	<ul style="list-style-type: none"> <li>● Decisions include sweeping language that prevents the FDA from granting or renewing certifications for all contraceptives pending process for opposing petitioners to provide evidence</li> <li>● Prohibits public clinics from procuring or distributing implants pending FDA review of evidence of abortifacient properties</li> </ul>
<p><b>January 2017:</b> President Duterte signs Executive Order 12 to spur the Supreme Court to lift its ban. Petition was filed with court in March 2017 with 300,000 signatures seeking a lifting of the TRO. <b>In May 2017,</b> Commission on Population issued a report that of total 43 registered contraceptive products, 29 have already expired, with all remaining due to expire in 2018.</p>	<ul style="list-style-type: none"> <li>● Aimed at enforcing the 2012 Act, the Order encourages LGUs to engage, collaborate and partner with civil society organizations and the private sector in attaining zero unmet need for FP in underserved areas.</li> <li>● All government agencies including DOH, National Youth Commission, are directed to implement interventions to support LGUs and civil society organizations in provision of FP services</li> <li>● PhilHealth is directed to ensure maximum benefits for FP</li> </ul>
<p><b>February 06, 2017</b> MOH issues Administrative Order 2017-0002</p>	<ul style="list-style-type: none"> <li>● The AO operationalizes the provisions in the 2012 RH law that (1) mandate the participation of NGOs and the</li> </ul>



prescribing procedures to certify private clinics	<p>private sector and (2) ensures free FP products and services for eligible individuals</p> <ul style="list-style-type: none"> <li>• Certification requirements to assure quality and safety of stand-alone FP clinics include (1) compliance with DOH training requirements, (2) provision of counseling to ensure informed choice, (3) mandatory referral system to DOH level 2 for surgical and complicated cases, (4) routine reporting, and (5) sign-off from DOH site visit.</li> <li>• Certified clinics will be eligible for free public supplies of contraceptives for eligible clients and reimbursement for services under PhilHealth.</li> </ul>
<b>May 26, 2017:</b> Supreme Court issues decision clarifying that registration ban intended only to cover Implanon and Implanon NXT, orders FDA to issue decision	<ul style="list-style-type: none"> <li>• FDA has deadline of 60 days to hear views of parties, issue a decision on implants. Significantly, this decision can only be reviewed by Office of the President, not courts. Timeframe for re-starting contraceptive registration uncertain.</li> </ul>

## Policy environment for reaching youth and adolescents

The 2012 RPRH law provides legal assurance that reproductive health information and services must be available for youth and adolescents. As noted in the table above, part of this effort includes the development of comprehensive sexual education programs that would be taught in schools throughout the country. Since the law’s passage, the Department of Health has worked with various partners, including Likhaan NGO and the Philippines Legislators Committee on Population and Development, to create new age-appropriate education programs. However, the Department of Education has been slow to introduce them in schools.

The RPRH law also codifies the need for parental consent for adolescents (19 years old and younger) to access FP services. This requirement eliminated previous grey areas in the law about when and where parental consent was needed. While the original law contained exceptions for adolescent women who had already had a child, the Supreme Court struck down this limitation in 2014. Key informants cited the age of consent as a key limiting factor for adolescent access to not only FP, but also HIV testing and treatment of sexually transmitted infections. They also indicated that there was movement in the Philippines Congress to lower the age of consent for HIV testing to 16; while some viewed this as a possible precedent to support a similar future effort for access to FP if teenage pregnancy rates continue increasing, others were more skeptical.

In addition to the RPRH law, the Philippines also developed a National Policy and Strategic Framework on Adolescent Health and Development in 2013. While this document deals with adolescent health broadly, it emphasizes the need to delay sexual initiation and provides a strong rights-based framework for increasing access to FP and other reproductive health services for youth and adolescents. The policy and strategic framework also emphasizes the need to improve providers’ skills to serve adequately and appropriately deliver care to adolescents.

Finally, the Commission on Population has submitted pending legislation to both houses of the Filipino Congress, the “Prevention of Adolescent Pregnancy Act.” The overall goal of the legislation is to reduce teen pregnancies by half and eliminate repeat births to adolescent mothers. If passed, the legislation would create a comprehensive program that would include interventions to increase access to health, education, and welfare services in an attempt to address conditions that lead to risky sexual behavior. Specific components include expanding

Teen Centers for Adolescent Health and Development nationwide, creating adolescent-focused information and service delivery networks, and implementing and expanding comprehensive sexual education programs in schools. The proposed legislation also confirms that “adolescents shall be allowed access to reproductive health services with proper counseling by trained service providers in public and private facilities.”

## **Regulation, oversight, and engagement with the private sector for FP**

The Philippines health system has a robust and well-functioning oversight structure. The Philippines Department of Health (DoH) licenses health providers to practice within the country. All cadres (doctors, nurses, and midwives) in both public and private sectors are required be licensed and trained in DOH-accredited curricula to demonstrate competency for any services provided. The DoH Bureau of Health Facilities and Services is also in charge of accrediting and licensing health facilities on an annual basis. The Traditional Medicine unit, now the Philippine Institute for Traditional and Alternative Health Care, an attached agency of the DOH supports the integration of traditional and complementary medicine into the national health care system. In addition, each cadre of health professional in the Philippines is licensed by a body authorized by the Professional Regulations Commission to adopt and maintain standards of practices. These include the Professional Regulatory Board of Midwifery, the Philippine Board of Nursing, and Board of Medicine. Doctors, nurses and midwives are all authorized to provide a range of FP services including injectables and IUDs, assuming they have received accredited training in the method. Integrated Midwives Association of the Philippines is currently working pursuant to a regulatory waiver to support the case for task-sharing the provision of implants to lower cadres of health workers through introduction of competency-based training on implants. The implant training and accreditation model have been recognized by the DOH (IMAP 2016).

Dual practice is generally proscribed under the Code of Conduct and Ethical Standards which provides that public employees are prohibited from engaging in private practice of their profession, unless authorized by law (Republic Act 6713, Philippines Code 1989). In the health sector, dual practice is permitted, common, and endorsed by DOH authorizations that permit private practice by government doctors as a retention incentive. Administrative Order No. 172 states “as an incentive and in recognition for their commitment to remain as members of hospital staff for a longer period and for continuous improvement of the health care delivery service of the faculty, private practice is allowed” (Policies and Guidelines on Private Practice of Medical and Paramedical Professionals in Government Health Facilities, 2001).

The DOH has a strong platform for engaging with the private sector in the policy development process at the national level. Its National Implementation Team includes representatives from IMAP and other provider associations to channel private provider feedback and comments on proposed policies and legislation. On the service delivery side, the government has emphasized the use of public-private partnerships (PPP). Under previous President Aquino’s Health Agenda 2010-2016, PPPs were prioritized as a strategy for achieving UHC. Under the Section 22(d) of the LGC, LGUs have full autonomy to exercise management of their economic enterprises including entering into joint ventures with NGOs and the private sector (Local Government Code 1991 Section 22(d); IRR Section 66). However, DOH representatives stated that most of this engagement takes place with larger franchises, associations, and hospitals; there is little engagement with individual, smaller clinics that operate outside of these groups due to difficulties identifying and reaching them.



## Key FP stakeholders

There are several key stakeholders in the Philippines FP market. In the public sector, the DOH is home to the Commission on Population, the main government agency responsible for leading and coordinating all FP programs and policymaking. The DOH Family Health Office works with the Commission and other stakeholders to develop policies, standards, and guidelines for the full range of family health programs, including FP. They also implement clinical trainings and other capacity building programs. DOH regional offices and LGUs oversee the network of public sector service delivery points. The Philippines Legislators' Committee on Population and Development (PLCPD) is a nonprofit organization that works with legislators in both houses of Congress to advocate for and draft FP-related policies and laws.

In the private sector, there are several service delivery organizations and associations (Table 5). In addition, the Philippines Obstetrical and Gynecological Society is a professional association focused on training, research, and advocacy for OB/GYNs. The Philippines Society for Responsible Parenthood (PSRP) is a nonprofit focused on training. PSRP is the primary institution accredited to train providers on the insertion and removal of implants. Due to constraints on their funding from UNFPA, PSRP has mainly focused on doctors and midwives who target lower income populations (i.e. those affiliated with a social franchise or NGO) and generally have not worked with the wider range of private providers.

**Table 5. Relevant private sector for FP service delivery organizations**

Organization	Year of Founding	Membership Size and Geographic Scope	Services
Likhaan	1995	Operates clinics in six low-income areas of Metro Manila and two community organizing programs	<ul style="list-style-type: none"> <li>• Provide free contraceptives at clinics</li> <li>• Worked with DOH and Department of education to develop comprehensive sexual education curriculum</li> </ul>
Integrated Midwives Association of the Philippines (IMAP)	1976	Over 131,000 members in approximately 150 local chapters	<ul style="list-style-type: none"> <li>• Builds on Philippines Midwifery Association, founded in 1947</li> <li>• Provides continuing medical education for midwives</li> <li>• Advocates on behalf of midwives</li> </ul>
Philippine League of Government and Private Midwives	1999	6 regional offices and 79 provincial chapters	<ul style="list-style-type: none"> <li>• Provides continuing medical education for midwives</li> <li>• Lobbies and advocates on behalf of midwives</li> </ul>
Mother Bless Birthing Clinics	2010	11 provinces with 58 clinics	<ul style="list-style-type: none"> <li>• Primarily offers MCH services, but also offers FP</li> </ul>
Population Services Pilipinas Incorporate (PSPI) / Blue Star	2008	267 franchised-midwives and 267 Clinics.	<ul style="list-style-type: none"> <li>• Local Marie Stopes affiliate</li> <li>• Offers quality sexual and reproductive health services</li> </ul>
Well Family	1997	20 provinces and includes 132 outlets. Currently has 80 members (when	<ul style="list-style-type: none"> <li>• Offers FP, maternal and child health, pregnancy tests, minor gynecological services, basic health services of a midwife (e.g., normal delivery, pre- and post-</li> </ul>

		supported by USAID they had over 300)	natal care, and immunization services)
Family Planning Organization of the Philippines	1969	15 active organizational chapters with 17 Community Health Care Clinics nationwide	<ul style="list-style-type: none"> <li>Local International Planned Parenthood Federation affiliate</li> <li>Offers integrated package of essential services on FP and reproductive health</li> </ul>

## Donor support for FP

In 2014, the Philippines was among the top ten recipient countries of donor assistance for FP and reproductive health and received the largest share of assistance in the Far East Asia region. The two largest donors were the United States (58 percent of this assistance) and UNFPA (20 percent) (Kates et al 2014).

USAID has invested in private sector FP programs for over two decades. Most recently, the last three project cycles have included bilateral programs with an explicit mandate to work with private providers: the Private Sector Mobilization for Family Health Project (PRISM) (2004-2009), PRISM 2 (2009-2014), and the current round of three regional projects (LuzonHealth, VisayasHealth, and MindanaoHealth; 2013-2018). These projects have provided financial and technical assistance directly to private providers and partnered with the government to increase provision of modern FP services (Table 5). While PRISM and PRISM2 had explicit mandates to focus on private providers, the most recent round of projects have tended to focus more on public facilities, with more limited outreach to bring private providers into SDNs. In addition, the mission previously engaged the global Banking on Health project to support a development credit authority (DCA) targeted at private midwives.

**Table 6. USAID/Philippines bilateral FP programs**

Project	Years active	Project focus areas and results
PRISM	2004-2009	<p>Three focus areas:</p> <ul style="list-style-type: none"> <li>Strengthen workplace FP and maternal health programs</li> <li>Develop commercially viable FP market</li> <li>build capacity of private providers to deliver high quality FP services</li> </ul> <p>Key achievements:</p> <ul style="list-style-type: none"> <li>Supported private sector to fill gaps caused by withdrawal of donor-procured commodities</li> <li>Delivered over 780,000 couple-years protection (CYP)</li> <li>Helped 211 private lying-in clinics obtain PhilHealth accreditation</li> </ul>
PRISM2	2009-2014	<p>Three focus areas:</p> <ul style="list-style-type: none"> <li>Increase and sustain private sector FP service delivery</li> <li>Increase use of quality FP products and services in the private sector</li> <li>Improve policy environment for private sector</li> </ul> <p>Key achievements:</p> <ul style="list-style-type: none"> <li>Delivered almost 1 million CYPs</li> <li>Increased private sector FP market share to 52.8 percent</li> <li>Streamlined PhilHealth processes; assisted 505 private midwives and 307 lying-in clinics to gain PhilHealth accreditation</li> </ul>

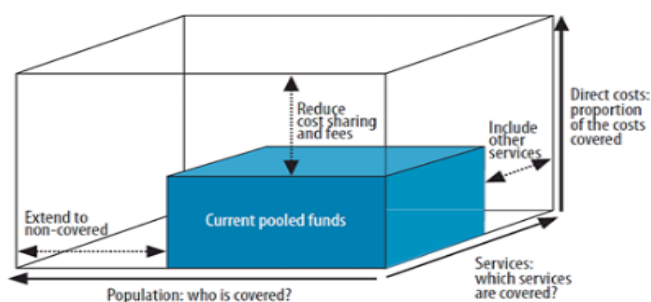
LuzonHealth MindanaoHealth VisayasHealth	2013-2018	Health system strengthening program targeting DOH sub-national organizations and LGUs in three geographic regions to support UHC and increased use of FP and other health services.
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UNFPA works to promote the achievement of Sustainable Development Goals 3 (health and wellbeing), 4 (education), and 5 (gender equality). Within this portfolio, UNFPA has two activities focused on FP and reproductive health. The first is Business Action for Family Planning Access, a partnership with the UN Foundation and Merck/MSD Pharmaceuticals to increase private sector participation in the delivery of FP information and services through workplace and community-based programs. The second is the U4U Initiative, a partnership with the Department of Education and Commission on Population to increase adolescent access to accurate information about their sexual and reproductive health.

## PhilHealth: In pursuit of universal health coverage in the Philippines

A common definition of UHC is that people are able to access the health services they need without financial hardship. According to the World Health Organization, UHC is achieved along three interrelated dimensions: population coverage, service coverage and financial risk protection (Figure 3).

**Figure 3. Dimensions of universal health coverage**



Source: World Health Organization

Since 1995, the Philippines government has operated the Philippines Health Insurance Corporation (PhilHealth), the country's national health insurance scheme, as its primary pathway to achieve UHC. PhilHealth aims to improve access to high quality health care. The scheme now covers nearly all citizens, and has begun to expand service coverage, recently increasing benefits for Indigent members for selected primary care services. PhilHealth has made remarkable progress with respect to the three dimensions of UHC, summarized below. The implication of this overall progress is that more Filipinos have greater access to FP and other health services covered under the PhilHealth benefit package, with less financial burden.

### Population coverage

In 2015, PhilHealth reported 93.4 million members, 92 percent of the eligible population, up from just 47 million members in 2010 (PhilHealth Annual Report, 2015). More than half of all members are indigent or senior citizens.

Sixty-one percent of PhilHealth members are fully subsidized, meaning they enroll with no out-of-pocket cost. The majority of these fully subsidized members are classified as Indigent (49%)

with premium costs shared by the national government and the LGU. The remaining subsidized members belong to other groups: senior citizens (eight percent), Sponsored members (two percent) and Lifetime members (also two percent). Pregnant women are also eligible to enroll in PhilHealth for no cost (PhilHealth Annual Report, 2015).

Thirty percent of PhilHealth members are formal sector households who pay premiums through mandatory payroll deductions. Premiums are split between employers and employees and are based on a percentage of salary; they range from PHP 2,400 to PHP 10,500 per family (WB Policy Paper 7258, 2015). Formal sector contributions represent 41 percent of all premium revenue (PhilHealth Annual Report 2015). People in the informal sector can voluntarily enroll in PhilHealth by paying an annual premium of approximately PHP 2,400 (PHP 3,600 if income exceeds PHP 25,000 – WB Policy paper 7258, 2015).

## **Service coverage**

PhilHealth endeavors to ensure quality care is geographically accessible across the archipelago. The scheme accredits nearly all public and private hospitals licensed by the DOH. As of the end of 2015, 2,553 outpatient clinics covering 99% of all LGUs were accredited to provide primary care service packages to Indigent members. Additionally, 2,981 providers were accredited for the maternal child health package, and 1,729 for directly observed treatment care for tuberculosis (TB-DOTS).

The Primary Care Package offered to Indigent members provides benefits for diagnosis and treatment, including medicines for 10 common conditions<sup>2</sup>. The Primary Care Package was initially available in designated public facilities, but in 2015 PhilHealth began accrediting private providers to enable greater access for these covered services. The Primary Care Package has been financed in part by the 2012 “sin” tax on tobacco and alcohol. An additional 13 service packages, called “Z benefit” packages, have been introduced by PhilHealth to expand benefits. Z-benefits currently cover higher-cost conditions such as common forms of cancer, kidney transplants and hemodialysis, certain heart surgeries, as well as emerging global health concerns such as Ebola.

PhilHealth covers counseling and provision of some but not all FP services. Notably, the removal of IUDs and implants is not covered. If a post-partum client chooses oral contraceptives, she can access the commodity for the first month from a pharmacy under the MCP package, after which the member must purchase pills out-of-pocket or obtain free commodities at a public facility (OCPs for are not covered under PhilHealth except for this one instance). PhilHealth is precluded by law from covering provision of FP methods to youth (19 years of age and younger), without documented parental consent. Similarly, the current TRO prevents PhilHealth from covering insertion of two implants, alleged to be (illegal) abortifacients.

## **Financial risk protection**

From 2000 to 2012, out-of-pocket health expenditure increased in real terms by 150%, with the sharpest increases in recent years; medicines account for about half of this increase (WB report 7258, 2015). Similarly, the incidence of catastrophic spending by households (at 10 percent of consumption) has tripled, to approximately 7.7 percent by 2012. Every year, 1.5 million families are pushed into poverty due to health expenditures. Still others simply forgo care due to financial barriers (DOH 2015). Despite this, PhilHealth provides a modest degree of financial

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<sup>2</sup> Asthma, acute gastroenteritis, upper respiratory tract infection, pneumonia, urinary tract infection, diabetes mellitus, hypertension, dyslipidemia, deworming and ischemic heart disease (PhilHealth Annual report 2015)

risk protection to members and members appreciate that PhilHealth benefits help reduce out-of-pocket expenditure for covered services, including those for FP, at the point of care.

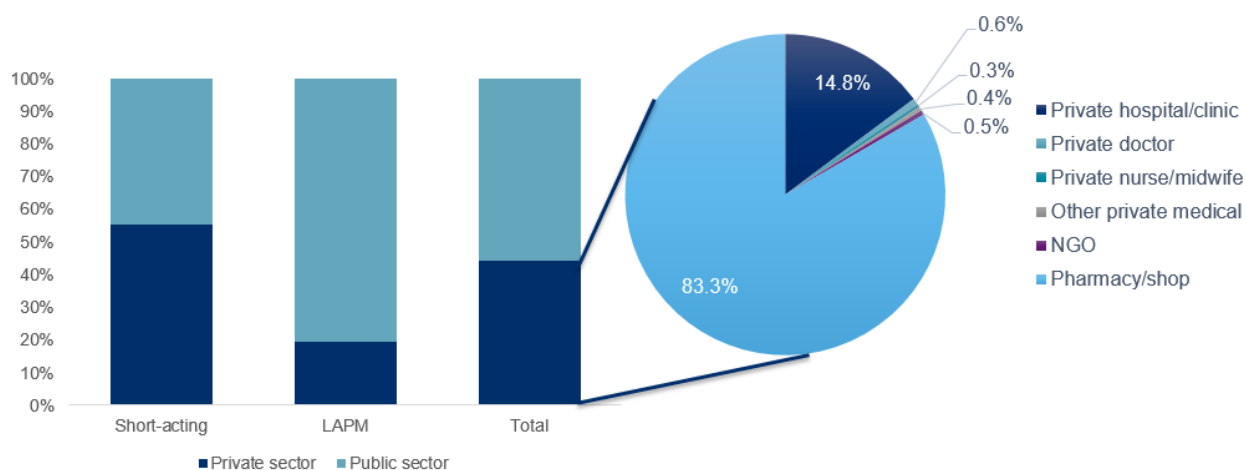
# Private providers' role in delivering FP services

While FP use has experienced little growth over the past several years, analysis of DHS data demonstrates that private providers are an important source of commodities and services. Interviews with key stakeholders highlight additional opportunities to further leverage private providers – especially nurses and midwives – to further increase access. In line with general tensions about serving adolescents, private providers' potential ability to accelerate FP use among younger populations is significant – but requires additional collaboration with public stakeholders.

## Sourcing patterns

The Filipino private sector is currently a major supplier of modern FP methods (Figure 4). Overall, the private sector is the source for just under half (44 percent) of modern method users due to the dominance of short acting methods. Within the private sector, private pharmacies are the largest single source of modern contraceptives, in line with the method mix and the high use of OCPs. As of the last DHS, public sites dominated the provision of LAPM.

**Figure 4. Sources of modern methods**

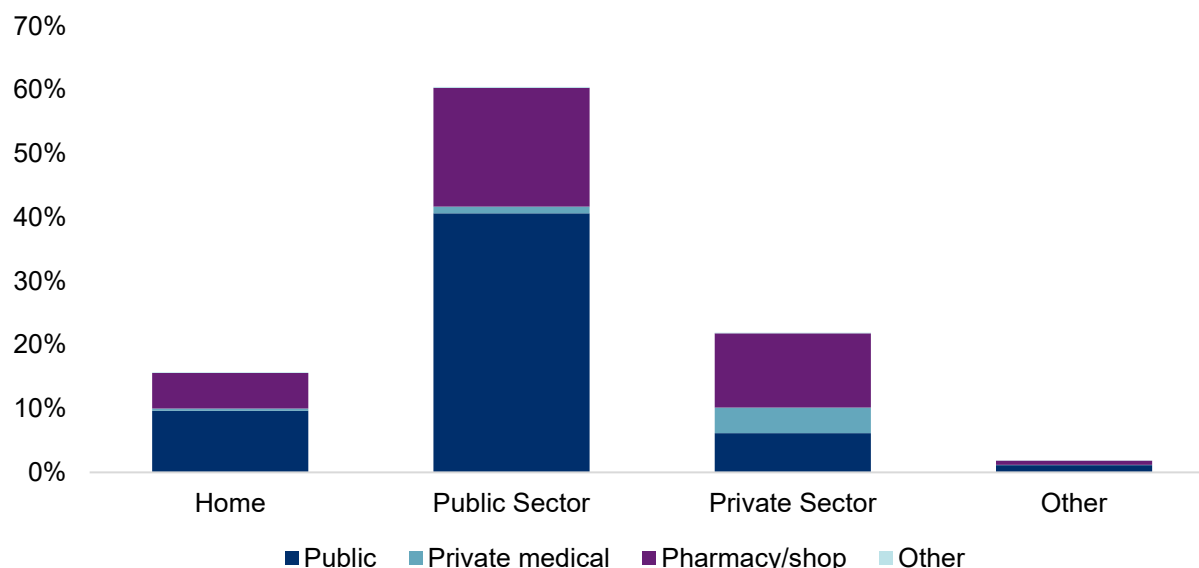


Source: PSA and ICF 2014

There have been several reforms during the intervening years that may have shifted this split. Specifically, PhilHealth has begun accrediting private providers under its Primary Care Package and has begun covering implant and IUD insertion. These reforms decrease out of pocket costs of receiving LAPM at private facilities for PhilHealth members and therefore could remove some financial barriers to seeking these services in the private sector. However, private midwives noted that they still experience limited options for training on long-acting methods. Specifically, PSRP's mission to train NGOs to deliver implants to low income populations has largely left-out for-profit providers. Without training from an accredited institution, providers cannot register with PhilHealth to receive reimbursement. As IMAP and other organizations gain accreditation to offer these trainings, private providers should have more options and opportunities to get trained, accredited with PhilHealth, and begin offering these services.

DHS data also reveals the importance of delivery sites for accessing FP (Figure 5). Women who give birth at home, public facilities, and private facilities all access their modern FP methods from a range of public and private sources. However, women who give birth at a private facility get their method at private sources – specifically private clinics and delivery homes – at much higher rates.

**Figure 5. FP source by location of delivery**



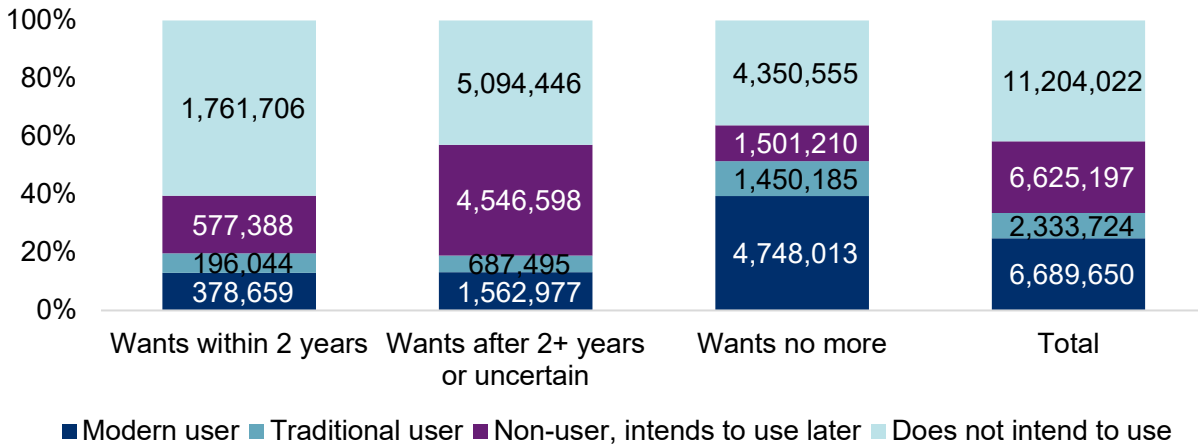
Source: PSA and ICF 2014

Additional analyses of the 2013 DHS data demonstrate the widespread importance of the private sector for different population groups. Across age groups, the private sector – including clinics, hospitals, NGOs, pharmacies, and shops – serves the majority of under the age of 34: 60.5 percent of the approximately 880,000 youth and adolescent (ages 15-24) women and 56.9 percent of the 2.5 million women ages 25-34. Even though women 35-49 are more likely to access their FP method at a public source (mainly due to the prominence of female sterilization among this group), the private sector still serves 42.8 percent of them (PSA and ICF 2014). For youth and adolescent women, in line with their current high use of OCP, pharmacies are the single largest source (PSA and ICF 2014).

## Potential market

The potential FP market is much larger than current use. Although modern CPR is low at 25 percent of all women of reproductive age, approximately 89 percent of women do not want a child soon or at all, regardless of whether or not they currently use a modern method. Among women who want to delay their next birth or limit them altogether, only 13 percent and 39 percent respectively are using a modern method. Between these two groups of women, there are approximately 6.0 million non-users who intend to use a modern method later and 2.8 million traditional users who could potentially switch to a more effective modern method (Figure 6).

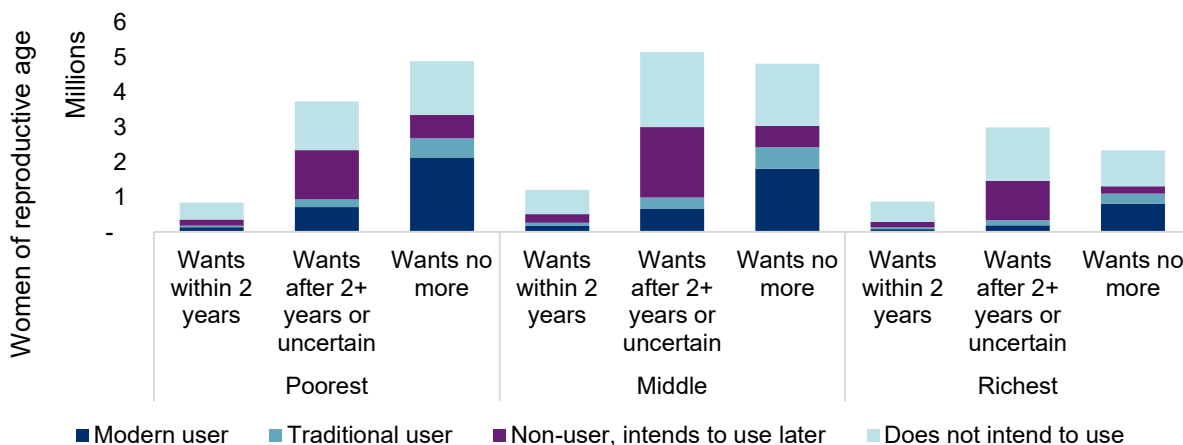
**Figure 6. Use and non-use by desire for more children**



Source: PSA and ICF 2014

Examining this population more closely reveals additional information about the potential size of the FP market in the Philippines. Segmenting the market by fertility preference (wants a child now; wants after two years; wants no more) and wealth status (poorest 40 percent; middle 40 percent; and wealthiest 20 percent), reveals several interesting findings (Figure 7). The desire to limit compared to delay pregnancy changes shifts based on income. The largest group of women in the poorest 40 percent wants no more children; women in the middle 40 percent and upper 20 percent indicate a slight preference for spacing. Across all income segments, the vast majority of women want to either delay or limit their next pregnancy. Women who want no more children are also the most likely to use modern method. The largest absolute numbers of women are those who want to delay their next pregnancy by at least two years and have no intention of using an FP method (approximately 5 million women). Reaching these groups would require intensive behavior change efforts that might not yield the desired impact. A more ripe group for interventions are the approximately 4.5 million women who want to delay their next pregnancy by at least two years and are not currently using a modern method and intend to do so later: 1.4 million women in the poorest group, 2.0 million in the middle group, and 1.1 million in the wealthiest group.

**Figure 7. Use and intention to use by fertility preference and wealth**

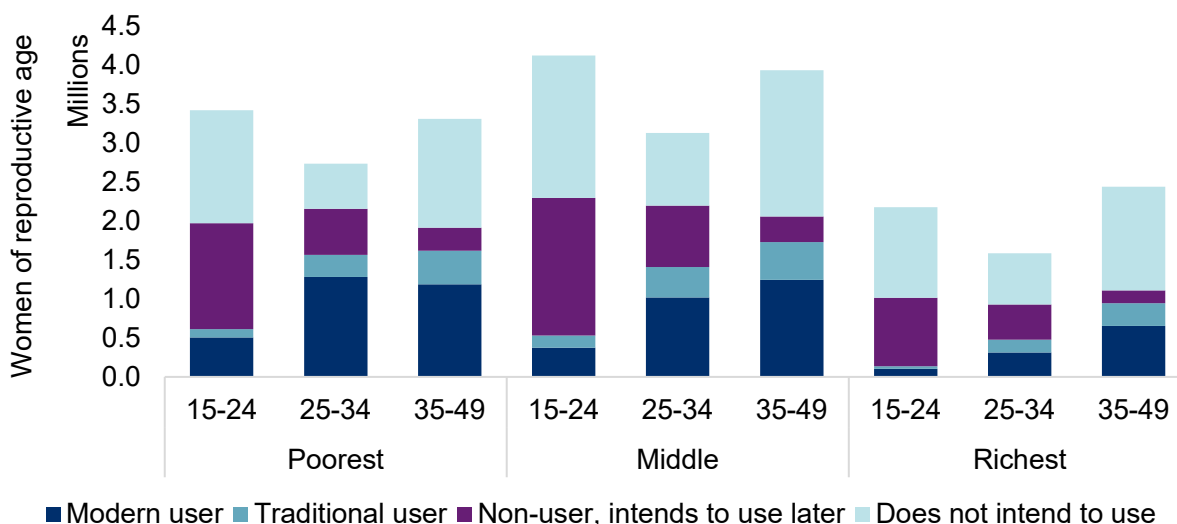


Source: PSA and ICF 2014



A second way to segment the market considers women’s age and socioeconomic status (Figure 8). This approach emphasizes an additional feature of the Philippine’s FP market: the importance of youth and adolescents. For the poorest 80 percent, women between the ages of 15 and 24 make up the largest age group in the market. Across all income groups, these youth and adolescent women exhibit the lowest use of modern methods. Non-users in this age group are also much more likely to state an intention to use later: 1.4 million women in the poorest 40 percent, 1.8 million in the middle 40 percent, and 1.2 million in the wealthiest 20 percent. The large numbers of women in the middle and richest tertiles who are either using a traditional method or no method (and intend to use later) present a significant opportunity for the private sector, as these women likely have the ability to pay for FP services.

**Figure 8. Use and intention to use by age and wealth**



Source: PSA and ICF 2014

Importantly, the majority of women who do not use a modern method even though they do not want to become pregnant are motivated by reasons related to their current situations. Primarily, either they are not married (44 percent) or not having sex (32 percent); only a limited number cite fear of side effects (16 percent) and high costs (five percent) (PSA and ICF 2014). These motivations are important to note because they are situational and can change relatively quickly, turning non-users with no need for FP into users. It therefore is important to ensure that an adequate number of providers – especially in the private sector given its current importance – are adequately trained and equipped to meet this potential demand.

## Role of private providers

The PSA intended to answer key questions about the private sector’s role, including: “who are the major players in FP service delivery? And are there any missed opportunities?” As shown by the DHS data, pharmacies are the predominant source for modern FP products in the Philippines (81 percent), followed by doctors (18 percent) and to a lesser extent, midwives (1 percent). FGD participants indicate that private providers offer a range of commodities (combined oral contraceptives, progestin-only pills, injectables, IUDs, condoms, and implants), although the degree to which they offer specific methods varies by cadre (Table 6). Although these figures are not a scientific sample, they do demonstrate that all cadres—if properly trained and accredited—are able to provide most modern methods. Notable exceptions include bilateral

tubal ligation and non-surgical vasectomy, as these services must be delivered in a hospital setting. As a result, most nurse-midwife and midwife-owned clinics cannot deliver them. Across all three cadres, injectables, oral contraceptive pills, and IUDs are the most widely offered. Although private doctors and midwives have not been affected by the TRO with regards to implants, many providers access the commodity from the government given current restrictions on delivering the method through public facilities. Emergency contraception is not available on the market as it was de-listed in 2001. The TRO, which limits the registration of FP products would need to be lifted in order to make this product available. DKT, the primary supplier of FP products in the private sector would likely be a candidate to introduce a product once the TRO is removed.

**Table 7. Percentage of FGD participants offering specific FP methods**

Method	Doctors	Midwives	Nurses
Injectables	50%	91%	54%
Pills	83%	86%	62%
IUD	50%	86%	46%
Implants	8%	52%	54%
Condoms	58%	43%	31%

An important element to FP provision currently is accreditation with PhilHealth as FP services and some products are covered. Accreditation by midwives is now widespread. All but one of the 24 midwives who participated in SHOPS Plus FGDs were accredited with PhilHealth, and midwife participants reported the accreditation process to be generally reasonable to comply with.

## Doctors

In the Philippines, private doctors tend not to provide standalone FP services. FGD participants indicated that most women who receive their method from a private doctor do so in a postpartum setting or as part of a larger package of reproductive health services. FP is not the primary reason for seeking services from an OB/Gyn; most clients tend to come for a gynecological concern and the doctors counsel on FP as part of that larger service. Doctors did report seeing in an increase among their clients in demand for post-partum FP to space births. FGDs and KIs indicate that doctors are most likely to prescribe OCs over any other method. This practice is driven both by a belief that patients prefer this method and by the medical indications the client is experiencing. Several doctors noted that Implanon, which they sourced from the DOH, had become the second most requested method prior to the TRO; however,

*“nung nagkaroon ng TRO, yung mga patients namin nag back out, natakot sila”  
 (“When the TRO was issued, many patients backed out. They were scared.”)*

– NCR doctor

*“Before, Implanon was the 2nd most provided FP method in our facility, but there is a restraining order.”*

– Davao private doctor

these doctors cited difficulties in continuing to procure implant commodities. Beyond implants, doctors face other constraints to providing the full range of modern methods. Many cited lack of training as a key obstacle for IUDs and commodity access challenges related to one-month injectables.

In the Philippines, many private doctors, primarily OB/Gyns, operate within private hospitals. Because of this setting, they tend to serve more

middle income and wealthier clients; private doctors participating in FGDs indicated that, on average, less than one in four FP clients were lower income. They also serve a wide range of women in terms of age. FGD participants indicated that approximately 1 in 4 of their FP clients is either a youth or adolescent. This trend is partially the result of a combination of the importance of post-partum FP and legal restrictions that dictate pregnant adolescents (along with older women and multiparous women (>5 births)) go to a hospital for their delivery, as they are considered high risk. Doctors did note that women who came to their facilities only for FP tended to hear about the services from a neighbor or friend.

Although doctors tend to be PhilHealth accredited, they were less familiar with many of its details than other cadres, due to their patient mix including wealthier households with greater ability to pay out of pocket, and proportionately higher amounts of revenue coming from private health insurance programs such as health maintenance organizations (HMOs). For example, few of the FGD participants knew that PhilHealth had introduced a standalone FP package. They also were less familiar with the payment terms and tended to underestimate how much PhilHealth paid for various services. One participant believed that it only paid P50 for an IUD insertion when the reimbursement rate is actually set at P2,000. Because many private doctors work in a hospital setting, they also tended to be less familiar with PhilHealth's day-to-day administrative challenges and opportunities.

## Midwives

There are over 170,000 midwives registered with the DOH with roughly about a third (~66,000) actually practicing. Rural health midwife placement programs have helped to distribute midwives across the country. Some midwives reported being one of a handful in their areas. However, opportunities for reimbursement by PhilHealth have increased competition. Most midwives operate a birthing home where they attend to pregnant clients. They tend to operate on an independent basis with standalone practices but there are nascent experiences with midwives grouping their clients for efficiencies. For example, DKT reported seeing midwives informally pool themselves in order to receive bulk discounts on commodity procurements.

In addition to maternity services, midwives cater to standalone FP clients (about 10 percent of their business). For both post-partum and standalone FP clients, midwives offer a wide range of products and services (OCs, injectables, IUDs, and implants), with the exception of implant removals and bilateral tubal ligations which are considered surgical procedures and therefore must be performed at a hospital. In FGDs, midwives' views on specific methods varied greatly. In Davao, respondents indicated that interval IUDs were a widely delivered method; with one stating that they were motivated to begin offering this method in part due to the high PhilHealth payment. In the other regions, midwives notes that they did not provide a large number of post-partum IUDs due to a combination of lack of training, lack of confidence in their skills, and low acceptor rates. Many midwives noted that implants had gained in popularity and were their top choice for breastfeeding mothers. However, midwives outside the National Capital Region noted that they have had trouble accessing implant commodities due to delays in receiving the post-training certificates that are necessary for PhilHealth accreditation. In Cavite, where private midwives treat a significant number of working mothers, FGD participants indicated that injectables were the most popular method due to their convenience. For both implants and

*“For an entrepreneurial midwife, new PhilHealth requirements are not a problem. For those who maintain the mind of a service provider, it will always be difficult”*

~ KII Marie Stopes

IUDs, lack of training was the number one cited main barriers to greater provision. For injectables, midwives cited supply issues, primarily for the one-month version, as the main constraint.

Many practicing midwives, especially those operating within a network or franchise, are currently accredited with PhilHealth. For example, 146 of the 165 midwives in the Blue Star Filipinas network have received accreditation. Key informants reported that in Region 3, a majority of the 152 registered midwives are accredited. PhilHealth accreditation has been a game changer for midwives. Reimbursement rates are generous and in most cases far exceed what midwives previously charged clients. However, beginning in 2018, birthing centers will be required to hold a license to operate (LTO) issued by the DOH, in order to have accreditation renewed with PhilHealth. The LTO stipulates that each center have a minimum of 50 square meters total space. Key informants estimated that approximately half of licensed birthing facilities have so far obtained a LTO from the DOH. For some midwives who own and operate smaller spaces, the cost to renovate may be too steep; for those who rent smaller spaces, the minimum space requirement may require relocation, which may be infeasible for financial or other reasons (e.g., distance from their existing client base). In the FGDs and KIs conducted, midwives expressed concern about impending changes to the accreditation requirements that affect them. Some were hopeful that numerous delays in implementing the LTO requirement would continue. Others felt that they may be exempted from the requirement due to how long they have been in operation. Given the financial windfall that many of the midwives experience as a result of PhilHealth, planning for meeting LTO requirements is a wise decision and worth the required investments.

## Nurses

Despite official records, key informants indicated that there are over 1 million nurses in the Philippines serving in both the public and private sector. Nurses ultimately seek to work in hospitals with the ultimate goal of obtaining an overseas opportunity in Canada, Middle East, New Zealand, among other countries. The current over supply of nurses in the Philippines (due to limited number of positions open) combined with low salary rates (nurses in private sector earn 10,000 pesos per month) has forced many qualified nurses to seek employment in other sectors. The burgeoning BPO industry has been one attractive option given pay (30,000 per month), but they are not applying their nursing skills or knowledge in these jobs.

*“Implant is progestin lang. pwede sa breastfeeding. May FP na siya paguwi.”  
[Implant has progestin, so it can be given for breastfeeding clients. She already has FP method when she leaves.]*

*-Quezon City private midwife*

Nurses in the Philippines are regarded as support to doctors and not as a service delivery provider. This perception has limited their participation as a FP service provider. While nursing law states that properly trained nurses can insert and remove implants and IUDs, PhilHealth has not yet included them as an accredited provider for IUD and implant packages, and they therefore do not have the same financial incentives that midwives have to expand their provision of these services as patients would have to pay out of pocket. Focus group participants included a few nurse-midwives who indicated that, possibly as a result of how they are perceived, there is not strong demand among their clients for FP services. Because of that lack, they do not have many opportunities to practice their skills and are uncomfortable with IUD and implant insertions, even when clients request the service.

*“Skills yan eh. For you to learn more, kailangan madami eh. Sa 20 patients na nanganak, di naman magpapalagay kaya difficult ma continue yung training mo and skills” [“It’s about skills, for you to learn more, you need to do more insertions. In 20 patients who give birth, none would want IUD insertion, so it’s difficult to have skills or apply what you learned in training.”]*

*-Davao private nurse*

FGD participants and key informants indicated that nurses would be interested in setting up their own practices if they could make them financially viable. PhilHealth has indicated that guidelines to accredit nurses as providers are in the process of being developed. In addition, the DOH issued an Administrative Order in February 2017 that provided guidelines for the certification of free-standing FP clinics; this order allows

for providers, including nurses, to own and operate such clinics and would help address perceptions that FP is only for post-partum women. PhilHealth aims to begin accrediting stand-alone FP clinics in 2018. These two developments could help legitimize nurses as independent service providers – and not just assistants to doctors – as well as create a financial incentive for nurses to utilize their clinical skills rather than joining the BPO industry. If nurses take advantage of these opportunities, they could create new convenient outlets that help reach non-postpartum FP clients and support increases in overall mCPR.

## Reaching youth and adolescents

One key population of interest for this PSA were youth and adolescents. Focus group discussions and key informant interviews with private providers revealed that the first point of entry to FP information for most adolescent females is after they have become pregnant and during post-partum visits. Efforts to prevent teen pregnancies are impaired by limited links between information campaigns and trained providers. Few programs focus on preventing first pregnancy. Standards of care dictate that pregnant women under the age of 18 must be referred to a hospital since they are classified as a high risk pregnancy; therefore, private doctors and midwives who own smaller clinics are not supposed to attend these births. Given this existing dynamic, private doctors and midwives are even more limited in their ability to serve adolescents. As DHS data indicate that women who deliver in the private sector access FP there at higher rates than other women (Figure 4), this restriction limits private providers’ ability to reach adolescent mothers.

Interviews with staff at teen health kiosks indicated that adolescents will often prefer private providers over LGU facilities due to perceptions about greater privacy. FGD participants noted a similar preference, with one private doctor stating:

*“Ayaw nila doon kasi mabisto sila. Maybe, they come here incognito kasi di sila kilala. If you go to your province, everyone knows everything. If you go to the health center, i-chismis ka ng midwife. Yung anak ni ano, nanghingi ng pills” (“They don’t want to access [in a public clinic] because people will find out. Maybe, they come here incognito because no one knows them. If you go to the province, everyone knows everything. If you go to the health center, the midwife may spread that the child of someone went to the facility to ask for pills.”)*

This preference could present a key opportunity to increase access to reproductive health information, especially since FP counseling is not subject to the parental consent requirements



included in the RPRH law. However, provider bias is still a challenge. One private midwife participant in the SHOPS Plus focus group discussions strongly disagreed with giving FP methods to adolescents, stating:

*“ang isip ng mga bata, tulog, tapos gigisingin mo. Through curiosity, marami ang mag try at magkamali dyan.” [If you awaken the minds of the youth, they will be curious. Many will try {engage in sex} and many will make mistakes].*

Private providers face additional capacity challenges to serving youth and adolescents. Stakeholders reported that adolescent health is not a focus – or even included – in most medical training programs. As a result, there is a lack of adolescent-friendly providers in both the public and private sectors. Stakeholders indicated that pediatricians are often tasked with serving this population, but that they do not have the skills or familiarity to do so, especially when it comes to FP counseling. The DOH and donors have developed a number of resources for increasing the number of adolescent-friendly providers. The DOH has introduced Adolescent Job Aids (AJA) to assist public providers. The Society of Adolescent Medicine of the Philippines (SAMPI) received UNICEF funds to develop a five module video training program for adolescent health. The DOH has also developed four standards for ensuring adolescent-friendly care (DOH 2013b):

- Standard 1: “Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and obtain services from it.”
- Standard 2: “The services provided by health facilities to adolescents are in line with the accepted package of health services and are provided on-site or through referral linkages by well-trained staff effectively.”
- Standard 3: “The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable.”
- Standard 4: “An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services.”

Donors have also sponsored training providers to conduct *Usapan*. *Usapan* are structured facilitated group discussions designed to change behaviors. PRISM2 previously trained over 500 private midwives to lead *Usapan* sessions targeted at different audiences, including youth and adolescents (PRISM 2014).

These tools have had limited reach into the private sector. Key informants indicate that only a limited number of private providers have been able to access trainings on the AJA, standards for adolescent-friendly care, and adolescent-focused *Usapan*. Adolescent and youth advocates also stated that the AJA are viewed as overly clinical and make providers overly reliant on a “checklist” approach to care.

SAMPI conducted formative research as part of the development of the UNICEF-funded training videos. Their findings indicate that adolescents view provider communication styles and lack of privacy as the biggest barriers to accessing care. Addressing these concerns does not require costly renovations or expensive investments. DOH and donors can use existing resources as a strong starting point for increasing the number of providers trained to deliver adolescent-friendly

care. For example, the DOH standards could be used to accredit private providers to participate in the adolescent-focused information and service delivery networks proposed in the pending *Prevention of Adolescent Pregnancy Act* (similar to what was previously done for TB-DOTS program). Expanded access to both AJA and the SAMPI-produced video training sessions can teach private providers how to effectively counsel and interact with adolescent clients. Expanded use of adolescent *Usapans* or adolescent-only days at private facilities can create additional sites where adolescent clients can access information and services in privacy.

## **Demand creation efforts among youth and adolescents**

The 2013-14 DHS results indicate that the most popular methods among youth and adolescents are short acting methods – primarily OCP. Key informant interviews with providers indicate that the majority of adolescents use OCP due to their ability to easily access them at pharmacies. However, these same providers stated that their adolescent clients actually would prefer to use an injectable or implant method for reasons related to increased discretion and convenience. Adolescents believe that they are less likely to be caught using these methods, and therefore less likely to face social stigma for being sexually active.

Effective outreach and demand creation is a key step in increasing youth and adolescents use of FP services. To date, there have been limited efforts to provide targeted comprehensive information on FP to this audience. The USAID-funded CHANGE project has implemented a series of nationwide radio and TV campaigns that feature both broad and method-specific messages. The project's work targeting youth and adolescents is limited primarily to supporting DOH and LGUs to prepare an adolescent and youth reproductive health campaign focused on preventing a second pregnancy among out-of-school young mothers.

While there have been delays implementing comprehensive sexual education programs nationwide, eleven high schools in Region 4A have established teen health kiosks with support from the LuzonHealth project and the region's Department of Education. These kiosks, staffed by trained peer educators, provide a private space for students to seek guidance and information—but not any products or services—on a wide arrange of health issues, including teen pregnancy. Stakeholders involved in the efforts to launch and run these kiosks are generally positive about their approach; however, they lack data on their ability to change behavior on a large scale. For the most part, these programs focus on delaying sexual initiation and do not counsel on specific FP methods. When needed, mainly in cases where a student is already pregnant or thinks she may be pregnant, the kiosk volunteer will refer them to a local health facility, primarily the local public clinic or RHU. Even though key informant interviews revealed that parents often prefer to take their pregnant daughter to a private facility for privacy-related reasons, Department of Education Region 4A records indicate that only two of the eleven kiosks have formal referral relationships with private facilities.

While comprehensive sexual education programs in schools have stalled, the Commission on Population and international donors have funded more limited efforts. Key informants implementing awareness raising campaigns stated that their formative research highlights that adolescents recognize the role that parents should play in these efforts, but parents do not feel comfortable with their ability to provide information or support. This same research indicates that adolescents would prefer to get reproductive and sexual health information from a trained clinical professional, but that they would prefer not to go to a facility to access it.

These insights have informed the design of U4U, a multi-pronged campaign developed by the Center for Health Solutions and Innovations Philippines. The prong consists of “Teen Trail” edutainment programs held in schools or local communities that bring together approximately

200 adolescents to educate them on reproductive health campaign. Each program is broken up into six 30-minute sessions that are led by peer educators and student leaders. For reproductive health, these programs focus on delaying sexual initiation and educating attendees about condoms, HIV, and sexually transmitted infections. The content does not currently cover other methods due to a lack of providers adequately trained in adolescent-friendly care to whom the program could refer participants for teen-friendly services. To date, there have been over 850 “Teen Trails.”

The call to action at these sessions refers attendees to the second prong of the U4U campaign: a phone line where teens can access more information about teen pregnancy, gender-based concerns, sexuality, and other topics. The line does not include any method-specific messages, again due to a lack of adolescent-friendly providers.

The final campaign prong uses social media, primarily Facebook and YouTube. Rather than acting as a straightforward information portal, U4U posts videos and engages in dialogue through comment sections. U4U staff credit this approach with their social media strategy’s success: the program’s most popular video (“How does a girl get pregnant”) has over 500,000 views and its Facebook page has over 600,000 followers. This channel has the potential to achieve significant scale. As of 2013, over 78 percent of youth and adolescents owned a cell phone, 58.9 percent used the internet, and 53.1 percent had a social networking account (DRD 2014).

U4U was initially funded by UNFPA and has now transitioned mainly to the Commission on Population. The Commission is working with the Department of Education to integrate the program into schools nationwide and estimates that this will take place sometime in 2018. In addition, the Commission on Population is supporting the development of complementary “Parent Trails” to equip parents with the skills and knowledge to support their children to access accurate and needed FP services.

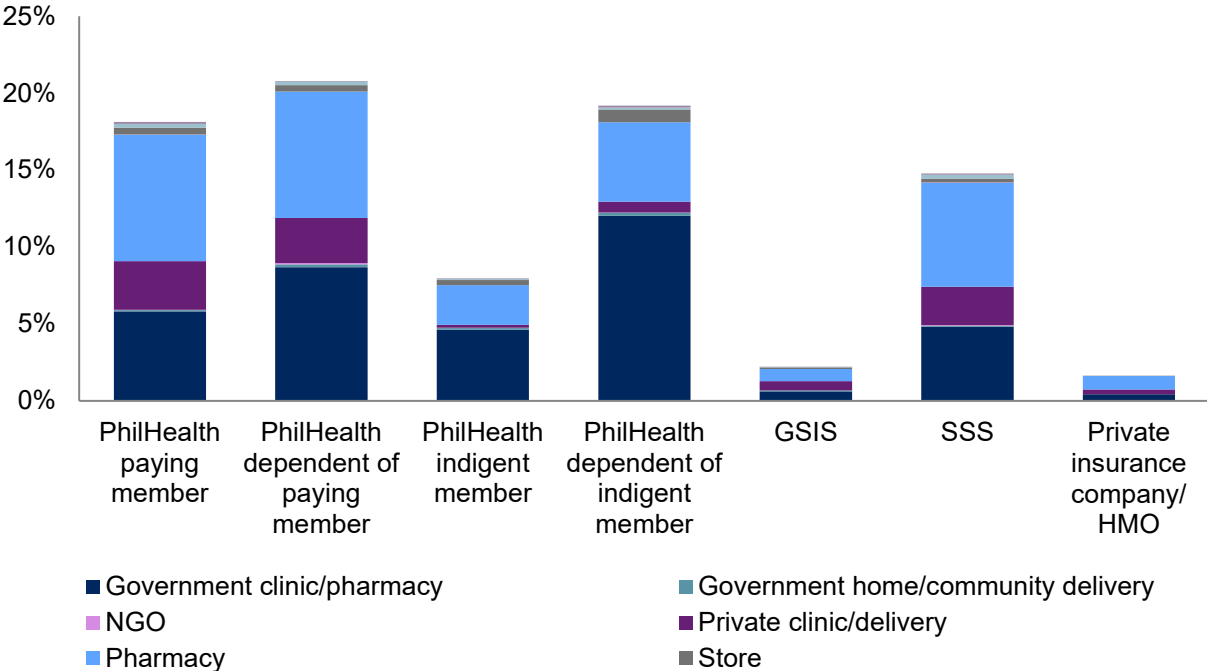
Moving forward, increasing youth and adolescent FP use will require innovative approaches that learn from and build on the successes of these efforts to reach youth with FP information and services.



# Health financing opportunities and barriers

The infusion of financing derived from PhilHealth’s expansion has reshaped the entire Filipino health system. As a significant source of revenue for providers, PhilHealth offers significant financial incentives that shape what FP services are delivered, and by whom. The private sector also serves the majority of women who are enrolled as a paying member or dependent of a paying member in PhilHealth, or as members of a private health insurance program, including HMOs (Figure 9). Of the major insurance coverage types, only Indigent members of PhilHealth are more likely to go to a public rather than private source for FP (PSA and ICF 2014). While much smaller in scale, private HMOs also offer an opportunity to reach more upper income and formally employed women with FP services, given the right interventions.

**Figure 9. Source of FP by insurance coverage**



## PhilHealth

In general, FP providers interviewed during the assessment were satisfied with PhilHealth and recognize the important contribution it makes in advancing the Philippines toward UHC. As PhilHealth coverage expands, its share as a purchaser of health services, including those for FP, in the Philippines will grow. In 2016, the scheme paid out PHP 100,752.5 million in benefits; in 2014, the last year this statistic was available, PhilHealth spending represented 14 percent of total health expenditure in the Philippines, and 45 percent of total government expenditure on health (Philippines Statistics Authority 2016b). Similarly, PhilHealth represents an increasing and material proportion of private provider revenue. For example, Fe del Mundo Medical Center

estimated that PhilHealth represents 25 percent of its payer revenue, now a slightly higher share than that paid by HMOs (23 percent).

The amount of a claim that is covered by PhilHealth will vary, depending on the services provided, the provider's charges for those services, the member's status (e.g., Indigent) and so on. Key informant private providers estimated that PhilHealth covers

*"We need to either lower prices at private hospitals while maintaining quality, or increase prices at public facilities and increase quality – we can tackle this problem from either, or both sides"*

*~ PhilHealth Manager*

on average 15-40 percent of their billed charges for health services. PhilHealth, on the other hand, reports that its "support value" is 50 percent on average (PH Annual Report statistics 2016). The key drivers of out-of-pocket spending are exclusions or limits to PhilHealth benefits for medicines and commodities and inpatient services (including more expensive hospital accommodation in semi- or fully private rooms instead of a hospital ward). Low-income members cope with these financial shocks in various ways. For example, they might borrow from friends and family, and arrange installment payments with the provider. Differences in out-of-pocket spending across income groups are stark: the 2012 mean health expenditure by the wealthiest income quintile was approximately 24 times higher than that of the poorest quintile.

In recent years, the PhilHealth has focused on increasing enrollment, expanding benefits and promoting quality through accreditation, including for FP services. Given the increased enrollment and rising claims costs, efficiency measures (such as case rates and capitation), enabled by electronic processes, will likely become increasingly emphasized by the scheme. Plans by PhilHealth to expand covered services and to increase financial risk protection are broadly recognized to also require additional financing, most likely through premium increases paid by the government for Indigents and other subsidized groups, and additional cost-sharing at the point of care. By law, Indigent members must receive the lowest premium. This means that premiums must also rise for other members and employers, a complicated public policy issue with significant financial implications. Thus, the rate at which PhilHealth benefits for FP and other services may be expanded is uncertain, and very dependent on a political, economic and other factors.

## Provider payment

Interestingly, the Primary Care Package is the first foray by PhilHealth into prospective, per-member payments to providers for these services, also known as capitation. Capitation payments are based on enrolment and do not fluctuate based on services utilized – capitation is a different payment mechanism than fee-for-service, which triggers payment by use of services. Capitation payments are currently PHP 500 per family per year. Payments are routed to the LGU, which then pays the RHUs, which in turn shares the payment among providers, with 50 percent going to doctors and remaining amounts split among others such as health workers. Compensation at this level may be inadequate to motivate quality care and productivity from public facility doctors and encourage them to seek dual practices, since income at private clinics can be considerably higher. As a next step, PhilHealth is considering expanding the Primary Care Package benefits to cover diagnostics and medicines and to attract additional (private) providers who are currently not accredited. The capitation payment would be increased to PHP 1,500 per family per year.

Currently PhilHealth pays for most services using case rates. Case rates are a variant of fee-for-service. They encourage efficiency by paying a single "bundled" payment for a treatment event

such as a delivery or an IUD insertion, regardless of which or how many services were provided. Public and private providers receive the same rates for a given case. Since public providers also receive line-item subsidies for staff, infrastructure, and supplies, PhilHealth payments are seen as a “top-up”, or additional revenue. Private providers, on the other hand, tend to view revenue from PhilHealth as “the first layer” of their cost recovery. They look to other revenue sources, such as HMOs or charitable programs in the case of indigent patients, and finally to the patients themselves to cover remaining and often substantial charges associated with a case.

Another feature of PhilHealth provider payment is the “No Balance Billing” provision (PhilHealth circular 03.2014). No Balance Billing applies to indigent and other subsidized members confined in public wards or receiving Primary Care Package services. It means that the provider cannot bill a member for any “balance due” for covered services. Compliance by providers with this provision has been limited; in 2013 it was only 7 percent, rising to 42 percent in 2014 (ILO 2014). However, reports still persist that providers don’t know, or don’t honor the provision, and members often do not understand that they are not required to pay out-of-pocket for these covered services.

In 2011, PhilHealth set payment for the Maternal Care Package (normal deliveries) at a lying-in clinic at PHP 8,000, to incentivize assisted deliveries outside of hospitals. This amount generally exceeds what midwives who own and staff these clinics charge an uninsured client. Generous payments from PhilHealth to midwives are widely believed to have supported the expansion of birthing centers manned by midwives. Post-partum insertion of an IUD (P2,000) or implant (P3,000) is now paid separately, and in addition to, the Maternal Care Package. Focus group participants and key informants indicated that these payment terms exceed what they used to charge clients, providing a financial incentive to undertake necessary trainings and upgrades to become PhilHealth-accredited.

In addition to adequacy of payments, timeliness and reliability of payments are important for contracted providers including midwives. PhilHealth is obligated by statute to pay claims within 60 days (and there is a bill proposing to mandate 30 days) of receipt, and reports that it is now generally paying claims within an average closer to 30 days. Key informants reported a range of responses on the average turnaround time they experience for PhilHealth claims. Answers ranged from 17 days (attained after a concerted effort to regularly submit and monitor claims by Mary Johnston Hospital) to three to six months (midwives, and Fe del Mundo Medical Center for complex cases such as heart surgery). Representatives of PhilHealth acknowledged claim backlogs since 2014 and a failure to consistently meet the 30 day turnaround time during the last several years – Batangas and Mindinao in particular have experienced greater delays.

A significant initiative underway by PhilHealth to improve scheme efficiency and transparency and to reduce exposure to fraud is the introduction of an electronic claims (E-claims) system. Starting in 2018, E-claims will automate tedious coding and data transfer tasks. Claim adjudication will remain manual, however. E-claims will improve the efficiency of evaluating the medical necessity of claims by shifting from prospective claim-by-claim evaluation to system-aided retrospective audits of selected claims. Accreditation and eligibility verification processes are also already digitized. There has been some resistance by providers and midwives in particular to adopt digital solutions due to the costs of upgrading and administering required IT systems, and indeed the implementation of E-claims by PhilHealth has been postponed several times in response. Although these reforms include significant upfront costs, the financial benefits of participating in PhilHealth provides a significant incentive for private providers to make investments both in making the necessary changes and in expanding to deliver the full range of FP services.

## Health Maintenance Organizations

Private health insurance programs complement PhilHealth coverage and enhance financial risk protection for formal sector clients in the Philippines. HMOs are one type of private health insurer. They pool health risks and finance care through regular premium payments on a “cashless” basis for clients who are typically employees of corporate sponsors. By paying contracted providers directly on behalf of clients, HMOs allow their clients to avoid having to pay up-front for services and submit a claim for reimbursement. HMOs also support case management by making referrals and authorizing hospital admissions. HMOs primarily contract with private health providers and tertiary government hospitals such as Makati Heart Hospital. In practice, HMO benefits “top up” benefits of PhilHealth – meaning they pay according to their policy terms after PhilHealth benefits have been applied. HMO benefits typically cover higher costs associated with semi-private or private wards in hospitals. Approximately 5 percent of Filipinos receive additional benefits and financial risk protection through HMO programs offered by their employers. Although there are at least 29 operating HMOs, three dominate the market: Intellicare (1.2 million members), Maxicare (1.2 million members), and Medicaard (800K members).

Health insurers, especially those using fee-for-service provider payment mechanisms, often struggle to manage claim costs due to moral hazard, adverse selection, fraud, growing disease burden, and other factors. HMOs in the Philippines have experienced medical inflation that exceeds the inflation rate for the general economy, around 10% annually. This is due to various reasons, including the financial incentives for private providers to treat under fee-for-service payment mechanisms; client behavior, such as bypassing a primary care provider and seeking care in a hospital emergency room; and increasing incidence of non-communicable diseases such as diabetes and hypertension. The previous trend to offer more and better services is now shifting toward provision of better value services. For example, Intellicare and Maxicare are pursuing innovations to increase cost-effectiveness while achieving better health outcomes and client satisfaction. These HMOs are establishing clinics located near client workplaces and staffed by employed providers trained to follow best practice treatment protocols; offering 24/7 clinic hours to accommodate clients working nights and weekends in call centers (BPOs); offering free transportation for follow up visits, and promoting tele-consultation services.

HMOs recognize the market opportunity to serve lower income and informal sector clients. They believe that to be successful in doing so, they first need to develop lower cost benefit options. Future products will be tailored to fit the needs and financial means of this untapped market segment. For example, a product may offer benefits available from a smaller network of owned clinics, or limit benefits for inpatient care to secondary illnesses, but exclude more expensive, tertiary services such as heart surgery or chemotherapy.

HMOs tailor the benefit package for each corporate client; typically, corporate clients choose not to cover FP or maternity care and so HMOs do not include those services in their packages. That said, HMOs present a possible opportunity to offer FP services via workplace clinics mandated for large corporate clients. The point of entry could be to address concern about sexually-transmitted diseases, including HIV/AIDS. Due to cultural sensitivities with respect to FP, one HMO CEO stated that the request to offer FP services would need to come from a corporate client, rather than the HMO promoting FP services as a standard feature of its workplace health programs. In order to leverage this

*“Health care is available, but not affordable”*

*~ Mr. Mario Silos, President, Intellicare*

opportunity, corporates themselves would need to come to understand the benefits of covering FP and request HMOs to cover it.

## Health insurance regulation

PhilHealth is regulated by the DOH, and not the Insurance Commission. HMOs have historically been minimally regulated by the DOH; in 2015 Executive Order 192 transferred regulation of HMOs from DOH to the Insurance Commission. According to the Insurance Commissioner, regulation of life and property insurance (and not health) has been the Commission's priority, and regulatory staff and capacity are limited. That said, there is a push within the Philippines to expand insurance to low-income households, and there exist separate regulations for microinsurance which apply international best practices on proportionality. This year is the first year that HMOs will be required to submit financial statements, though these and other regulatory standards are currently promulgated on a piecemeal basis. Licensed insurance companies (life and non-life) are also permitted to offer health insurance, though penetration is quite low. Carriers such as Pacific Cross offer traditional health insurance products that require clients to pay for services and then submit claims for reimbursement. There is some debate between licensed insurers and HMOs – HMOs claim they are disadvantaged to pay 12 percent value added tax on services, compared to a 2 percent premium tax levied on insurers, while insurers argue that HMOs are subject to less regulation, and not held to the same standards as insurers, including for financial reporting and solvency.

## Digital financial solutions

Digital financial solutions have been slow to take root across the Filipino health care system. However, the ICT for Health Policy (2011) establishes a Philippines e-health strategic framework that calls for providers to tie up with a health information exchange, and movement is afoot for greater digitization. The Philippines Health Agenda 2022 is called ACHIEVE; a component of this agenda includes the goals to “invest in eHealth and data for decision-making”. Currently there are four accredited electronic medical record (EMR) providers and an EMR platform called I-Clinic-Sys. So far, I-Clinic-Sys is used by a limited number of RHUs to provide digital transfer of enrollment and encounter data related to capitated families covered under PhilHealth's Primary Care Package. Private sector e-health service providers such as Wireless Access for Health and their backers (e.g., Qualcomm) are still seeking viable, scalable business opportunities, for example subscription models that replace grant funding. As capitation payments are implemented to pay for other services and providers, these systems will expand and can support additional insurance transactions, such as claims submission and processing.

# Access to finance by the private health sector

Access to finance by the private health sector and in particular FP service providers, is constrained by a range of supply and demand side factors. These include perceptions of risk by financial institutions, inadequate lending methodologies, the cost to serve small-scale and/or rural providers, and the lack of sufficient collateral that is acceptable to the bank. A further constraint is the low level of business and financial management skills of health business owners.

## Overview of the financial sector

The Philippine financial sector has gone through various crises over the past 40 years: the 1980–1985 financial crisis, the 1997–1998 Asian financial crisis, and the 2007-2010 global financial crisis. The sector has come out of these, and now finds itself in a relatively strong position. This is in part a result of the continuing effort of the government to institute reforms and strengthen the sector. The government reform measures included higher reserves requirements, cleaning books of non-performing loans, and increasing supervisory powers of the central bank, *Bangko Sentral ng Pilipinas* (BSP).

The Philippine financial system is dominated by the banking sector, which controls over 80 percent of the resources of the financial system, with the non-bank financial institutions accounting for the rest. Universal and commercial banks account for 90% of total bank assets. In terms of number of branches/agencies, non-bank financial intermediaries have a wider physical network; these consist mainly of pawnshops. Bank branches have grown to over 11,000 at end of 2016. While growth continues, according to the BSP, 591 out of 1,634 cities and municipalities (36 percent) still remain unbanked in 2016.

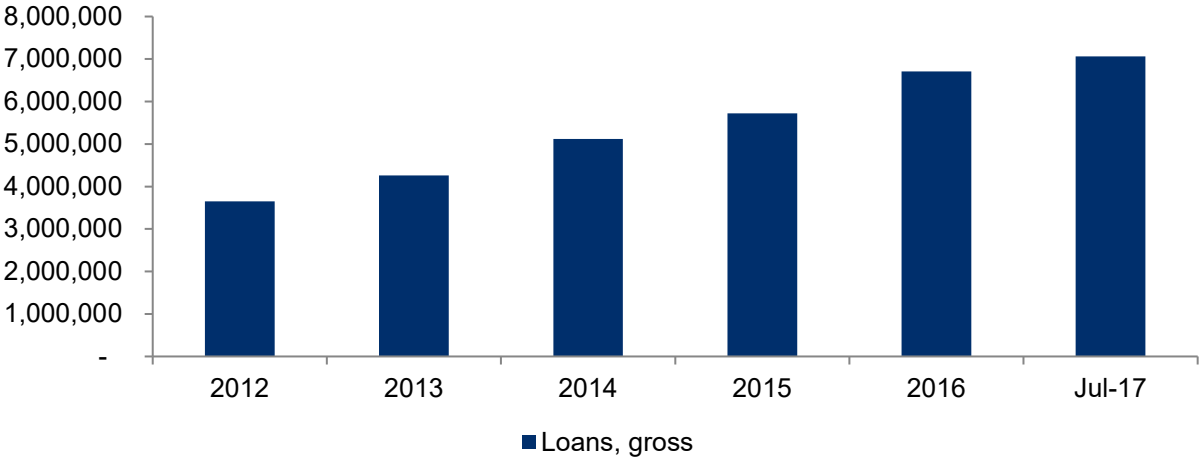
The number of banking institutions decreased to 602 by December 2016, down from 632 the previous year and 996 in 1998. The remaining 602 were comprised of 42 universal and commercial banks, 60 thrift banks, and 500 rural banks<sup>3</sup>. The consolidation and acquisition of banks has been driven by the need to grow market share and geographic expansion.

Portfolio growth of universal and commercial banks has been strong since the last financial crisis. In 2016, banks' loan portfolio grew by approximately 20 percent, and growth has continued into 2017, although at a slower pace (Figure 10). Growth in consumer banking has been strong, with large increases in credit card, motor vehicle loans and salaried loans leading the way. Interestingly, consumer loans make up a small proportion of banks total loan portfolio (less than 15 percent), crimping the profitability of the financial sector. This partly reflects the fact that households are net savers, owing to uncertainty about the sustainability of the remittance inflows that they receive from Filipinos based overseas.

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<sup>3</sup> Bangko Sentral NG Pilipinas, Report on financial and economic developments, 1<sup>st</sup> quarter 2017

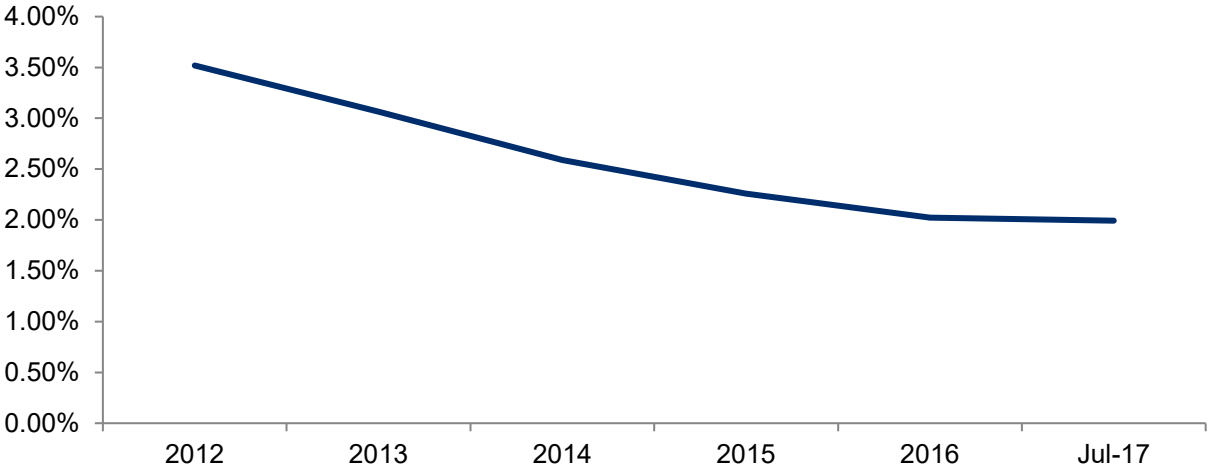
**Figure 10. Outstanding loans at commercial banks gross of RRP (trillion pesos)**



Source: BSP

Banks portfolio quality had been strong. Non-performing loans (NPL) have seen a decrease over the past five years to relatively low rates, although saw a slight uptick 2017 (Figure 11).<sup>4</sup>

**Figure 11. Percent of non-performing loans**



The banking sector's loan-to-deposit ratio is among the lowest in Asia. This suggests that local banks have financed loans mainly by using deposits rather than through potentially risky international wholesale borrowing. It also indicates opportunities for banks to continue growing their loan portfolio with low-cost funds and to enter different sectors of the economy. Banks interviewed by the PSA team indicated increased competition in the corporate sector and as a result a need to move towards the small and medium enterprise sector (SME).<sup>5</sup> Currently, banks

<sup>4</sup> Enterprise Survey 2015

<sup>5</sup> SMEs are classified as businesses with assets amounting to P30 million and below



are required to allocate 10 percent of funds to the micro, small, and medium enterprise sector (8 percent for SME and 2 percent for microenterprises) or pay a fine.

The microfinance market in the Philippines<sup>6</sup> is one of the largest in Asia. Its recent growth in both outreach and financial performance has been fueled by increases in mobile banking and favorable government policies. Institutions that provide microfinance services include commercial banks, non-bank financial institutions, cooperatives, rural banks, credit unions, pawn shops and NGO-MFIs. It is important to note that commercial banks participate in the sector indirectly through their social foundations or by providing wholesale funds to traditional microfinance institutions.

## Demand

Private provider demand for financing has been consistently listed as a challenge to growth. In 2006, the USAID Banking on Health project completed a survey of 513 midwives across 15 of the 17 regions of the Philippines. Notably, the highest percentage of respondents - 65 percent - identified lack of funding as one of the biggest obstacles to growth. While the survey indicated finance was demanded, only 17 percent of the sample had experience with borrowing for their business. Some of the reasons given by those who have not applied for loans included lack of knowledge on how to apply and manage bank loans, lack of collateral, bureaucracy of the banks, lack of business skills, and desire for financial independence. For those providers who had unsuccessfully applied, the reasons for not applying again included high interest rates, too many terms and conditions, unachievable conditions, lengthy loan approval process and other reasons such as poor customer service and a perception that they are unwelcome at financial institutions.

The FGD that was conducted as part of the PSA found that not much had changed since 2006; access to finance is still a challenge to growth. Of the midwives participating in the FGDs, 54 percent indicated their facility required financing for renovations or expansions. While 25 percent indicated they had borrowed from a bank (Land Bank, BPI, BDO, RBBC), these loans were primarily for consumer purposes. As previously indicated, consumer loans are easier to acquire given they do not require real estate as collateral. FGD respondents also indicated that midwives were more likely to borrow from rural or thrift banks, cooperatives, or 'loan sharks' (Turko). While funding from these sources is easier to access, it is significantly more expensive than funding from banks. Respondents who require financing but had not applied for loans frequently cited lack of knowledge on how to apply and manage bank loans, lack of collateral, bureaucracy of the banks, lack of business skills, and preference for financial independence as reasons for not applying. In meetings with midwives, the PSA team identified a need for them to shift mindset from social to business enterprise. There appears to be a 'spend what you earn' mentality which impacts growth and long term viability of business.

FGDs with doctors revealed that this cadre is generally able to access financing for personal consumer loans. Many of these doctors are salaried employees, either at public or private health facilities. As a result, they draw a salary which the bank uses to evaluate the loan application. The discussion found that financing for their practice is acquired from non-bank sources such as family, friends, business partners, or savings. Doctors' primary reason for not using financial institutions to finance their practice is burdensome collateral requirements.

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<sup>6</sup> Microenterprises are classified as businesses with assets amounting to P3 million and below

## Supply

Philippine banks' lending is heavily driven by collateral, with the preferred, and in some cases only, type of collateral accepted being real estate. Maximum loan amounts are based on a percentage of value of real estate, averaging around 60% to 70%. The banks with which the team met indicated that they are hesitant to consider real estate from which a health provider operates – such as a clinic building – as they see a reputational risk associated with repossessing the asset in case of default. As such, private health providers are further hindered in their ability to provide collateral that is acceptable to the bank.

A second challenge the team identified is that in addition to a heavy reliance on collateral, only few financial institutions will consider midwives or other small-scale providers' business cash-flow in their analysis. They will provide financing to these health providers, but will only consider cash flow tied to their "other job" in cases where private providers, in addition to their practice, have a government job through which they generate salary.

### Private financial institutions

There are more than 600 financial institutions in Philippines, yet the private health sector remains vastly underserved by them. While some of the financial institutions support the health sector, they do so in an opportunistic manner, or indirectly through their consumer lending department. Of interest to the financial sector are the more formal facilities such as hospitals and medical doctors, dentist clinics, and health equipment vendors.

Financial institutions interviewed by the PSA team indicated limited institutional knowledge of the health sector. While this context is typical of SME lending, the social nature of health service provision coupled with complex revenue streams and layered payments from user fees and claims reimbursements, presents unique challenges in appraising loans in segments small and large. Smaller and more rural hospitals, clinics, doctors, midwives, and others tend to have weak record- and bookkeeping capacity. Loan officers are required to reconstruct cash flows in order to assess debt service capacity. Moreover, staff at financial institutions are usually accustomed to dealing with entrepreneurs; dealing with health providers that have a clinical background and little or no business acumen can be challenging.

Sole proprietorships, the legal structure used by majority of midwives, tend to access formal financing through banks' consumer departments or through non-bank financial institutions. Collateral for consumer loans is less burdensome and usually limited to post-dated checks. Non-bank financial institutions have a less burdensome loan process and lower collateral requirements than banks; however, pricing is significantly higher.

USAID has previously attempted to support private provider's access to private financing by working with a financial institution through a DCA guarantee. The project was implemented with a small MFI and targeted small-scale midwives.<sup>7</sup> Unfortunately, the project faced various challenges, including:

*"We are uncertain as to how to approach the health sector. Unclear as to how to determine profile and banking requirements."*

*~ Senior Manager at local bank*

- Partner selection – the MFI selected by USAID focused on the rural poor, with a small

<sup>7</sup> 2003 to 2008 DCA with Opportunity Microfinance Bank

network of branches and limited reach to midwives.

- Partner MFI did not work with health sector nor did it have knowledge of sector peculiarities.
- The DCA's focus was on midwives that received support through grants and were not fully established. This not only limited pool of potential candidates, but also focused on the higher risk facilities.
- No technical support was provided, and no loan product was developed to address credit risks associated with midwife facilities.
- There did not appear to be a partnership with stakeholders to support MFI.

As a result of these and other challenges, utilization of DCA was less than expected at 7.8 percent. It is worth noting that USAID currently has eight active DCAs in the country, none of which are focused on health sector.<sup>8</sup>

## Public financial institutions

The Philippines has two state-owned banks: the Land Bank of the Philippines (LBP) and the Development Bank of the Philippines (DBP). LBP was created to finance the acquisition and distribution of agricultural estates for division and resale to small landholders and now offers universal banking. DBP is the seventh-largest bank in the Philippines in terms of assets and one of the largest government-owned and controlled corporations in the Philippines. The bank provides a wide offering of banking products, although its mandate is to support the national government's key development programs. As such, it has created products to support development of the health sector. DBP management indicated interest in developing a health sector product, however, their approach is similar to that of private banks with potentially more burdensome and higher pricing – they basically service the sector through their SME department without a differentiated approach. Management did indicate an interest and ongoing effort to develop a sector focused offering.

In 2009, DBP joined forces with Asian Development Bank (ADB) to develop a program, Credit for Better Health Care (CBHC), aimed to provide financing to upgrade health services of local governments and facilitate private sector participation in improving health care through access to finance. The project consisted of a US\$50 million facility to be on-lend to the health sector through private financial institutions and LGUs. Of the \$50 million, US\$19 million was committed prior to the end of the project in 2015.

The CBHC project was intended to be implemented through two approaches, wholesale lending and retail lending. The wholesale lending program was to be implemented through DBP's accredited financial institutions, including MFIs and rural and thrift banks. The institutions were to on-lend funds to the target sector consisting of small-scale health providers such as midwives, physicians and drug dispensers. No projects were financed through this approach. The retail lending program was intended for LGUs and larger health providers such as hospitals. Through the project, a total of seven loans for US\$19 million were approved. An additional four loans for US\$1.6 million were approved direct through DBP retail arm and not through intermediaries as originally conceived. The program was not deemed a success, having faced numerous challenges ranging from the cost of funds being set above market rates and competition against government grants, to political aspects impacting LGUs' focus. In addition,

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<sup>8</sup> Eight targeting general SME space, one for water infrastructure project

the Asian Development Bank's (ADB) assessment of the program indicated that the project took few risks and as such was unable to generate expected loan volume. The project evaluation drew some relevant and important lessons<sup>9</sup>, including:

- Private sector providers need motivation to invest and expand their services, and to strive for better quality care. The hurdles for small-scale providers in accessing a loan should be reduced as much as possible.
- Midwives should have been better analyzed in project design phase. They are able to borrow from DBP if they have sufficient collateral at their disposal. However, few midwives have such collateral. Innovative solutions should be considered.
- Targeting midwives should be done in partnership with nongovernment organizations and women's groups.

Lastly, ADB's reviewed DBP's loan requirements and found these to be overly cumbersome for midwives to meet. The two biggest challenges were collateral and loan application documentary requirements (e.g., audited financial statements, business permits). These were found to be too complex for the applicants.

## Other

Efforts have been made by NGOs and other entities to support health providers' financing requirements. PSPFI has looked at providing small financing sums to providers based on their average PhilHealth invoices. While there may be other efforts, these appear to have been small in scale and not sustainable.

## Key opportunities

The Philippines' banking sector continues to grow and expand. As it does, banks will give greater consideration to entry into new market segments, such as the private health sector. To the extent the financial sector sees an opportunity in a market segment, and feels comfort in the level of risk, they will increase their activities. Currently, there are no significant specialized loan offerings for health providers that the team was able to identify. Small to mid-scale health providers are attended under the financial institutions' SME department. Requirements for health providers are same as any other SME and do not consider the intricacies of health sector, such as PhilHealth reimbursements. Health providers are required to go through the standard SME underwriting process which includes, among other things, requirements for audited financial statements and high collateral. Furthermore, banks penalize health providers in that they do not accept real estate from which health provider operates as collateral.

Health care providers can access finance from a variety of private and public financial institutions. However, most of the financing available targets conglomerates and corporate entities. Financing for small-scale health providers is limited, and not a priority of financial institutions. While findings indicate doctors have access to finance, further analysis shows that financing is primarily for consumer purposes and based on salary from work with private or public sector health facilities, usually hospitals. Midwives are more likely to access funding from savings, family and friends than from financial institutions. If they do look at financial institutions,

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<sup>9</sup> ADB Completion Report, Philippines Credit for Better Healthcare Project

they are more likely to consider non-bank institutions that carry less requirements but at much higher cost.

USAID can improve and build on its previous experience working with banks to address these needs. Credit requirements from midwives are for the most part under US\$20,000. While the credit amount of individual providers is not very attractive to Philippine banks (which focus on larger amounts), the volume of midwives who require financing may be of interest. To support banks focused entry into the space, a more detailed study of market potential should be undertaken.

Participation in Philhealth creates two strong incentives for banks to attend the private health sector. If Philhealth opts to work with additional banks in reimbursing providers – currently they only work with Land Bank but it was mentioned that they were looking at expanding to four or five banks – these banks would be very interested in seeing the reimbursement. Philhealth could also be leveraged to develop an innovative loan product aimed at midwives and/or other health providers. The product would benefit from strong payment source (Philhealth) that could serve both as verifiable cash flow as well as collateral, and should significantly reduce banks operating costs. If properly structured, and with the right partner financial institution, a DCA or other guarantee support instrument, could well complement such an innovative product.

It is recommended that Philhealth consider banking requirements of midwives and other private health sector providers in deciding whether or not to work with additional banks. Philhealth is in a position to require partner banks to offer tailored products to private health providers in exchange for using bank for reimbursements. Accreditation and new (soon to be implemented) licensing requirements will lend credibility to midwives given increased levels of formalization. As the level of formalization improves, availability of documentation required by banks to consider a loan request will improve and sector may become of interest of banks.

# Opportunities for strengthening private sector provision of FP services

Based on the findings presented in the previous section, the SHOPS Plus PSA team identified several opportunities for strengthening private sector provision of FP services. Recommendations for capitalizing on these opportunities are presented below.

## Enhance social entrepreneurial orientation of midwives to enhance sustainability

Through PRISM, PRISM2, and its current regional health projects, USAID has invested significant resources in strengthening the business and clinical performance of midwives. This support appears to have been successful given the number of midwives operating profitably, and expanding their practices. What is more, some are looking at creative approaches such as consolidating practice with other midwives into group practices. Such an approach would, among other benefits, allow midwives to share administrative burdens including PhilHealth-related paperwork, expand services provided, increase midwives' ability to attend larger number of patients, and increasing profitability. There continues to be an unmet demand for FP that midwives can continue to address. However, impending changes to PhilHealth accreditation requirements and LTO mandates will mean that current practicing midwives will need to make changes to meet new standards.

There are a number of midwives who have benefited from years of USAID investments and are well placed to meet PhilHealth LTO requirements. Many have an entrepreneurial spirit that has helped them to establish viable businesses. There are also many midwives who are not prepared to meet new requirements. Despite a long runway to make changes necessary to meet LTO requirements and numerous delays by PhilHealth in implementing new standards, some midwives are not prepared and likely would require a significant amount of support to get them ready. USAID should consider targeting their support towards those midwives who are more likely to continue to be successful. This could include support in establishing group practices to benefit from economies of scale. As health systems evolve and competition and pressure for efficiency increases, solo practitioners may merge to gain economies of scale (e.g., bulk purchasing), and to justify hiring in-house specialists for specific clinical or business services (e.g., billing). Currently in the Philippines, solo midwife clinics are the norm. Since group practices are not common, support in understanding best practices as well as technical assistance to support efforts to merge practices would be needed.

Support can also include links to financing to support expansion of their businesses. Entrepreneurial midwives, as well as other private providers looking to expand their practices, would benefit from loans that are tailored to their needs and their realities. The fact that the majority of midwives are self-financing the investments needed to grow their practice and serve more clients indicates that those investments may suffer delays, and that other potential investments are discarded. It also indicates a potential opportunity for financial institutions. This sector has peculiarities that create a lack of comfort with the financial sector, but there are also solutions that could be of great value both to the health sector and the financial institutions. To capture these opportunities, a differentiated and innovative approach that considers these peculiarities is required. As an example, Philhealth provides for both an interesting source of



deposits for financial institutions, and a payment scheme that financial institutions could leverage to reduce credit risk and increase financing for the sector.

Past attempts by USAID, Asian Development Bank, and others at supporting small-scale health providers to access finance have not generated expected results. In evaluating these projects, there were some weaknesses identified in the structure of previous efforts. These included selection of institutions, and restrictions placed on activities, such as limiting project implementation to specific regions and defining profile of qualifying health provider that limited potential market/loan clients. As USAID and other stakeholders work to increase access to finance for small-scale health sector in the future, the structure of intervention needs to not only consider the health provider that is the target, but should also consider financial institutions' overall strategy, sector in which they operate (small, medium, corporate, consumer, etc.), business case of entering new sector, branch presence in priority areas, and experience/knowledge of the sector which would be required to implement project.

An interesting finding from field activities was that midwives rely on each other for information that impacts their business. USAID should consider working towards developing a mechanism for midwives to share information and ask questions digitally through online "peer networks" that connect these social entrepreneurs. Information on business practices, accreditation or new requirements, issues with PhilHealth, access to finance, and other would be available in one space to all midwives. Blogs that target specific subjects and segments have been found to be a useful low cost way to address such a need, and could be an option.

## **Leverage opportunities presented by PhilHealth expansion**

There is a clear opportunity for USAID to support the Philippines to increase access to FP and to contribute toward achieving UHC. One way to do this is by linking with PhilHealth's efforts to expand covered services, and its growing emphasis on primary care and preventive and promotive health services. USAID should continue efforts to advocate for expanded coverage of the full range of FP services by PhilHealth. This is in line with PhilHealth's broader efforts to expand primary healthcare benefits. Advocacy efforts could focus on covering removal of IUDs and implants, since these services are currently excluded, establishing reimbursement rates for nurses and on better incentives for providers to provide a full range of FP services.

As previously mentioned, participating as a PhilHealth accredited provider has been lucrative for midwives and other FP service providers. It is therefore critical to midwives future participation to continue. In line with previous investments by USAID to build capacity and infrastructure of midwives and lying-in clinics, a new opportunity for USAID to support is to link midwives with electronic medical record providers who could provide administrative and IT services in support of submitting E-claims, and monitoring accuracy and timeliness of claim payments.

In FGDs, midwives noted that many do not have the hardware (computer, printer/scanner) or the know-how needed for the transition to e-claims mandated for continued participation in PhilHealth. As part of its efforts to support group practices, USAID should document if and how this new business model helps health workers come up with the resources to purchase and maintain the necessary equipment and staff. Over time, USAID could support broader turnkey solutions for FP providers to outsource functions of their practice such as insurance claims, collections, accounting, accreditation, reporting, and purchasing. The aim of the technical assistance would be to improve providers' readiness to be accredited as a providers for PhilHealth and other insurance programs, and to operate profitably under those programs and overall.



## Capitalize on emerging market opportunities to expand access

Nurses are an untapped resource in the Philippines with regards to FP service delivery. Key informants estimate that there are over a million nurses in the Philippines which is far greater than the number of midwives. As seen in the DHS data, midwives currently only serve 1% of current FP users. Efforts to expand uptake of modern contraceptive methods could be supported by engaging nurses, especially the many nurses who have switched to other higher paying fields, such as the BPO industry. FGDs and KIIs do point to some interest on the part of nurses. However, there would need to be a viable and enticing market opportunity to attract them back to the health sector. The AO on freestanding FP clinics and PhilHealth accreditation and reimbursement for services delivered may be the enticing proposition needed. With these reforms in place, nurses would be able to own their own businesses (much like midwives), practice the skill that they studied for, and be their own boss. A financial analysis on whether there is sufficient demand to make nurse run standalone clinics for FP viable would be a critical first step. Should there be sufficient financial returns, additional support such as linking nurses to loan products and providing technical assistance on business and financial management training and links to public sector provided commodities would be essential.

Another market opportunity that exists in the Philippines is leveraging the BPO industry expansion. BPOs employ a large number of young people, a critical target for information on preventing pregnancy and STIs. While workplace programs were not a focus of this assessment, many stakeholders discussed the importance of the BPO industry as a platform to reach young people. A partnership should be explored with the IT and Business Process Association of the Philippines to expand access to FP and reproductive health information and commodities at work sites. USAID has a long history of supporting workplace programs so partnering with the BPO industry may have already occurred.

Beyond a partnership, there is an opportunity to expand HMO benefit packages to include FP. Currently, BPOs partner with HMOs to provide health care coverage for certain services, but not FP. In discussions with HMOs who provide health insurance coverage to corporate clients, if the corporate wanted to include FP as a covered service they would be in a strong position to comply. In a win-win scenario, employees would benefit from easier access to FP services; employers would be able to share costs of delivering services with HMO coverage.

## Break the paradigm that only sees adolescents enter health system after becoming pregnant

In order to see real changes in adolescent use of contraceptives and decreases in teen pregnancy rates, the Philippines needs to break the paradigm that currently sees adolescents enter the health system for FP after they have already become pregnant. There are several avenues that the DOH, PopCom, USAID/Philippines, and other donors could partner on to pursue this goal.

**Develop mass media campaigns that focus on interactions between parents and teens.** To date, there have been limited behavior change campaigns targeted at adolescents; there have been even fewer targeted at their parents. Given how influential parents are to their adolescent children's ability to access any kind of FP method, there needs to be greater emphasis on convincing parents to address this issue. Campaigns should emphasize the importance of creating an open dialogue between parents and children and empower parents

with the skills and knowledge to talk to their teenaged children about these issues. This mass media campaign could complement the Commission on Population's ongoing efforts to develop "Parent Trails" edutainment seminars.

**Leverage social media to provide teens with a direct link to providers and other credible sources of FP information.** Adolescents want to access FP advice from trusted professionals but they do not want to have to go to a health facility to do so. Facebook and WhatsApp are two key tools that the DOH and donors could leverage to create new, discrete links between adolescents and trained counselors. USAID could pursue a partnership with these organizations to better understand how youth and adolescents currently use and interact with their platforms: how long they use them at any one time; what kind of pages and groups they are most likely to interact with; and other browsing behavior patterns. Program designers can use this information to create a new chat program that leverages platforms adolescents are already using to conveniently and privately link them with high quality sources of information.

**Address socioeconomic and behavioral factors that lead to risky sexual behavior.** Few conditional and unconditional cash transfer programs have specifically targeted FP usage (Khan et al. 2016). However, those that have targeted or included adolescent females have found that they can successfully improve behaviors that are associated with higher rates of FP use and lower rates of risky sexual behavior (Darney et al, 2013; Baird 2012; de Wale 2012; Taafee et al 2017). The Philippines has already proven that it can effectively implement a well targeted and effective conditional cash transfer program through the 4 P's. Stakeholders should consider creating a targeted program under the 4 P's to specifically target adolescent girls and empower them with more and more accurate FP information.

**Better integrate private providers into programs focused on educating and serving youth and adolescents.** A key barrier for reaching adolescents is the lack of providers trained on adolescent-friendly service delivery. Private providers represent a significant opportunity for addressing this gap, especially given parents' and adolescents' perceptions about greater privacy at these facilities. If the proposed *Prevention of Adolescent Pregnancy Act* is signed into law, DOH and donors should consider how they can best incorporate private providers into the new adolescent information and service delivery networks to ensure that teens can seek FP services from the providers they prefer.

## Strengthen public sector engagement with wider range of private providers

In key informant interviews, the DOH stated that their primary experience with the private health sector is limited to work with larger hospitals and franchised clinics. They expressed both a need and a desire to expand engagement with full range of private providers to increase access to clinical trainings, commodities, and other resources needed to increase access to the full range of modern FP methods. However, given limited staff and technical resources, the DOH needs to be strategic in its outreach. DKT currently uses the Philippines Government Electronic Procurement System (PhilGEPS) to identify LGUs most likely to be FP-friendly based on current procurement practices. A USAID program could do the same to identify regions where local governments are most supportive and trade expanded private sector access to free commodities in return for increased reporting from private providers to meet public health goals.

# Conclusion

USAID has a long and successful history of partnering with the private health sector in the Philippines. This history has helped strengthen the private sector's ability to offer high quality family planning products and services to all Filipinos with minimal financial burden. Still, though, there are many significant challenges for the country to achieve its goals, including a teen pregnancy crisis, uncertainty caused by the TRO, and sociocultural barriers to adopting FP methods. At the same time, there are several opportunities that were not present at the start of the last round of bilateral programming. These opportunities – including the significant financial opportunities represented by the expansion of PhilHealth, the growth of the BPO industry, the passage and implementation of the RPRH law, and policy and regulatory changes that will increase the number and types of facilities and providers able to deliver FP services – present USAID and other stakeholders with an opportunity to change how business as usual is done and accelerate progress. New business models can help midwives and other cadres who historically have been significant sources of FP operate more efficiently, expand their scale, and serve new clients. Recent policy changes will bring new cadres into the fold, thereby creating new channels for potential clients to access their preferred method. And new communications strategies can help educate the right people to empower them with the information they need to take control of their reproductive health. The findings and recommendations contained in this report can help inform how USAID designs its next round of programs to make the most of these opportunities. It is a critical time in the Philippines to make sure that all resources – public and private – are brought to the table to achieve its health goals.

**Addendum to original report:** Since the completion of the original report, the Filipino FDA certified that 51 contraceptive products – including Implanon and Implanon NXT – qualified as non-abortifacients. With this decision, the FDA cleared the way for FP programs to proceed without the uncertainty caused by the TRO. Since this decision, numerous efforts have started to increase access to implants: PopCom has relaunched the National Program on Population and Family Planning;<sup>10</sup> the DOH has begun to distribute over 250,000 implants it had in storage;<sup>11</sup> Likhaan NGO has started offering implants<sup>12</sup>; and UNFPA and PSRP have begun efforts to reach 40,000 women from poor and indigenous communities with implants<sup>13</sup>. These efforts represent just the start of the work to widen the method mix for all women. Although there is still political opposition, these activities show the potential of impact that implants can have. With the artificial barriers that the TRO created now removed, it is important that stakeholders make sure that private sector opportunities identified in this report are fully leveraged to increase access to this and all other methods of FP so the Filipino women can access their preferred method from their preferred provider.

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<sup>10</sup> <http://www.popcom.gov.ph/10-press-releases/661-national-program-on-population-and-family-planning-to-be-re-launched-in-albay-bicol>

<sup>11</sup> <https://www.philstar.com/headlines/2017/11/14/1759052/tro-contraceptives-now-lifted-doh>

<sup>12</sup> <https://www.channelnewsasia.com/news/asia/women-in-the-philippines-turn-to-implants-to-protect-themselves-9951310>

<sup>13</sup> <https://www.unfpa.org/news/expanding-family-planning-choices-women-philippines>

# Annex A. Focus Group Discussion Reports

## Private Midwives

**Table 8. Profile of FGD participants**

City/Municipality	Dates of FGD	Number of Respondents
Quezon City	June 28, 2017	6
Davao City	June 30, 2017	9
Cavite	July 4, 2017	9
Total		24

**Table 9. Profile of FGD participants**

Study Area	Results
FP Services offered in the facilities	<ul style="list-style-type: none"> <li>• Injectables- 91%</li> <li>• Pills- 86%</li> <li>• IUD- 86%</li> <li>• Implants- 52%</li> <li>• Condoms- 43%</li> <li>• SDM- 3%</li> </ul>
PhilHealth membership	<ul style="list-style-type: none"> <li>• 100%</li> <li>• All respondents are PhilHealth accredited providers and all facilities are PhilHealth accredited</li> </ul>
PhilHealth member clients	<ul style="list-style-type: none"> <li>• Range: 75% to 100%</li> <li>• Mean: 94%</li> </ul>
Duration of PhilHealth Payment	<ul style="list-style-type: none"> <li>• Range: from 30 days to 120 days</li> <li>• 12 respondents: 60 to 90 days</li> <li>• 5 respondents: 45 days</li> </ul>
Mode of payment from PhilHealth	<ul style="list-style-type: none"> <li>• Check payments</li> </ul>
Accept other Private insurance Schemes	<ul style="list-style-type: none"> <li>• None</li> </ul>
PhilHealth coverage for own healthcare needs	<ul style="list-style-type: none"> <li>• Yes- 17</li> <li>• No- 3</li> <li>• No answer- 4</li> </ul>
Work with non-PhilHealth insurance programs	<ul style="list-style-type: none"> <li>• None</li> </ul>
Financial Access	<ul style="list-style-type: none"> <li>• Self-financed (from savings/ equity)- 17</li> <li>• Family or friends- 5</li> <li>• Supplier credit- 7</li> <li>• Banks – 6</li> <li>• Cooperatives, lending firms and individual- 6</li> <li>• no response- 2</li> </ul>
Financial institutions	<ul style="list-style-type: none"> <li>• LandBank-2</li> <li>• BDO- 2</li> <li>• BPI-1</li> <li>• RCBC-1</li> <li>• Bayan Edge- 2</li> </ul>
Applied for loan	<ul style="list-style-type: none"> <li>• Yes- 18</li> </ul>
Does the facility need a loan?	<ul style="list-style-type: none"> <li>• Yes- 13</li> </ul>

Purpose of loan	• Renovation/ expansion of clinic- 13
Amount needed	• Range: P50,000 to P5million pesos

## Service delivery

### 1. What family planning services are being offered in the facilities?

In the 3 study sites, only 1 clinic owner did not provide FP services in her lying-in clinic. She is a retired government midwife, who used to be a family planning advocate but wants now to concentrate on deliveries. Her midwives (staff) are trained but do not provide FP services because she stopped procuring FP commodities. If a patient wants an IUD or injectable, her clinic staff advises the clients to purchase the FP method and go back to the clinic.

In Davao, interval IUD is the top FP method being provided in their clinics. According to the one respondent, she prefers IUD insertion because she can get PhilHealth reimbursements.

Implanon is becoming the second most popular FP method in 2 USAID project sites: Davao and Quezon City. Implanon is the top FP method of choice among clients in Quezon City. Midwives prefer giving implants to breastfeeding mothers.

*“implant is progestin lang. pwede sa breastfeeding. May FP na siya paguwi.”  
[implant has progestin, so it can be given for breastfeeding clients. She already has FP method when she leaves.]*

Most lying-in clinics access free implant commodities from Philippine Society of Responsible Parenthood (PSRP). While they do not bill for the commodity, midwives charge the clients P50 to P500 for the accompanying service. In Davao, Implanon became the second most popular FP method of choice among clients. Most clients heard about Implanon from their neighbors. However, in Cavite and Davao City, most of the midwives cannot provide it because they have not yet received their post training evaluation certificates—which are a requirement for PhilHealth accreditation—and so cannot receive PhilHealth reimbursements for implants.

In Cavite, injectable is the top FP method. Cavite midwives report that most of their FP clients are working mothers and find injectables to be more convenient for their schedules. Among injectable users, 1-month injectable (Norifam) was more popular compared to the 3-month injectable (DMPA). However, due to procurement/ availability of Norifam stocks, most midwives advise clients to take DMPA.

PPIUD is the least offered FP method. Reasons cited include provider bias, lack of training, and lack of skills to administer PPIUD. Even when trained, midwives reported that they are not confident in their skills due to low acceptor rates and lack of practice.

*“Pag PPIUD, nag e-expel ng di nila nalalaman kasi malakas ang bleeding.” [“for PPIUD, it gets expelled because of heavy bleeding.”]*

*“May case ako, syempre umuwi siya pagka anak, bumalik after 1 week, nung na check ko, wala na si IUD. Di advisable yun. Meron nga ako pasyente na nabuntis na nilagyan ko, di niya alam na nawala. Ayaw ko ng PPIUD. Interval na lang.” [I have a case where the patient came back a week after giving birth and IUD wasn't there when I checked. The client didn't know that IUD was removed. I don't like PPIUD”]*

*“Many of my clients before... kasi [because] traumatic for them because they really experience pain during insertion unlike with interval, smooth talaga yung pag deliver namin ng insertion.” [... smooth insertion if interval IUD]*

## **2. What prevents you from providing other FP services?**

- For permanent methods (i.e. bilateral tubal ligation (BTL) and vasectomy), midwives refer clients to hospitals. Clinic owners have a memorandum of agreement with their partner obstetricians that prevent them from delivering BTL in lying-in clinics.
- For implants, midwives cited a lack of training; lack of post-training certificate usually due to delays in achieving the performing the required number of post-training, supervised insertions; delays in PhilHealth accreditation due to delays in trainers submitting lists of trained providers; and lack of commodities on the market due to the TRO.
- For PPIUD, midwives cited a lack of training; lack of post-training evaluation certification from when they were trained under the PRISM project; lack of payments from PhilHealth; and costly training fees

*“Hinto muna ko sa PPIUD kasi walang bayad sa PhilHealth. Interval ang may bayad. Nakasalang pa man ang payment sa PPIUD, hanggang ngayon, wala pa. Yung sa Interval IUD, pina enjoy ko muna ang LAM, tapos pagka 1 month, insertan ko na ng interval kasi may bayad yang interval sa PhilHealth” [I stopped PPIUD because I cannot be paid by PhilHealth. PhilHealth is still processing payments for PPIUD. For interval IUD, I let the clients enjoy LAM for 1 month, then I do interval IUD after 1 month because PhilHealth pays for interval IUD.]*

- For IUD, midwives stated a lack of interest from clients and a need for refresher trainings to keep skills up to date.
- For injectables, midwives stated supply issues, specifically for 1-month injectables

## **3. Why do you think clients come to your facilities broadly for FP services?**

Many FGD participants believe that clients go to private lying-in clinics for FP services because their clinics are open 24 hours daily. For working clients, they usually go to the clinics after office hours (5pm onwards) or during weekends.

Respondents also believe that clients prefer private lying-in clinics to health centers because midwives attend to all the questions and concerns of clients unlike in health centers where there are so many patients that proper counseling is not given.

*“Ma’am, di kami makapagtanong doon dahil sa oras.” [“ma’am, we can’t ask questions there because of lack of time...”]*

*“Sa center, may sermon na kasama.” [“In the center, we get reprimanded.”]*

## **4. How do you access FP commodities for your business? Are there any challenges that you face?**

Most of the respondents purchase their commodities through medical representatives of distributors such as Alphamed and DKT, paying via cash on delivery or post-dated checks. For NCR and Cavite, the respondents also purchase their commodities using cash in Bambang, a place in Manila where they can purchase commodities at wholesale price. Midwives at Blue Star clinics purchase their commodities from the NGO (PSPI). Two respondents (1 in Davao and 1 in Cavite) received FP supplies from nearby public health centers. In Davao, the midwife gets IUD supplies from the health centers because the staff there is not trained on IUD insertion and refers clients to her lying-in clinics. The health center gives the IUD for free but the lying-in clinic



charges for the insertion. In Cavite, the midwife gets referrals from the nearby health centers. Respondents experience problems in procuring Norifam (1-month injectable) from AlphaMed. According to respondents, med reps stopped visiting their clinics and when they call to place orders, stocks were not available. In Cavite, Norifam availability is no longer an issue because a pharmacy (ERS) became a local retailer. Respondents in Cavite got feedback from the clients that Marvelon (OCP) is no longer available in the market. [Note: manufacturer is Merck; distributor is Zuellig Pharma.]

**5. Do clients go to clinics solely for FP? Do clients go to the lying-in clinics with a Family Planning method in mind?**

Most clients go to the facility with a family planning method in mind, usually pills. A few go to clinics because they want to switch methods. In Cavite, many of the walk-in clients are pill users who experience side effects, so the midwives advised the clients to switch to DMPA. In Quezon City, clients are aware of FP methods because of the government campaigns featuring community-based FP lectures by Barangay health workers (BHW). In Davao, 3 clinics reported that they regularly conduct information drive and outreach programs in their communities. One clinic previously received assistance from PRISM to conduct Buntis (pregnant) parties and mother's classes, during which they discussed FP methods. Currently, this clinic receives assistance from Rotary Club to continue these activities and so most of her walk-in FP clients learned about FP through her outreach programs.

**6. What do you think of youth accessing FP services?**

Most adolescents come to the lying in clinics for pre-natal checkup. There are only few cases that adolescents go to the clinics to ask for FP services. The majority of youth who ask for FP services come to the facility after giving birth. These young clients go with their guardians or parents, since consent is needed before FP services are provided. One midwife in Quezon City reported that she had one adolescent client who was brought by her mother; the client had not given birth but the mother knew that her daughter was sexually active. One respondent had a few cases of teenagers, wearing school uniforms, coming to her clinic for pregnancy test but not for FP counseling or services. One respondent strongly disagreed with giving FP methods to adolescents.

*“ang isip ng mga bata, tulog, tapos gigisingin mo. Through curiosity, marami ang mag try at magkamali dyan.” [If you awaken the minds of the youth, they will be curious. Many will try {engage in sex} and many will make mistakes].*

Another respondent believes that fertility awareness can be taught among 3rd year and 4th year students because this is the period when many teen pregnancies occur. Another respondent provides FP services to adolescents and always advises for dual FP methods (condoms and another method) because she believes that these adolescents may have multiple partners and are prone to sexually transmitted infections. Respondents also cited cases where adolescents think that their lying-in clinics cater to all forms of FP methods, including abortion. The midwives stated they make sure to do a proper assessment and request a pregnancy test before they provide FP services. Midwives mentioned that they use the GATHER approach, which was part of their FP CBT 1 training, to assess their clients.

## **Health Financing (PhilHealth)**

**7. What made you decide whether or not to participate in PhilHealth? How did you get to participate in PhilHealth as a provider?**



All the respondents' lying-in clinics and the providers themselves are PhilHealth accredited. Most respondents agree that all facilities should be PhilHealth accredited. By being PhilHealth accredited, the lying-in clinics can help their communities and at the same time increase the profit of the clinics.

*"If di ka PhilHealth accredited, mapag iiwananan ka. Mas malaki ang kita sa PhilHealth" ["If you're not PhilHealth accredited, you'll be left behind. We earn more because of PhilHealth."]*

In Quezon City, the respondents mentioned that clinics will be questioned by the LGU if they do not receive PhilHealth accreditation. One clinic in Davao caters to poor communities. It participates in PhilHealth in order for their clients, mostly indigents whose PhilHealth memberships are sponsored by the LGU, to avail themselves of the PhilHealth benefits. PhilHealth accreditation also sustains their clinic operations, as they use the funds to cross-subsidize other patients (e.g., Badjaos and indigenous people), who could not get PhilHealth membership because of lack of birth certificate and other supporting documents.

#### **8. What was the accreditation process like when you started? How long did it take?**

Most respondents did not experience difficulties in having their clinics accredited for the first time. The trainings are considered expensive but the majority received assistance from DOH, PRISM and clinic networks such as Blue Star and Well Family Midwife Foundation. According to the respondents, if the provider has received all the trainings and the supporting documents are complete, a facility can be accredited in less than a month. Accreditation fees are P3,600 for providers (renewed every three years) and P1,500 (renewed every year).

The midwives reported difficulties complying with the DOH LTO requirements. In 2016, DOH issued a Department Order that all lying-in clinics need DOH LTO before they can renew their PhilHealth accreditation. The LTO costs a yearly fee of P3,000. All respondents reported that they could not comply with the required clinic space requirement (50 sq. m. for 1 bed capacity) and the majority of the respondents had to renovate their facilities, prompting them to use their personal savings or avail of loans. Getting the permit to construct and floor plan approval for these renovations took three to six months. One midwife reported paying DOH engineers and architects to have her floor plan approved while another one hired DOH architects to design her floor plan.

There are also several inconsistencies in the requirements of PhilHealth and DOH:

- PhilHealth allows unlimited deliveries; DOH allows deliveries for G2 up to G4, G1 is still pending; PhilHealth still reimburses claims for G1 deliveries
- PhilHealth does not have a clinic space requirement as long as the clinic has delivery room, recovery room and consultation room
- PhilHealth requires isopropyl alcohol while DOH requires ethyl alcohol
- PhilHealth requires a crib but DOH prohibits cribs in lying-in clinics
- PhilHealth requires two drop lights but DOH promotes skin-to-skin, so drop lights are not used
- PhilHealth requires midwives to have a memorandum of agreement with diplomate doctors (which midwives report is difficult to do). DOH doesn't require this.

Midwives consider the additional training requirements to be too expensive. BEMONC training costs P10,000 to P12,000, with costs depending on the training institution. Midwives also have a hard time getting schedules for trainings.

In Quezon City, the midwives also need to comply with Quezon City government regulation to get a sanitation permit (e.g., monthly water analysis that costs P700 per month and quarterly pest control). Without a sanitation permit, the business permit—a required supporting document for PhilHealth accreditation—is not issued.

#### **9. What are the PhilHealth packages that a clinic can claim?**

All of the respondents are aware of the PhilHealth packages that a lying-in clinic can claim from PhilHealth:

- Maternity Care Package (MCP): P8,000 (P7,840 net of taxes)
- Newborn Care Package (NCP): P1,550 (P1,519 net of taxes)
- PPIUD: P2,000
- Implants: P3,000

In Quezon City, the respondents would rather charge for FP services instead of submitting for PhilHealth reimbursement. One respondent complained about tedious requirements to submit a claim while another respondent complained about the length of time before payments are received from PhilHealth.

*“Pinapacash ko na lang kesa mag antay ako sa claims.” [I ask the clients to pay in cash instead of waiting for my claims.]*

#### **10. What is your experience on PhilHealth claims?**

Most respondents receive their MCP claims within two to three months. However, not all claims submitted are paid by PhilHealth. According to midwives, 20 to 30 percent of submitted claims are either returned to hospital (RTH) or unpaid. In all 3 study sites, some midwives have not yet received any claims for the January to June 2017 period. According to one midwife who followed up her claims from PhilHealth, the staff admitted that PhilHealth has backlogs in processing claims. One midwife does not experience any problems with her claims and reported 100 percent payment of submitted MCP claims. PhilHealth payments for NCP take longer than MCP claims. Midwives reported not receiving some of their NCP claims submitted in 2015 or 2016. Only one midwife reported denied claims for subdermal implant because PhilHealth required an additional form (CF-3) even though their policy only asked for CF-1 and CF-2. Midwives have logbooks to track their PhilHealth claims.

Most respondents recently attended PhilHealth’s orientation on e-claims. The majority feel that the e-claims process is an added burden to them because the lying-in clinics would either need to hire their own IT personnel in-house or tap a PhilHealth accredited IT company to process their e-claims. In Davao City, one such IT provider charges P2,000 per month.

#### **11. What are your suggestions on how to improve PhilHealth accreditation and DOH licensing processes?**

Midwives’ suggestions focused on synchronizing the timeline for PhilHealth accreditation for facilities and providers (i.e. make both every 3 years). Monitoring of facilities could continue on a yearly basis. They also emphasized the need to ensure consistency in policies and standards of DOH and PhilHealth.

## **12. Has PhilHealth enrollment increased client flow? Changes in client demographics?**

Most of the clients in lying-in clinics are PhilHealth members. There are indigent programs and sponsorships from LGUs or other politicians, so even poor clients have PhilHealth. Some midwives even cover the P2,400 yearly PhilHealth contributions of patients who cannot afford to pay for their PhilHealth contribution. This payment is viewed as an investment since the midwives would then be able to submit claims to PhilHealth for the client's care. One midwife in Cavite has established a partnership with the LGU, in which she enrolls her patients and the LGU pays the membership fee.

## **Access to Financing**

### **13. What kind of obstacles do private providers face to expand their practices?**

One key challenge is competition. There are so many private lying-in clinics and now government lying-in clinics as well. In Quezon City, some lying-in clinic clients reported that government midwives, nurses and BHWs aggressively push to have pregnant mothers give birth in the government lying-in clinics, warning that their children will not receive immunizations if they do not do so. This is because the government lying-in clinics' payments from PhilHealth are spread across all lying-in clinic staff, from doctors to BHWs.

A second challenge concerns personnel turnover at the clinics. In Davao, midwives and nurses are transferring to a government hospital due to increased job security. Respondents also believe that there are very few enrolling in Midwifery course while many midwives are retiring. Next year is also the start of the full implementation of the 4-year midwifery course.

A third challenge relates to the DOH LTO requirements. If a lying-in clinic wants to expand its current facility, the clinic needs to submit a layout to DOH. Many midwives find the LTO process to be tedious. The need to finance renovations to receive their LTO has placed additional financial burdens on the midwives.

### **14. What is your experience working with financial institutions?**

Midwives mostly finance their clinic operations or renovations using their own savings. Some midwives availed of loans from banks, lending companies, or loan sharks ("turko"). In Davao City, most midwives tapped loan sharks (Turko/ Indians). One midwife received a loan of P200,000; the loan shark charged P40,000 interest is P40,000, which she paid off at a rate of P800 per day. Blue Star clinics can avail of loans from the NGO (PSPI). PSPI also provides an advance against PhilHealth claims, for which it charges 10% of the total claims. According to most respondents, it is easy for midwives to access loans because they only need to have a business permit in order for a bank to process the loan.

### **15. In your experience, why are private providers likely to need loans?**

Most midwives needed loans to finance the renovation of their facilities to comply with the LTO requirements of DOH. However, in Cavite, most midwives are inclined not to access loans through banks or lending companies because of the experience of other midwives who did so and then did not get their license to operate. These clinics closed and the midwives ended up in debt.

## Private Nurses

**Table 10. Profile of FGD participants**

City/Municipality	Dates of FGD	Number of Respondents
Davao City	June 30, 2017	8 (4 clinic owners and 4 clinic staff, including 2 hospital-based)
Cavite	July 4, 2017	5 (4 clinic owners and 1 staff)
Total		16

**Table 11. Profile of FGD participants**

Study Area	Results
FP Services offered in the facilities	<ul style="list-style-type: none"> <li>• Injectables – 54%</li> <li>• Pills – 62%</li> <li>• IUD - 46</li> <li>• Implants – 54%</li> <li>• Condoms – 31%</li> <li>• SDM – 23%</li> </ul>
PhilHealth membership	<ul style="list-style-type: none"> <li>• 100%</li> </ul>
PhilHealth member clients	<ul style="list-style-type: none"> <li>• Range: 50% to 98%</li> <li>• Mean: 84%</li> </ul>
Duration of PhilHealth payment	<ul style="list-style-type: none"> <li>• Range: from 30 days to 60 days</li> <li>• 7 respondents: 30 to 60 days</li> <li>• 3 respondents: 30 days</li> <li>• 3 respondents: no answer</li> </ul>
Mode of payment from PhilHealth	<ul style="list-style-type: none"> <li>• Check payments – 8 respondents</li> <li>• Bank deposit – 4 respondents</li> <li>• No answer – 1 respondent</li> </ul>
Accept other private insurance Schemes	<ul style="list-style-type: none"> <li>• 1 Respondent (Maxicare, Intellicare)</li> <li>• 1 Respondent (Medicare, Maxicare, Intellicare)</li> </ul>
PhilHealth coverage for own healthcare needs	<ul style="list-style-type: none"> <li>• Yes: 10</li> <li>• No: 0</li> <li>• No Answer: 3</li> </ul>
Work with non-PhilHealth insurance programs	<ul style="list-style-type: none"> <li>• None</li> </ul>
Financial Access	<ul style="list-style-type: none"> <li>• Self-financed: (from savings/ equity): 11</li> <li>• Family or friends: 4</li> <li>• Supplier Credit: 1</li> <li>• Banks: 1</li> <li>• Cooperatives, lending firms and individual: 1</li> <li>• No response: 2</li> </ul>
Financial institutions	<ul style="list-style-type: none"> <li>• No answer: 13</li> </ul>
Applied for loan	<ul style="list-style-type: none"> <li>• Yes: 4</li> <li>• No: 9</li> </ul>
Does the facility need a loan?	<ul style="list-style-type: none"> <li>• Yes: 1</li> <li>• No: 11</li> <li>• Not Sure: 1</li> </ul>
Purpose of loan	<ul style="list-style-type: none"> <li>• Transfer of facility – 1</li> </ul>

## Service delivery

### 1. What family planning services are being offered in the facilities?

All facilities providing FP services in their lying-in clinics, with most preferring LAM. One third of the facilities cited being pro-breastfeeding. DMPA is the second preferred FP method. According to respondents, women can have progestin-only injectable (3 months) while breastfeeding.

*“I always explain yung benefits ng LAM. Syempre it would only be applicable for 6 months. May mga instances na hindi siya talaga pwede dahil na-interrupt na yung LAM. I will ask kung ano yung choice nila and before that, I will explain kung ano yung available sa amin. Yung pills, injectables at condom” [“I always explain the benefits of LAM. Of course it would only be applicable for 6 months. There are instances that she can’t do LAM. I’ll ask for her choice but before that, I will explain what is available here—pills, injectables and condom.”]*

In Cavite, DMPA is a popular contraceptive method because most clients are factory workers, with shifting schedules. DMPA is more convenient to them than taking pills. According to one respondent, DMPA has fewer side effects. FP counseling is done during pre-natal and postnatal checkups. Most clients accept a family planning method during postnatal/postpartum check-ups. Implanon became a popular FP method of choice in Davao prior to the TRO due to strong advocacy by the public health centers. In both study sites, respondents had clients who requested an IUD. Most respondents do not want to perform an IUD insertion because of lack of confidence in their skills to provide this service. These respondents either refer the clients to their partner obstetricians or to the RHUs.

*“Skills yan eh. For you to learn more, kailangan madami eh. Sa 20 patients na nanganak, di naman magpapalagay kaya difficult ma continue yung training mo and skills”- Davao nurse*

*[“It’s about skills, for you to learn more, you need to do more insertions. In 20 patients who give birth, none would want IUD insertion, so it’s difficult to have skills or apply what you learned in training.”]*

### 2. What prevents you from providing other FP services?

- For permanent methods (i.e. bilateral tubal ligation (BTL) and vasectomy), nurses refer clients to hospitals or obstetricians.
- For implants, nurses cited a lack of training; high costs of training; difficulties in accessing the training schedule; a lack of patient demand due to the TRO; and provider bias based on the misperception that it causes abortion.
- For PPIUD and IUD, nurses cited a lack of training and a lack of confidence in their skills, so they refer to their partner obstetricians.
- For injectables, nurses stated that the method is not available in their facilities.

### 3. Why do you think clients come to your facilities broadly for FP services?

The main reason cited concerned lack of availability in the public sector; due to supply shortages, RHUs refer clients to the nurses’ facilities.

**4. How do you access FP commodities for your business? Are there any challenges that you face?**

FP commodities generally are purchased through medical representatives of distributors such as DKT and AlphaMed. Blue Star Clinics get their commodities through PSPI. In Cavite, aside from DKT and Alphamed, the clinics also get supplies from ERS Enterprises and Louvell Enterprise (a retailer of FP commodities and other medical supplies). AlphaMed requires a minimum order of the 1-month injectable and charges P50 for each one. Nurses report paying for these commodities either cash on delivery or by issuing post-dated checks. In Davao, nurses refer clients to the RHUs when their clinics run out of FP commodities.

**5. Do clients go to clinics solely for FP? Do clients go to the lying-in clinics with a Family Planning method in mind?**

Most clients go to the facility for pre-natal check-ups. In three Cavite clinics that receive referrals from RHUs, nurses estimated that 50 percent of those clients seek FP services.

**6. What do you think of youth accessing FP services?**

Most adolescents go to the nurses' facilities for pregnancy test or pre-natal check-ups. During pre-natal checkups, pregnant adolescents are informed that the lying-in clinics cannot perform normal deliveries for those below 19 years old. In Cavite, one respondent refers pregnant adolescents to the teen center while another respondent refers pregnant adolescents to Philippines General Hospital. One facility reported that it occasionally sees adolescent clients seeking FP services, probably due to its location clinic is near a school.

In Davao, adolescents go to their facilities for FP services after giving birth. It is usually the mothers who decide on the FP method for their daughters. In Davao, UNICEF sponsors adolescent outreach programs. As part of them, nurses and doctors (internal medicine and pediatricians) go to barangays to lecture on FP, provide free pap smears (for all ages) and other services.

*“Ang focus namin sa teens pero ang kasama all ages. Kasi di magpunta ang teens kung alone lang.” [Our focus is on teens, but we include all ages. Teens won't go {to clinics} on their own.]*

Overall, nurses expressed mixed responses regarding the provision of FP services to adolescents; some respondents are only willing to provide FP counseling.

*“Discussion lang siguro para magka knowledge on FP. Magbigay? Siguro, hindi. Baka mabuntis” [Maybe, I'll discuss FP methods so that they become knowledgeable but to give FP, probably not. They might get pregnant] – Cavite nurse*

*“Men are already condom users.”*

*“Pag active, ina-advise ko na mag injectable.” [If sexually active, I advise injectables] – Cavite nurse*

## **Health Financing (PhilHealth)**

**7. What made you decide whether or not to participate in PhilHealth? How did you get to participate in PhilHealth as a provider?**



All respondents cited that Philhealth accreditation is a requirement. In Cavite, respondents mentioned that the requirements to get a business permit are similar to DOH licensing requirements, which is needed for PhilHealth accreditation. One facility mentioned being pressured by the local government to fast track their Philhealth accreditation. Competition is also a key factor. According to one respondent, other lying-in clinics in her town are already Philhealth accredited, so she needed to apply in order to compete with them.

**8. What was the accreditation process like when you started? How long did it take?**

Most respondents felt that the Philhealth accreditation process was easy. Some respondents received assistance from PRISM Project and NGO networks (PSPI). PRISM Project and PSPI sponsored the necessary trainings and provided equipment for some facilities. PSPI also assisted Blue Star Clinics in renovating the clinics. Nurses also felt that renewing their accreditation (both provider and facility) is easy but costly. Trainings, such as Basic Life Support and BEMONC training, are needed every year and very expensive. BEMONC training costs P20,000. Respondents also cited difficulty in getting the schedules for these trainings. For the FP CBT 1 training, clinic owners formed a group and paid P4,500 per participant in order to get a schedule.

Clinic owners had difficulty complying with DOH licensing requirements, especially those related to clinic space. Two clinic owners transferred to a new location to comply with this requirement. Many clinic owners renovated their facilities. In Davao, some clinic owners reported that they had to have blueprints for their renovations approved in Manila, which took additional time.

**9. What are the PhilHealth packages that a clinic can claim?**

All respondents are aware of the Maternity Care Package and New Born Care Package. Many respondents know about the IUD and subdermal implant packages. In Cavite, respondents knew about IUD and implants packages but not the amount provided. In Davao, respondents know that Philhealth reimburses lying-in clinics P3,000 for Implanon and P2,000 for IUD insertion.

**10. What is your experience on PhilHealth claims?**

Most respondents receive their MCP claims within two to three months, although sometimes it took up to six. Nurses also noted that not all submitted claims get paid and that clinic owners need to track their PhilHealth payments.

*“In case magpasa ka ng 6, good na yung 5 ang babayaran. Yung ika anim, parang missing pa ilang months pa bago... hanapin pa siguro sa file.” [“It’s good when you pass 6 claims and get paid for 5 claims. The 6th claim takes months. They {Philhealth} will probably check their files.”]*

Some reported having claims returned to the facility, mainly for missing signatures; lack of documents and valid ID; and incomplete claim forms. The most common reason for denied claims related to errors encoding the date and time of admission/ delivery.

Respondents believe that claims should be paid within a week of submission because the clinic relies on PhilHealth payments to sustain their operations. Clinics cannot charge clients because of the no balance billing (NBB) policy of Philhealth. According to one respondent, P50,000 is the monthly revolving fund needed by a facility. Clinic owners have assigned staff to process PHIC claims and one clinic has started using e-claims.



**11. What are your suggestions on how to improve PhilHealth accreditation and DOH licensing processes?**

Nurses suggested reducing the training requirements; improving consistency between PhilHealth policies and standards for reimbursement and DOH licensing; and starting joint monitoring visits of DOH and PHIC.

**12. Does your perspective change on Philhealth from provider to user/member?**

Most respondents consider the Philhealth benefits okay for pregnancy-related concerns but not other medical concerns. For other medical concerns, there are still out-of-pocket payments if a patient gets confined in a hospital.

**13. Has PhilHealth enrollment increased client flow? Changes in client demographics?**

Most clients are Philhealth members. These members only update their contributions when they are pregnant. Most clinic owners enroll their clients to Philhealth. Clinic owners also pay their client's yearly contribution because uncovered clients will most likely not pay them.

*“Pag cash, di ka mababayaran eh. Kaya nag tiyaga kami sa Philhealth. Minsan, kami na nagaabono sa pambayad nila” [If they opt to pay cash, we won't get paid. So, we rely on Philhealth. We even cover their contributions.]*

## **Access to Financing**

**14. What kind of obstacles do private providers face to expand their practices?**

Some respondents want to provide ultrasound services for their clinics but the equipment is very expensive (portable ultrasounds costs P150,000) and it requires training. Construction or renovation of clinics are very expensive. Nurses also feel that there are too many requirements, including requirements to get a business permit, Bureau of Internal Revenue requirements, and DOH licensing requirements. One clinic owner closed a clinic branch because of difficulty in getting a business permit.

**15. What is your experience working with financial institutions?**

Nurse respondents expressed that there was a fast approval process, with some banks only asking for a government ID or business permit.

**16. In your experience, why are private providers likely to need loans?**

Most nurses described needing loans to purchase cars/ transport service for the clinic or to finance renovation or construction of clinics.

## Private Doctors

**Table 12. Profile of FGD participants**

City/ Municipality	Dates of focus group	Type of Specialization	Type of Facility	Number of Respondents
Caloocan City	June 27, 2017	OB-GYNE	Stand-alone – 4 Hospital based clinics- 7	11
Quezon City	June 28, 2017	OB-GYNE	Stand-alone clinics- 3	3
Davao	June 29	OB-GYNE	Hospital-based clinics - 2	2
Davao	June 30	OB-GYNE	Stand-alone clinics- 3	3
Total				19

**Table 13. Profile of FGD participants**

Study Area	Results
FP Services currently provided	<ul style="list-style-type: none"> <li>• 58% provide condoms</li> <li>• 83% provide OCPs</li> <li>• 8% provide implant insertion and removal</li> <li>• 50% provide IUD insertion and removal</li> <li>• 50% provide injectable</li> <li>• 42% provide BTL</li> <li>• 67% provide counselling</li> <li>• 17% provide LAM</li> <li>• 42% provide Natural Methods</li> </ul>
PhilHealth membership	<ul style="list-style-type: none"> <li>• 92% of the Facilities participate in Philhealth</li> <li>• 1 facility is due for accreditation</li> </ul>
Duration of PhilHealth payment	<ul style="list-style-type: none"> <li>• range from 60 – 270 days</li> <li>• (Mean: 123 days)</li> </ul>
Mode of payment from PhilHealth	<ul style="list-style-type: none"> <li>• 8 facilities (67%) receive payments from Philhealth through Check</li> <li>• 1 facility (8%) receive payments through Bank Deposit</li> <li>• 1 Facility (8%) receive through other method</li> </ul>
Accept other private insurance schemes	<ul style="list-style-type: none"> <li>• 83% accept other private insurance schemes</li> <li>• Other insurance schemes include HMOs (AsianLife, Valuecare Cocolife, HPPI, Intellicare, Medicaid, Medicare, Maxicare, Philcare)</li> </ul>
PhilHealth coverage for own healthcare needs	<ul style="list-style-type: none"> <li>• 11 facilities (92%) have coverage for own healthcare needs</li> </ul>
Financial Access	<ul style="list-style-type: none"> <li>• 92% are interested in growing and expanding their practice</li> <li>• 92% finance their investments from savings/ equity, 25% from banks, 25% from family and friends</li> <li>• 42% applied for loans and only one (1) facility currently needs a loan</li> </ul>
Worked with financial institutions	<ul style="list-style-type: none"> <li>• 25% worked with financial institutions</li> <li>• Financial Institutions that the respondents have worked with are Citiphils., Prulife UK, and Sun Life of Canada</li> </ul>
Worked with Financial Institutions	<ul style="list-style-type: none"> <li>• 25% worked with financial institutions</li> <li>• Financial Institutions that the respondents have worked with are Citiphils., Prulife UK, and Sun Life of Canada</li> </ul>

Clients Seeking FP	<ul style="list-style-type: none"> <li>• Clients ages from 15 – 24 years has an average of 23%; the highest percentage is 50%</li> <li>• <b>Poor:</b> An average of 23% from the 12 facilities while one facility provides 70% are poor</li> <li>• <b>Middle Income:</b> The middle class has the highest percentage of clients seeking FP services with an average of 47%</li> <li>• <b>Wealthy:</b> An average of 13% where facilities only provide 10 – 30% of FP services.</li> <li>• An average of more than half of the clients is married at 57%.</li> </ul>
Trainings and Resources Received	<ul style="list-style-type: none"> <li>• Only 4 facilities received trainings:</li> <li>• IUD Insertion and Removal, FP Counselling, Basic FP Training, and LAM and Breastfeeding Advocacy Seminar</li> </ul>

## Service delivery

### 1. What family planning services are being offered in the facilities?

All respondents provide FP services in their facilities. Most respondents provide OCPs, injectables, and condoms. There are variations in the provision of other modern methods such as IUD (interval and PPIUD), long acting and permanent methods (BTL and NSV), and sub-dermal implant.

OCPs are the most common FP method of choice in the private facilities, followed by injectables. Most respondents stated that most clients would come to the facilities with pills as their preferred method. One doctor believed that women are more knowledgeable when it comes to pills compared to other contraceptive methods. However, doctors expressed conflicting views about the effects of the TRO on availability of methods. Some respondents cited availability issues on pills, since they believe that the TRO also covers DKT, the manufacturer of pills. One doctor stated that DKT no longer sponsors the activities of the Philippine Obstetrical and Gynecological Society (POGS) because of the restraining order. Another respondent mentioned that the TRO is specific to Implanon and not pills.

In three private facilities, Implanon became the second most popular choice among women prior to the TRO. These facilities received training and a few batches of subdermal implants from DOH or UNFPA. Following the TRO, clients opted for other FP methods and facilities reported issues procuring the commodity because it is not available in the market. According to doctors, most patients would hear about Implanon from other sources (neighbors, friends) and want their obstetricians to provide it. When it is not available, doctors offer patients the chance to go to another facility or choose another method.

### 2. What prevents you from providing other FP services?

- For BTL, doctors refer to a hospital. Private doctors do not know that a clinic can be accredited by Philhealth to provide and submit claims for BTL performed on site. They also reported cases of women, after caesarian section, opting for BTL but not able to get their husband's consent as required under the RH law.
- For vasectomy, there are a very low number of acceptors. Husbands would rather push for their spouse to accept a family planning method. Some private facilities conducted medical missions and encourage vasectomy but there were no takers. There is only a 0.5% chance that a husband would show interest on vasectomy.

*“sinasabi namin na libre yan kaya lang may counseling, tapos we refer to Dr. Art, kaya lang, most of the time, tinutulak ng husband ay yung asawang babae na mag FP” – NCR doctor*

*(“We told them that this is free, but you have to undergo counseling. Then, we refer to Dr. Art. But most of the time, the husband pushes the wife to avail of the FP service.”)*

- The one month injectable option is limited by lack of supplies and stock outs. One doctor in Davao stated that it used to be the most popular method at her facility, so she had to buy stocks from a fellow doctor in Cotabato who had purchased the commodity abroad at a higher price. She eventually asked clients to shift to the three-month option.
- For implants, a few doctors were limited by the TRO (they had previously received their implant supplies from the DOH or they believed it was now illegal for them to deliver); lacked training, or unable to re-stock. A private facility used to provide Implanon to patients but eventually opted to refer the patients to a private hospital that offers the service for free. This hospital gets its supplies from PSRP. Another private doctor cited problems purchasing Implanon. Their facility used to get the stocks from UNFPA and PSRP. Implanon NXT by Merck is not available in the market because of the TRO.

*“nung nagkaroon ng TRO, yung mga patients namin nag back out, natakot sila” – NCR doctor*

*(“When the TRO was issued, many patients backed out. They were scared.”)*

*“Before, Implanon was the 2nd most provided FP method in our facility, but there is a restraining order.” – Davao private doctor*

- For PPIUD doctors cited a lack of training.
- For IUD, doctors cited availability issues. Private doctors in one hospital stated that IUDs were not available because the hospital administration had reservations about it.

### **3. Why do you think clients come to your facilities broadly for FP services?**

One respondent mentioned that a client went to the private clinic because the contraceptive method was not available in the public health center. Most women go to the private facilities for pre-natal checkup and not solely for family planning services. It is rare that a client goes to a private facility for family planning. One doctor believed that FP is more service or charity work.

*“Even us na private practitioner, manganganak sa amin, tapos pag may BTL na, punta na sa health center kasi it is offered for free.” (“even us, private practitioners, we handle the delivery, then if they want BTL, they go to the health center because it is free.”)*

Another doctor agreed that a clinic will not sustain its operations if it only provides family planning services. A clinic should provide reproductive health services such as deliveries, prenatal checkups, gynecological checkups, ultrasound, etc.

The facilities provide FP counseling during pre-natal and postnatal checkups. Most women decide to accept a family method after delivery. Most doctors believe that right after delivery is the ideal time to offer FP methods to the patients. One respondent said that in 10 clients, only two would go to the clinic solely for FP services. However, she believes that there is increasing trend in women seeking FP services after deliveries. This doctor is an FP advocate and offers IUD to postpartum patients.

*“Noon kasi, paanak lang ng paanak. May skills kasi ako, so I offer it. So, aware ang patients ko na you need to go for FP, especially 2 years pa lang na nagka anak, dyan medyo aggressive ako for FP services.” (“Before, I just performed deliveries. I have the skills [on FP] so I offer it. So, my patients are aware that they need to go for FP. I am aggressive in providing FP services to women who gave birth in less than 2 years.”)*

Another respondent said that during the six-week postpartum follow up, there was a time that she had 80 percent of her postpartum clients would accept OCP.

For women who go to the clinics solely for family planning, most women heard about it through their neighbors and friends. They seek the doctors' advice on the side effects and misconceptions that they heard from their neighbors and friends. One respondent emphasized the opportunity doctors have to increase family planning acceptors due to their status as trusted sources of information by their clients.

*“Ultimately, dapat doctor talaga ang mag explain and they will believe you. Sasabihin nila, kung ano sinabi mo doctora. If I lay down FP options: Ikaw doctora, ano maganda para sa akin.” – Davao doctor*

*(“Ultimately, the doctor should explain, then the patients will believe. My patients will tell me: whatever you say, doctor. So, if you lay down the options, they will say: it's up to you, doctor, what you think is good for me.”)*

#### **4. How do you access FP commodities for your business? Are there any challenges that you face?**

Private doctors either purchase the commodities or issue prescription. Private facilities that purchase commodities usually have payment schemes with the manufacturers/ distributors or pharmaceutical companies. They pay cash on delivery for the first three purchases and then are able to access consignment deals (payment up to 30 days) from the manufacturers. Medical representatives usually go to the clinics and offer their products. According to one respondent, most medical representatives of pharmaceutical companies or distributors go around the hospitals to talk to the doctors but they seldom go to stand-alone clinics. The medical representatives know their clinics because they started their practice in the hospitals.

DKT is the main distributor in NCR and Mindanao. One doctor mentioned getting deals from DKT such as buy 10, get 2 or buy 20, get 5. These facilities do not make bulk purchases for FP commodities. They only buy a few supplies because demand is low. While majority of the respondents do not have any challenges in procuring FP commodities from the DKT, three respondents have experienced stock outs. In Davao, two doctors mentioned not receiving IUD stocks for three months; one private doctor in NCR mentioned a patient's inability to purchase prescribed OCPs in the pharmacies due to a lack of availability. Respondents also noticed that deliveries of commodities during Christmas season are delayed, so they usually purchase more commodities before the Christmas season.

#### **5. What do you think of youth accessing FP services?**

The majority of respondents believe that adolescents are more open, liberated and sexually active. There are clients as young as 11 years old going to the facility. In one facility, the doctor would check if it's an abused case and would find out that the 11-year old is sexually active.

Most adolescents go to the clinics because they suspect that they are pregnant or seeking pre-natal care. The adolescents, with their parents, are provided FP services after deliveries. Adolescent (below 19 years old) seldom go to a clinic for FP services.

*“We have a 15-year old patient na gravida-2. So, nagtatanong na doc, ayaw ko pa muna mabuntis, Ano’ng family planning ang pwede gamitin?” (“We have a 15-year old patient who is pregnant. So, doc asks, I do not want to get pregnant, what family planning can I use?”)*

One respondent never had a youth FP or pre-natal client because residents in the community are advised that lying-in clinics cannot attend deliveries for women younger than 19 (the age limit set by Philhealth for deliveries). A few doctors have experienced providing FP services to adolescents. The main concern is the need for parental consent. Among the few adolescents who go to the clinics, they usually go alone, with the boyfriend, or with friends. According to one doctor in Davao, her young clients usually come from middle income families from the city and are educated. She had young clients from the provinces but these clients seek FP services because they already have children. There are also cases of adolescents from neighboring towns or provinces going to the city to ask for FP services because of anonymity.

*“Ayaw nila doon kasi mabisto sila. Maybe, they come here incognito kasi di sila kilala. If you go to your province, everyone knows everything. If you go to the health center, i-chismis ka ng midwife. Yung anak ni ano, nanghingi ng pills” (“They don’t want to access there because people will find out. Maybe, they come here incognito because no one knows them. If you go to the province, everyone knows everything. If you go to the health center, the midwife may spread that the child of someone went to the facility to ask for pills.”)*

One doctor provides FP services to the youth even if it is illegal without parent’s consent and usually provides OCPs. POGS informs their doctors to abide by the law but in her practice, she provides FP methods to adolescents.

*“Alam mo na these kids, I believe that every time they go for contraception, it is a call for help. Alam mo na sexually active sila and just because natakot ka, when you can save a soul, help an individual more if you give her contraception” (“.. You know that they are sexually active and you can’t give them FP service because you are scared, when you can save a soul...”)*

The majority of respondents cited the Adolescent Health Issues and Perspectives (AHIP) of POGS. This program started 10 years ago and still conducts lectures among high school students on sexually transmitted infections (STIs); the program’s goal is to discourage early sexual initiation among youth. POGS is initiating a similar program for out-of-school youth. The program was scheduled to be launched in Davao last May 2017 but it was postponed because of the declaration of Martial Law.

## Health Financing (PhilHealth)

### 6. What made you decide whether or not to participate in PhilHealth? How did you get to participate in PhilHealth as a provider?

Most respondents are Philhealth accredited doctors. Hospital-based clinics require doctors be accredited. If a doctor is not, the doctor will pay the portion that Philhealth has to pay for its member. For lying-in clinics, doctors also need to be accredited. Philhealth accredits both the health provider and the facility. Among the respondents, only 1 facility is not Philhealth



accredited because of the DOH LTO requirement. The majority of respondents believe that a doctor needs to be Philhealth accredited for the benefit of the patients. A majority of the respondents also believe that Philhealth accreditation of providers and facilities should be automatic since most potential clients are Philhealth members. Respondents believe that the no balance billing (NBB) of Philhealth allows them to cater to all kinds of clients, including indigents.

*“Kung wala ka Philhealth, wala magpunta sayo and bihira na pupunta na patient sa isang doctor not accredited to Philhealth kasi sisingilin ko siya ng Philhealth amount compared to covered na siya.” (“If you’re not Philhealth accredited, no one will go to you and it is rare that a patient goes to a doctor that is not Philhealth accredited because a patient would have to pay instead of being covered by Philhealth.”)*

For normal spontaneous deliveries, there is emergency Philhealth or point of care for non-members who go to the hospitals. At lying-in clinics, non-members who go there for pre-natal care are encouraged to pay the Philhealth membership before they get admitted or before they deliver, so they can be covered.

#### **7. What was the accreditation process like when you started? How long did it take?**

The accreditation and renewal process for doctors are easy, according to most respondents. Doctors need to fill out forms, submit documents such as good standing from the Philippine Medical Association and their professional societies, then go to the Philhealth office to submit the paperwork. The accreditation process for a doctor can take only a day if all the forms and supporting documents are correct and the ID is delivered with three months. The accreditation process is good for 3 years. While easy, a majority of respondents believe that the accreditation process is very costly (P15,000). That amount includes the yearly Philhealth accreditation fees and fees to get certificate of good standing from PMA and their specialty societies.

Most respondents did not experience any problems in the Philhealth accreditation process for their clinics. The challenge is in getting DOH LTO. Before, Philhealth accredited clinics even without the LTO; now, DOH licensing is a pre-requisite. Even if clinics are already PhilHealth accredited, they have to receive their LTO this year in order to continue receiving payments from Philhealth. Most respondents consider the DOH licensing requirements to be tedious and costly. To comply with the required clinic space, lying-in clinics had to renovate their facilities, which took 3 to 6 months.

A majority of respondents are concerned with the continuing changes in DOH policies and requirements for the LTO. According to one respondent, the DOH is now on their 3rd or 4th revision. A majority of respondents are also concerned with the new Department of Health-Department of Environment and Natural Resources (DOH-DENR) joint administrative order on environmental compliance. This policy requires a lying-in facility to have a pollution control officer and to secure an environmental compliance certificate from DENR. Moreover, a clinic staff is required to attend seminars thrice a year. The seminar costs P10,000. Most respondents are concerned about the training requirements in order to get accreditation. Respondents believe that the private facilities are not offered the same training opportunities as public facilities. The respondents believe that there are very few training institutions and they don’t know how to access the trainings. Majority of the respondents consider trainings as a costly investment. A BEMONC training costs P25,000. A clinic owner would have to carefully choose which staff (midwife or nurse) to send to these trainings because turnover of clinic staff is high.



#### **8. What are the PhilHealth packages that a clinic can claim?**

Most of the doctors are aware of the Maternity Care Package (MCP), New Born Care Package (MCP) and antenatal care. MCP is P8,000 while NBC is P1,700. Philhealth pays P1,500 for antenatal care. Very few doctors know about the FP packages that a facility can claim from Philhealth. Some doctors knew about FP packages but are not aware of the exact Philhealth payments for each package. One doctor thought that Philhealth only pays P50 for IUD. The PPID package of Philhealth is P2,000. One doctor said that there is profit in providing FP services. According to her, Philhealth pays P3,000 for Implanon. The doctor says that they also charge the patient aside from the package that the facility gets from Philhealth. There is minimal cost to the doctor to provide FP services.

#### **9. What is your experience on PhilHealth claims?**

Most respondents in Davao do not experience problems in their Philhealth claims. When claims are delayed, doctors can easily call Philhealth office in Davao to follow up. For NCR respondents, about 20 percent of claims submitted to Philhealth are returned. There are various reasons for returns, usually due to missing signatures. Claims payments are received from 3 weeks to 6 months. According to respondents, Philhealth usually pays no claims during January to March because that is when facilities usually renew their Philhealth accreditation.

Most doctors have assigned staff that process the Philhealth claims. They have a master list of patients and admissions and they track payments.

#### **10. If you have PhilHealth coverage for your own needs, how does your perception of it change from a provider vs. client perspective?**

A majority of the doctors believe that being a Philhealth member is important. It helps the patient pay for health care costs, albeit minimally. As a Philhealth member, it is easier now to access members' records. There is a portal where the members' records are easily accessed.

One respondent believes that there are questionable processes in the Philhealth system. The respondent cited his experience where he had to stay two more days in the hospital so the hospital can claim from Philhealth.

#### **11. How do other health insurance programs compare to PhilHealth?**

Doctors report getting paid less and more slowly by HMOs compared to Philhealth. Some doctors, especially new ones, prefer to be HMO accredited because they have few patients.

A majority of the doctors do not recommend HMOs for their patients who want to access reproductive health services because most HMOs do not cover deliveries or pregnancy-related cases. There are some HMOs that cover deliveries but the premium is really high.

### **Access to Financing**

#### **12. What kind of obstacles do private providers face to expand their practices?**

Some respondents consider expanding services by providing colposcopy or ultrasound in their facilities but these are very expensive. Colposcopy costs P1.5 Million. Medical equipment suppliers offer flexible terms of payment. Doctors can pay a down payment of 10% to 20% for ultrasound and the remaining amount can be payable in 3 years.

One respondent put up an ultrasound clinic in a mall. The construction of the ultrasound clinic already cost P2million because the clinic design had to follow the mall's design. The ultrasound machine is also very expensive, so the doctor had to access loans from several banks.

Some respondents borrowed money from their family members or relatives to finance their clinic operations. One respondent tapped a colleague to be a business partner.

**13. What is your experience working with financial institutions?**

According to the doctors who accessed loans from banks, the approval process is fast. Private doctors do not have problems accessing loans from banks.

**14. In your experience, why are private providers likely to need loans?**

Most doctors would borrow from banks for personal needs (e.g., car, house) and not for clinic operations.

# Annex B. Key Informant Interview List

Organization	Stakeholder
Association of Health Maintenance Organizations of the Philippines	Carlos D. Da Silva
BPI	
BPI Century Tokyo Lease and Finance Cocrporation	
BPI Family Savings Bank	
CHANGE Project/ Campaigns and Grey	Dr. Cecilia Lantican
CHSI	Cecila Manual Nilo Yucat
City Health Officer, Quezon City	Dr. Verdades P. Linga
Commission on Population	Dr. Juan Antonio Perez III
Department of Education- Region IVA	Dr. Poi Intia
Department of Health	Dr. Diego Danila
Department of Health	Dr. Kenneth Ronquillo
Department of Health	Dr. Lilibeth C. David
Department of Health	Dr. Maria Joyce Ducusin
Department of Health	Dr. Melissa P. Sena
Department of Health	Atty. Nicolas B. Lutero III
Family Planning 2020	Alvin CLoyd Dakis, RN
Family Planning Organization of the Philippines (FPOP)	Mr. Nandy Senoc
HPDP	Dr. Carlo Panelo
IMAP Integrated Midwives Association of the Philippines	Dr. Asuncion Esmele
Insurance Commission	Atty. Dennis B. Funa
Intellicare (Asalus Corporation)	Dr. Ricardo Jocson
Likhaan	Dr. Junice Melgar
LuzonHealth	Easter Dasmarinas
Makati Medical Center Obstetrics and Gynecology	Dr. Zet Palala
Mary Johnston Hospital	Dr. Glenn Roy V. Paraso
Maxicare	Dr. Erlinda Tiuseco
Medicard	Sharon Catapang
Pacific Cross (formerly BlueCross)	
PhilHealth – Accreditation Department (under Quality Assurance Groups)	Dr. Leilani V. Asprer
PhilHealth- Benefits and Development Research Department (under Quality Assurance Groups)	Dr. Melanie C. Santillan
Philhealth- Health Finance Policy Sector	Francisco Z. Soria Jr.
Philhealth- Management Services Sector	Dr. Shirley Domingo
PhilHealth – MDG Benefits	Dr. Mary Antonette Remonte
Philhealth- Member Management Group	Elizabeth M. Manga
PhilHealth- quality assurance groups	Gilda Salvacion A. Diaz
Philippine Business Bank	Rolando R. Avante
Philippine Legislators Committee on Population and Development (PLCPD)	Mr. Romeo Dongeto
Philippine Obstetrical and Gynecological Society	Dr. Mayumi Bismark
Philippine Savings Bank	Angelo Calingo
Philippine Society for Responsible Parenthood Inc (PSRP)	Dr. Coly Catindig
Population Services Pilipinas, Inc.	Rostom Deiparine
Population Services Pilipinas, Inc.	Virgilio Pernito

PPMAP – Mangahas Lying-in Clinic	Lourdes Mangahas
Security Bank	
Society of the Adolescent Medicine of the Philippines, Inc. (SAMPI)	Dr. Emma Llanto
Tanzana National Comprehensive High School	Justin Celeste
Well Family Midwife Clinic	Bing Luderico
Well-Family Midwife Clinic	Carol Millan, R.M.,

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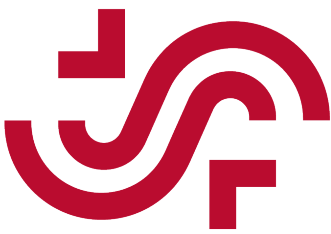
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