Family Planning Spending Assessment (FPSA) of the Philippines for 2018

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LIST OF ACRONYMS AND ABBREVIATIONS

ARMM	Autonomous Region in Muslim Mindanao
BHS	Barangay Health Stations
BLGF	Bureau of Local Government Finance
BMGF	Bill and Melinda Gates Foundation
CGA	Commodity Gap Analysis
CIP	Costed Implementation Plan
CO	Capital Outlay
COA	Commission on Audit
CPR	Contraceptive Prevalence Rate
DILG	Department of the Interior and Local Government
DOH	Department of Health
EO	Executive Order
FBO	Faith-based Organization
FDA	Food and Drug Authority
FHSIS	Field Health Service Information System
FP	Family planning
FPSA	Family Planning Spending Assessment
HNPC	Health, Nutrition and Population Control
LGUs	Local Government Units
mCPR	Modern Contraceptive Prevalence Rate
MOOE	Maintenance and Other Operating Expenses
NASA	National HIV/AIDS Spending Assessment
NCR	National Capital Region
NDHS	National Demographic and Health Surveys
NFPE	National Family Planning Expenditure
NFPP	National Family Planning Program
NGOs	Non-government Organizations
NHA	National Health Accounts
NIT	National Implementation Team
OOP	Out-of-pocket
PDP	Philippine Development plan
PhilHealth	Philippine Health Insurance Corporation
PNHA	Philippine National Health Accounts
POPCOM	Commission on Population and Development
PPMPE	Philippine Population Management Program Expenditures
PSA	Philippine Statistics Authority
PS	Personal Services

RA	Republic Act
RHSC	Reproductive Health Supplies Coalition
RHUs	Rural Health Units
RPRH	Responsible Parenthood and Reproductive Health
SDGs	Sustainable Development Goals
TFR	Total Fertility Rate
THE	Total Health Expenditure
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

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1. INTRODUCTION

1.1. Background

Family planning has long been considered as a health intervention and a development strategy. The Philippines, in its latest national development plan (Philippine Development Plan for 2017-2022), has dedicated a whole chapter for interventions to manage population growth as means to accelerate economic growth through reaching the demographic dividend. Likewise, the family planning program is considered as an essential intervention in achieving the targets set by the country for its Sustainable Development Goals (SDG) 2030.

For this reason, Executive Order (EO) No. 12 on "Attaining and Sustaining Zero Unmet Need for Modern Family Planning" was issued in 2017 further strengthening the Responsible Parenthood and Reproductive Health Law (Republic Act 10354), the primary policy intervention which promotes sexual and reproductive health of Filipinos. The Executive Order explicitly recognized the right of Filipinos to decide freely and responsibly on the number of children they want and provided the mechanisms to attain zero unmet need for modern family planning by 2018 for all poor households and all Filipinos by 2022. The EO directed all concerned national agencies to allocate resources for the FP program and mandated the local government units (LGUs) to operationalize the Order and achieve its objectives.

Following the strong political and policy support to the family planning program and the clear-cut directive to aggressively pursue the family planning program, the country developed its Costed Implementation Plan (CIP) for Family Planning 2017-2020 to guide the program implementation on the resources needed to achieve the country's family planning goals.

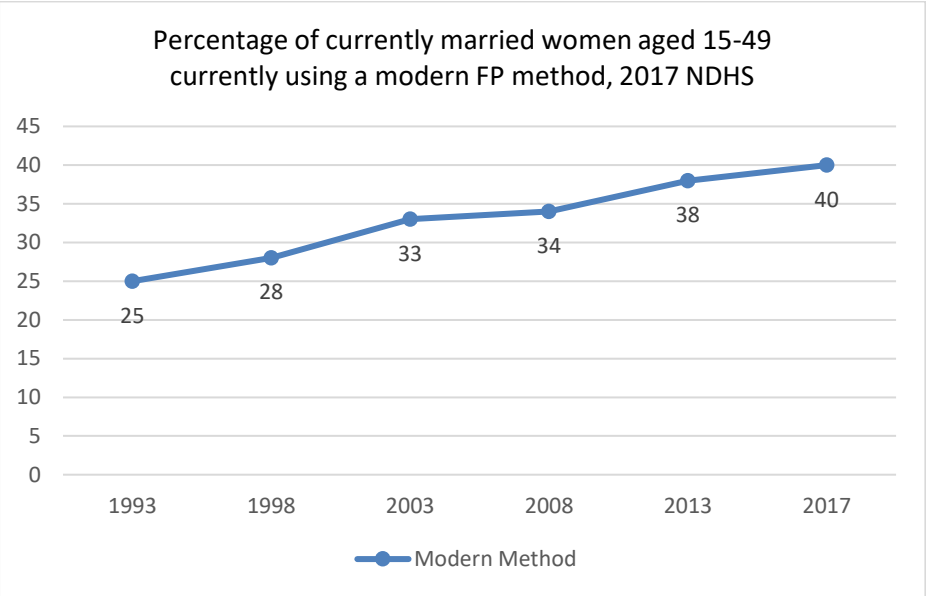
In this regard, studying the flow of resources for the National Family Planning Program will be very important to improve program implementation particularly efficiency of resource allocation and utilization as well as in strengthening policy measures to effectively fulfill the objectives of the program.

1.2. Overview of FP in the Philippines

In the Philippines, women of reproductive age comprise about 25.91% of the total population. In 2013, of the 100,981,437 estimated total population, 26,164,290 are women of reproductive age (DOH, 2017).

The country's family planning outcomes continue to grow albeit a very slow pace. Reports of the National Demographic and Health Surveys (NDHS) of 1993 to 2017, showed that contraceptive prevalence rate grew from 24.9% to 40.4% while unmet need for FP has declined from 30% in 1994 to 17% in 2017. This translates to some 7.7 million women wanting to use contraception but were not able to do so in 2017 (NIT, 2018).

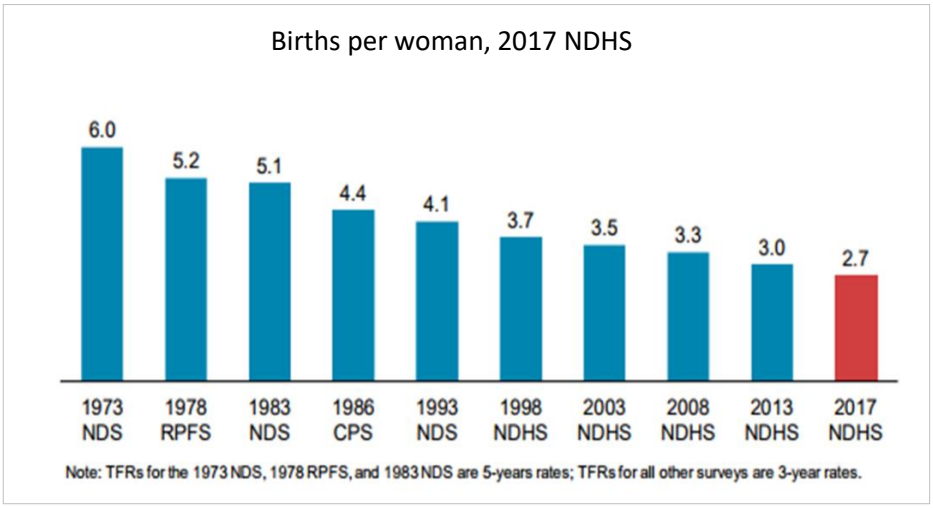
Figure 1. Trends in modern contraceptive use



According to the 2017 NDHS, among the modern contraceptives, pills continue to be the most preferred FP method among currently married women at twenty-one percent (21%), followed by female sterilization at seven percent (7%) and injectables at five percent (5%).

The increasing mCPR contributes to the gradual reduction of the country's total fertility rate (TFR). The 2017 NDHS reported that a Filipino woman is expected to have 2.7 children within her childbearing years, half of the total number of children a woman will bear in the 1973 NDS (PSA, 2018).

Figure 2. Trends in total fertility rate



The current level of contraceptive use is still far from the national target of 65% by 2022 as contained in the Philippine Development Plan. Among the challenges that continue to impede the attainment of better FP outcomes as reported in the 4th Annual Report of the RPRH Law includes: "a) unsuitability of FP Program indicators and targets; b) low coverage of estimated women with unmet need for FP; c) difficulty in scaling up FP service provision; d) commodity stock-outs; and e) weak monitoring of budgets and resources for program activities."

1.3. Context for the Assessment

As early as 1994, there was already an attempt to examine resources spent for the implementation of FP activities in the country through the National Family Planning Expenditure (NFPE) Report. The initiative was repeated in 1998 and both reports have identified the expenditures of national and local governments, foreign donors, NGOs, and households from out-of-pocket. The NFPE, implemented through the support of USAID, was not conducted since then.

In 2001, Racelis and Herrin, of the University of the Philippines School of Urban and Regional Planning and School of Economics (UP SURP and UP SE), reported the use of the Philippine National Health Accounts methodology in estimating specific components of national health expenditures such as family planning. On the same year, the Commission on Population (now renamed into Commission on Population and Development) came-up with a systematic and sustained effort to develop and maintain a system for estimating the Philippine Population Management Program Expenditures (PPMPE). However, said initiatives have not taken off.

Current tracking of specific family planning expenditure in the country is limited to the country's participation to the UNFPA/NIDI project on Resource Flows for reproductive health and the submission of program implementers to the annual reporting for the RPRH law implementation. The NIDI project collects detailed data on expenditures while the submission for the RPRH Law are aggregate amounts. However, as pointed out in the 2017 Annual Report of the RPRH Law Implementation, there is a weak monitoring of budgets and resources for program activities on reproductive health including family planning.

This Family Planning Spending Assessment (FPSA) is a study on the family planning expenditure of the country and is an integral indicator of the Track20 – a Gates Foundation-funded project which tracks the progress of achieving the goals of FP2020.

The study provides estimates of expenditures on FP from the government (both national and local) and the private sector as well (including development partners and out-of-pocket payments). Result of the study will contribute to the:

1) monitoring of actual allocations and spending for the National Family Planning Program (NFPP) by the mandated government agencies;
2) assessment of the resource gap at national level by comparing available resources and resource needs based on the strategic and operational plans;
3) support planning and budgeting at the local level in order to strengthen family planning service provision to contribute to the national development agenda;
4) creation of financial facts and figures that will inform policy dialogue;
5) advocacy for increased funding for FP programs and services; and
6) global monitoring of expenditure for family planning.

2. METHODOLOGY

2.1. Overall Scope of the Research

In general, the objective of this family planning spending assessment report is to track the over-all national expenditure for family planning in 2018 from various sources of financing which includes both public and private sources as well as internally allocated and externally provided support (donors) to the FP program.

Specifically, the report will identify detailed information on the flow of funds for family planning in terms of:

1) Financing source and agents;
2) FP service providers;
3) Spending by function (spending categories); and
4) Spending by activity (production factors).

Family planning program implementers and other related institutions were identified to provide their financial reports on FP expenditures. This included national government agencies, hospitals and other health facilities, non-government organizations, health insurance corporation, and development partners (donor agencies). For local government expenditures, estimation was used using a sample population from the provinces and the cities/municipalities.

The FPSA report will inform policy-makers, program implementers and the development partners on the spending level, sources of financing and items of expense for the FP program to guide in future policy-making and program planning and implementation particularly vis-à-vis the implementation of the Costed Implementation Plan (CIP) for Family Planning.

2.2. FP Spending Assessment Approach

The family planning spending assessment is an approach to track resource flow for the country's family planning activities. It is an adaptation of the National HIV/AIDS Spending Assessment (NASA), a globally accepted method of tracking expenditure developed by UNAIDS.

FPSA is a comprehensive and systematic approach to determine the flow of resources to implement the family planning program in a country. It tracks the actual expenditure from public, private and international sources for all FP related

interventions, services and activities. Same with the NASA, it follows the national health accounts framework and principles that applies standard accounting methods to reconstruct all transactions in a given country, 'following the money' from the funding sources to agents and providers and services provided.

The FPSA report will describe the flow of resources spent for the provision of family planning services in the country from their origin to the beneficiary populations.

2.3. Classifications used to build the FP spending Accounts

The FPSA likewise adapted the NASA classifications to fit the tracking of FP expenditures. It examined three sets of entities in the flow of funds for family planning namely: 1) the financing sources, 2) the financing agents, and 3) the service providers.

Financing Sources: *Financing sources are defined as entities which ultimately bear the expenses of financing FP services and related activities.*

Table 1. Classification of Financing Sources

Financing Source	***Where funding originates from.***
Public	*This is further broken into National Government, Regional Government, Local Government.*
Private	*Include households, private for-profit and not-for-profit organizations.*
International	*Include wide range of entities such as bilateral, multilateral, foundations such BMGF, and international private organizations.*

Financing Agents*: Financial agents are defined as entities which pass funds from financing sources to other financial agents or service providers in order to pay for the provision of FP services. They determine how funds are allocated to finance the different FP services.*

Table 2. Classification of Financing Agents

Financing agents	***Channels for funding.***
Government	*Includes ministries and departments at national and regional government, state corporations*
Private	*Include households, private insurance firms, private employers, for profit and not-for-profit organizations, national NGOs.*

International	*Include wide range of entities such as bilateral, multilateral, foundations such BMGF, and international NGOs.*

Service providers: *Providers are defined as entities that produce and provide health care goods and services as they relate to FP.*

Table 3. Classification of FP Service Providers

Service providers	***Actors engaged in the production and delivery of FP services.***
Public sector providers	*Providers that are integrated in government. This would also include government agencies (such as Ministries, hospitals, schools, etc.)*
Private sector providers	*Not-for-profit and for-profit organizations including private health facilities and national NGOs.*
Bi/multilateral agencies	*Bilateral and multilateral entities – in country offices*
Rest-of-the world providers	*Other international organizations such foundations.*

In addition to the three major categorizations for the resource flows on FP, expenditures were also further classified into family planning spending categories (FPSC) and the production factors of FP services or specific budget items.

Family Planning Spending Categories

Table 4. Classification of FP Spending Categories

FPSC	***Activities or programs on FP.***
Family Planning Services	*These are comprehensive set of activities or programmes that will result to effective provision of FP to those who need them. It involves provision of different FP methods and associated services.*
Programme Management and Administration	*Programme expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as national or local level FP programme management, monitoring and evaluation (M&E), and facility upgrading through purchases of medical and other equipment for FP services and capital investment, such as health facility renovation for FP services.*
Human Resources	*This category refers to services of the workforce through*

	approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the FP specifically. If the expenditure refers to entire RH, allocation needs to be done. Included in this category is the direct payment of wage benefits for health care workers. These expenditures are aimed at ensuring the availability of human resources from what is currently available in the health sector. However, cost of human resources for provision of FP methods is already covered under the FP services and should not be included here.
Enabling Environment	*Mainly advocacy and institutional development expend.*
FP related research	*Classified into different types of research excluding operational research.*

Family Planning Production Factors

Table 5. Classification of FP Production Factors

FPPF	***They consist of budgetary items in terms of recurrent and capital expenditure.***
Recurrent Expenditure	*Recurrent expenses are those which occur periodically to produce the FP services, and which are fully consumed during the provision of the service. It includes salaries, FP methods and services and all operational spending and contracted services such as security, or the production of quarterly dissemination of family planning-related information, etc.*
Capital Expenditures	*The assets held by the health system to include new acquisitions, and major renovation and maintenance of tangible and intangible assets used repeatedly or continuously in production processes of health care or of social amenities over periods of time longer than one year. The main categories of the classification features are buildings, capital equipment, and capital transfers.*

2.4. Sampling

Identification of the respondents was closely discussed with the NFPP. Initial list was made using the usual respondents of the UNFPA/NIDI project on Resource Flows for Family Planning conducted yearly. In 2018, the study reported the expenditures of

eleven organizations in both private and public sectors (Reyes, 2018). The respondents from the public sector are DOH, POPCOM and Philippine Health Insurance Corporation (PhilHealth) which are the lead implementers of the RPRH Law and EO 12 while major non-government organizations working on reproductive health and family planning represented the private sector.

There are over 1,715 LGUs in the form of provinces, cities, and municipalities in the Philippines (DILG, 2019). Measuring local-level FP expenditure across all LGUs was not feasible for the scope of this study. As such, the study focused on using the data of a sample population of local government units to represent local government spending for FP. For provincial level LGUs, sixteen provinces were selected, each representing a region in the country (except for the National Capital Region (NCR) which do not have any province). For city and municipalities, thirteen LGUs were selected composed of nine (9) cities and four (4) municipalities. However, one municipality was dropped given that it has no financial reports to provide since it does not receive national appropriations/internal revenue allotment yet.

Selection of the LGUs were in consultation with POPCOM using purposive sampling based on three criteria: (1) has an active population (appointed or designated) officer, (2) can represent the major island groups and comes from special regions such as the National Capital Region (NCR) and the Autonomous Region in Muslim Mindanao (ARMM), and (3) perceived LGU cooperation along with the availability of budget and expenditure data. Purposive sampling method was chosen for this research to maximize efficiency which random sampling may not be able to provide. The use of purposive sampling ensures that all samples will be valid and complete given their perceived willingness to participate (Tongco, 2007), lower cost since dispersion of targeted LGUs to be interviewed are anticipated, and sample LGUs are considered information-rich cases (Palinkas, 2015). Furthermore, in several studies in Indonesia concerning finances at the local government level, the use of purposive sampling was the method of choice (Amyulianty, 2016) (Aswar, 2020) (Muda, 2017).

2.5. Data Collection

Data collection was done for almost six months, from last week of May until end of October. The research was designed to be implemented in collaboration with the National Family Planning Program (NFPP), the country's over-all program for family planning which is being jointly implemented by the Department of Health (DOH) and the Commission on Population and Development (POPCOM). As the main beneficiary of the results of the FPSA, the NFPP's support is not only crucial in the data collection but in the validation of the data collected and the utilization of the same.

Prior to the actual data collection, the Research Team separately met the Department of Health through the Public Health Services Team (PHST) and the Commission on Population and Development through its Planning and Monitoring and Evaluation Division (PMED) to present the research project and obtain their approval for its conduct. Both agencies were requested to provide focal persons to directly collaborate with the project in terms of assisting in the actual implementation of the research. For the DOH, the Family Health Office (FHO) and the Track20 Monitoring and Evaluation Officer were assigned while for the POPCOM, its Planning and Monitoring and Evaluation Division together with the Financial Management Division (FMD) were tasked to support the data needs of the research. Additionally, the DOH requested the Research Team to also present the research project to the Philippine Statistical Authority (PSA), the national government agency primarily responsible for the compilation of national health accounts, for its permission to conduct the FPSA. Upon meeting, the PSA posed no objection in the conduct of the research and allowed the team to proceed immediately.

Once approval was obtained, the Research Team proceeded to conduct the data collection. The DOH assisted by providing a memorandum for all its offices including the DOH-retained hospitals to submit the requested data to the researcher. POPCOM on the other hand, provided introduction letters for the Research Team undertaking data collection to the NGOs and local government units. The major non-government organizations were met by the Research Team to inform them about the research and to get their support.

Primary data collection was undertaken through the administration of the FPSA-designed structured questionnaire to gather information in relation to financing sources and agents, spending categories and production factors. The questionnaire is the main data collection tool of the research and was used for collecting information from the national government agencies, DOH-retained hospitals, and non-government organizations. Each institution was oriented on the tool to ensure universal understanding and application of the classifications of FP expenditure used in this research. Still, there were some difficulties for the respondents in completing the forms. As such, visits and regular communication were undertaken. For some organizations, financial data based on their report formats were provided by the respondents and was later transferred to the forms by the research team. Due to the difficulties in administering the FPSA-designed structured questionnaire, for local government agencies and the health insurance corporation, the questionnaire was modified to make it more user-friendly.

Respondents for the DOH offices were directed to use the online platform developed for the research for ease of access and use. The google-based survey form was utilized for this purpose.

Interviews and consultations with key program implementers were also carried out simultaneous to the survey mainly among government agencies at the national and local level.

Aside from primary data reported in the survey and obtained from key informant interviews, secondary data were also collected to complete the country's expenditure for family planning. Particularly, the secondary data was used for cross-referencing the expenditures reported by the government agencies. For national government agencies, the following documents were gathered and reviewed: a) National Expenditures Program (NEP) of the agency from the Department of Budget and Management (DBM); b) Work and Financial Plan (WFP) containing the itemized objects for expenditures; c) Statement of Allotment, Obligation and Balances (SAOB); and d) Annual Financial Report obtained from the Commission on Audit (COA).

For the local government agencies, several documents were also reviewed including: a) the Statement of Receipts and Expenditures of each local government unit (LGU) from the Bureau of Local Government Finance of the Department of Finance (DOF-BLGF); b) the Programmed Appropriation and Obligation by Object of Expenditure; c) the LGUs Annual Gender and Development (GAD) Accomplishment Report from the Department of the Interior and Local Government (DILG); d) the Provincial Local Investment Plan for Health (LIPH) from the Department of Health; e) the Annual Financial Report for Local Governments by the COA; and f) the Annual Audit Reports on the LGUs by the COA. Initial visits to present the research project were conducted.

The United Nations Population Fund (UNFPA) Philippine Country Office and the United States Agency for International Development (USAID) reported their annual disbursements provided to their implementing agencies. For UNFPA, they were able to provide expenditure information up to the spending categories of their disbursements while USAID was not able to provide dis-aggregated data.

Family planning expenditures from UNFPA implementing partners were gathered to triangulate the reported data. Correspondingly, for NGOs that reported to have received funds from UNFPA, their information was cross-referenced to the report of UNFPA to avoid double reporting of expenditures.

However, for the USAID data, the research relied on the information given by their office since all of their implementing partners no longer operate projects for the USAID in 2019. This is because 2018 was the end of the project cycle of the USAID-assistance and all financial reports have been turned over to their office. USAID only provided aggregated data for family planning expenditure.

2.6. Data Analysis

The FPSA has developed a database for FP expenditure using the Excel Spreadsheet. Encoding of financial information for each of the respondents was done using the database. Likewise, analysis of the data was facilitated by entries in the database.

The database identifies the expenditure by a given FP service provider and traces said funds back to a financing agent and financing source one at a time. This process allows immediate validation and cross-referencing to ensure no double counting will be made. Each row in the database contains one entry composed of the financing source, a financing agent, a service provider, an FP spending category, and the FP production factors.

2.6.1. Estimation of Local Government Expenditure

For the local government expenditures, a sample population size was identified to represent the average local government spending. After deriving the average FP expenditures of the sample LGUs, the computed average was used to calculate the total local government spending for the program. This method was the so-called "allocation rule" that is also utilized by the Philippine National Health Accounts (PNHA). Family planning expenditures of provinces, cities and municipalities are estimated by applying the percentage share of family planning to the total expenditures for Health, Nutrition and Population Control (HNPC) of each level of local government.

Health, Nutrition and Population Control is one of the major classification of expenditures of LGUs. It represents the total sector expenditures for health program including medical, dental and health services; planning and implementation of nutrition programs; population and family planning programs; and administration of these programs. HNPC is further disaggregated into three types of expenditure by function:

a) Personal Services (PS) for current operating expenses for payment of services that include salaries and wages, employee benefits and other compensation;
b) Maintenance and Other Operating Expenses (MOOE) for all current expenses incurred for the purchase of goods and services used for maintenance and operational expenses such as traveling, communication, supplies (which includes pharmaceutical supplies such as contraceptives among others) and, repair and maintenance, etc.; and

c) Capital Outlay (CO) for the purchase of goods and services, the benefits of which extend beyond the fiscal year and which add to the assets of the government.

Provincial level estimates

At the provincial level, the family planning proportions were computed using secondary data from the: a) Annual Financial Report for LGUs; b) the Annual Audit Reports for LGUs, both documents sourced from COA; c) LGU Fiscal Data particularly the Statement of Receipts and Expenditures from DOF-BLGF; and d) Annual GAD Accomplishment Report from the DILG. The data were also cross-referenced with the Provincial Local Investment Plan for Health (LIPH) from the DOH.

For this study, provincial FP expenditures are limited to expenses related to the MOOE since information to estimate time spent of personnel for FP programs and services is limited while projects under capital outlay are multi-year disbursements. Furthermore, dividing the project cost coming from the capital outlay to estimate the cost of yearly usage of the facility is very complex.

Sixteen provinces representing their respective regions were selected as sample population (all regions except for NCR which is composed of cities and a municipality only). Based on the 2018 reports, total expenditure for HNPC for all of the eighty-one (81) provinces of the country is USD 400,696,454 (PhP 20,435,519,169). Fifty-four percent (54%) of the total HNPC expenses went to PS while 44% went to MOOE. Only about two percent (2%) were spent for capital outlay.

For the sample 16 provinces, their total HNPC expenditures was USD 116,497,421 (PhP 5,941,368,503). Similar to the national average, about 53% were spent for PS, 42% for MOOE and the remaining five percent (5%) were spent for capital outlay.

The total reported family planning expenses under MOOE of the sixteen provinces was USD 324,878 (PhP 16,568,787) representing an average of 6.91% of the total MOOE for HNPC. This percentage share was used to calculate the total family planning expenditure of all provinces in the country.

Table 6. Share of FP Expenditure over MOOE of the HNPC of Provinces, in USD

Region	Province	HNPC Expenditure				FP Expenditure	FP expenditure over MOOE Expenditure
		PS	MOOE	CO	Total		
CAR	Benguet	4,633,088	2,098,152	346,400	7,077,641	11,424	0.54
1	Ilocos Norte	2,779,923	3,336,083	148,917	6,264,922	13,176	0.39
2	Quirino	2,350,471	2,713,232	69,120	5,132,824	7,316	0.27

3	Tarlac	4,765,579	3,766,558	27,664	8,559,802	11,212	0.30
4a	Rizal	4,813,571	6,017,214	3,885,869	14,716,654	52,941	0.88
4b	Marinduque	2,529,347	484,804	519,248	3,533,399	7,077	1.46
5	Albay	2,762,813	3,095,303	421,410	6,279,527	9,804	0.32
6	Aklan	1,365,331	537,825	-	1,903,156	8,137	1.51
7	Negros Oriental	6,350,662	8,226,691	228,111	14,805,464	42,427	0.52
8	Leyte	7,271,238	3,885,244	48,183	11,204,665	27,836	0.72
9	Zamboanga del Norte	3,552,137	1,424,549	-	4,976,686	14,029	0.98
10	Bukidnon	10,721,983	5,331,846	1,884	16,055,713	40,543	0.76
11	Davao del Norte	1,932,920	3,503,119	234,502	5,670,541	13,088	0.37
12	Sarangani	1,823,121	2,112,229	75,448	4,010,797	22,039	1.04
13	Agusan del Sur	3,810,696	2,315,073	148,490	6,274,259	12,456	0.54
ARMM	Sulu		31,373	-	31,373	31,373	100
						Average	**6.91**

City/Municipal level estimates

For the local government units at the city/municipal level, they were requested to provide their family planning expenditures using the modified FPSA-survey questionnaire. In the modified form, they were asked to identify their specific family planning expenditures along the five (5) FP Spending Categories and the specific items of expenditures (FP Production Factors). They were also made to submit the outputs corresponding to their FP activities. Aside from the survey questionnaire, several documents were also reviewed including: a) the Statement of Receipts and Expenditures of each local government unit (LGU) from the Bureau of Local Government Finance of the Department of Finance (DOF-BLGF); b) their Programmed Appropriation and Obligation by Object of Expenditure; c) the LGUs Annual Gender and Development (GAD) Accomplishment Report from the Department of the Interior and Local Government (DILG); d) their administrative data/ accomplishment reports for Reproductive Health, Responsible Parenthood and Family Planning Programs; and e) the LGU's Annual Audit Report from the COA.

A total of twelve (12) LGUs, composed of three municipalities and nine cities were examined under the research. One LGU (the 13th) was later excluded in the study because it is operating on bare minimum budget since it is not yet provided with national government allocation.

In 2018, the total combined expenditures of all cities and municipalities in the entire country on Health, Nutrition and Population Control was USD 682,266,935 (PhP 34,795,613,720.70). The same with the provinces, expenditure for PS is at 54% while 44% went to MOOE and the rest (2%) for capital outlay.

For the twelve sample cities and municipalities, total HNPC expenditure is at USD 26,862,075 (PhP 1,369,965,836). Expenditure is slightly different for the twelve

sample LGUs relative to the average where they reported to have spent 57% for PS, 36% for MOOE and 7% for capital outlay.

On an average, the expenditure of the twelve cities and municipalities for family planning under MOOE is estimated at 10.94%.

Table 7. Share of FP Expenditure over MOOE of the HNPC of Cities-Municipalities, in USD

Region	City/ Municipality	HNPC Expenditure				FP Expenditure	FP expenditure over MOOE
		PS	MOOE	CO	Total		
NCR	San Juan City	1,346,047	408,010	13,875	1,767,932	56,906	13.95
Luzon	San Jose City	707,405	241,140	8,405	956,950	39,666	16.45
	Binan City	2,486,057	1,295,260	324,368	4,105,685	107,843	8.33
	Antipolo City	3,749,828	2,780,488	1,240,020	7,770,336	31,373	1.13
	Puerto Princesa City	1,561,426	1,689,161	84,062	3,334,649	108,438	6.42
	Victoria	187,254	111,321	1,713	300,288	3,524	3.17
	Binangonan	464,079	681,955	4,275	1,150,308	28,052	4.11
Visayas	Iloilo City	2,506,360	675,542	975	3,182,877	77,252	11.44
	Ormoc City	952,472	708,187	12,255	1,672,914	40,576	5.73
	Tacloban City	1,104,916	847,585	183,656	2,136,157	91,423	10.79
Mindanao	Cotabato City	129,598	103,859	4,838	238,295	41,150	39.62
ARMM	Upi	12,620	233,065	-	245,685	23,721	10.18
						Average	**10.94**

Cities and municipalities maintain primary health care facilities in the country which includes the City/Municipal Health Offices, Rural Health Units (RHUs) and Barangay Health Stations (BHS).

One of the major services provided in these health facilities is family planning. Expenditures for the operations of the mentioned health facilities are included in the MOOE of the LGU. However, for the individuals working on the said facilities, both medical and administrative personnel, their share of salaries are included in the personnel services budget of an LGU. Thus, by determining the share of the FP services to the total health services provided in the facility, the expenditure for salaries for direct services provision can be approximated (Racelis, 2000). For this process, the 2018 Field Health Service Information System (FHSIS) – the country's annual report on the service statistics provided by the government to the public – was analyzed.

The number of FP visits used for the estimation were:

1. pill acceptors at 4 visits per year (wherein clients are given 3-month cycle per visit);
2. four visits each for new IUD acceptors;
3. ten visits each for all condom users; and
4. one visit for each all other methods.

The total health services included:

1) control of diarrheal diseases and pneumonia;
2) dental health care;
3) visits for environmental health;
4) visits for immunizations;
5) FP visits;
6) visits to RHUs and BHS nutrition services;
7) visits for pre-natal and post-partum care; and
8) other health services (Tuberculosis Control, Malaria, Schistosomiasis, Leprosy, Filariasis, etc.).

Due to the limitation of the administrative reports reviewed, only the data of the nine cities were examined. Upon examination of the health service statistics reported in 2018 by sample cities, it was found out that about 23.44% of the total health services provided are family planning. Thus, following the allocation rule, total expenditure for staff cost for direct FP service provision was estimated to be at 23.44%.

Table 8. Share of FP services to Total Health Services by LGU

Region	City/ Municipality	FP Services over Total Health Services of LGU
NCR	San Juan City	9.93
Luzon	San Jose City	21.64
	Biñan City	30.01
	Antipolo City	13.56
	Puerto Princesa City	33.10
Visayas	Iloilo City	33.40
	Ormoc City	17.94
	Tacloban City	14.77
Mindanao	Cotabato City	36.58
	Average	**23.44**

2.6.2. Estimating Out-of-Pocket FP Spending

For out-of-pocket spending on family planning, the study relied on the estimation made by the Reproductive Health Supplies Coalition (RHSC) under its Commodity Gap Analysis (CGA 2019). RHSC is a global partnership of public, private, and non-governmental organizations that assesses the volume and cost of contraceptives required to meet the growing demand for family planning in low- and middle-income

countries.

The estimation of out-of-pocket cost included the actual cost of family planning products (contraceptives) to the clients and the cost of services to avail the family planning method.

Private sector supplies and services is estimated by the CGA using a range of sources including country, regional and global data. It uses projections of method mix based on sub-regional patterns and latest country surveys.

The CGA tool also computes OOP payments for family planning services obtained from the public sector. However, the survey of several public facilities including public tertiary hospitals, district hospital and primary health care facilities, found that FP services are offered for free including the contraceptives which are provided by the Department of Health to the said health facilities. Thus, the reported out-of-pocket expenditures for FP are limited to the consumption of private sector services.

2.6.3. Private Sector expenditures

Private sector expenditures were limited to major national and local non-government organizations (NGOs) working primarily for women's reproductive health including family planning. About forty (40) organizations were invited to be part of the study however not all opted to participate.

Financial data on family planning were gathered from twenty-eight NGOs. About 30% of the target respondents have declined to provide their financial data including the contracting agencies of the USAID citing confidentiality of their data.

The high refusal rate and exclusion of other private sector providers such as company-provided FP services and health maintenance organizations (HMOs) or private health insurances, among others, may inadvertently under-estimate private sector contribution and expenditures on FP.

2.7. Data Validation and Presentation to Partners

Throughout the conduct of the research, the FP2020 Focal points have been regularly updated and provided initial reports for guidance. The final report was also presented to the Commission on Population and Development for inputs and validation. The Department of Health together with the National Implementation Team of the RPRH Law will also be consulted on the final results of the study.

2.8. Limitations

The conduct of the study faced several challenges including the following:

a. Delay in the conduct of the research activities since approval of several agencies (DOH, POPCOM and PSA) were sought prior to the actual data collection.
b. For NGOs, sharing of information is very restricted that some opted not to provide their information. About thirty percent of the NGOs contacted declined to provide financial information.
c. Difficulty of implementing partners to delineate FP expenditure from other programs particularly those implementing RH initiatives as programs and activities tend to intersect and convergence is usually promoted as a holistic approach of addressing women's health.
d. Some respondents do not provide detailed information on their expenditure particularly USAID which reported a large amount of FP spending for the country.
e. While the study focuses on public sector expenditure, limited access to financial data from the private sector was observed. More private providers of family planning services in the country were not covered by the study.
f. For maximum efficiency despite limited time and resources, purposive sampling method was chosen for this research in identifying local government respondents as opposed to random sampling which provides complete unbiased random selection of participants. However, the utilized sampling technique provided the opportunity to obtain information from LGUs from different selected criteria.

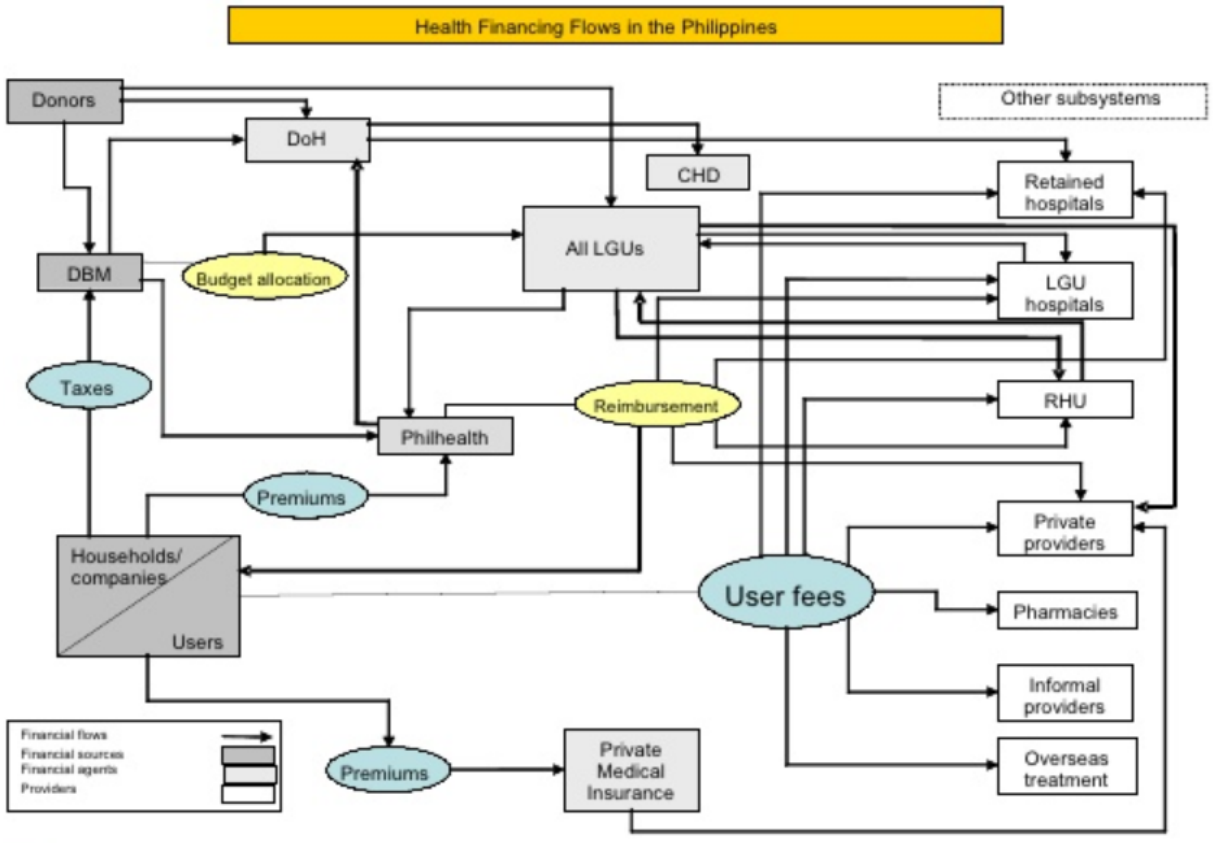
3. RESULT AND DISCUSSION ON FINANCING THE FP PROGRAM

3.1. Flow of Fund for the FP Program in the Philippines

The flow of fund for family planning program in the Philippines follows the existing health financing system in the country. The Philippine health financing flows is complex as it involves different levels of financial sources, financing agents and regulatory bodies, and several health service providers. The figure below shows the financing flows for health as to sources and uses.

Generally, there are four main sources of financing: (1) national and local government, (2) government and private insurance (government health insurance is the PHIC), (3) user fees or out-of-pocket, and (4) development partners or donors.

Figure 3. Health Financing System in the Philippines, DOH



3.2. Total Expenditure on FP in 2018

In 2018, the total expenditure for family planning in the Philippines amounted to USD 218,249,805 (PhP 11,130,740,091)[1] as reported and gathered from both top-down and bottom-up approaches. This is about one-point thirty-nine percent (1.39%) of the USD 15,668,627,450 Total Health Expenditure (THE) of the country in 2018 (PNHA, 2019). The THE of the country stands at 4.6% of the Gross Domestic Product (GDP) and is comprised of 96% Current Health Expenditures (CHE) and 4% Health Capital Formation Expenditures (HK).

3.3. FP Expenditure by Financing Sources

Majority of the family planning expenditures were sourced from the public sector (government) at USD 156,700,090 followed by the private sector (domestic) with USD 42,258,579 and the international sources completing the funding at USD 19,291,137. In terms of proportion, the figure below illustrates the share of the three major sources of FP expenditures:

Figure 4. Total FP Expenditure by Financing Sources, FPSA 2018

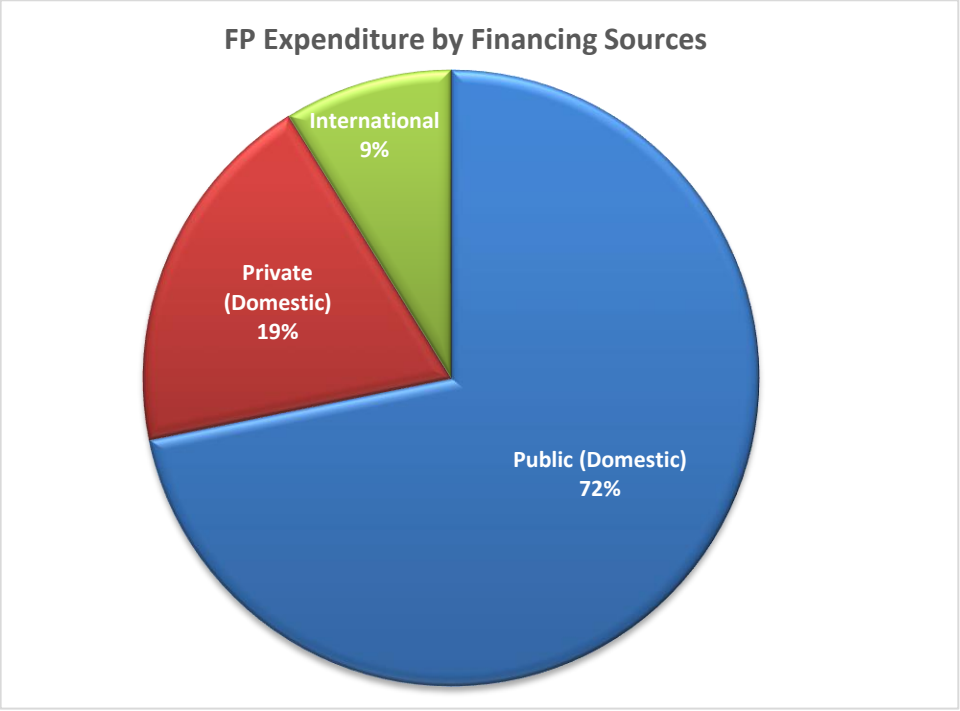


Table 9 further shows the major sources of FP funding for 2018. Local governments, as the frontline provider of basic services in the country since the devolution in 1991,

[1] Exchange rate used for the entire report if 1USD = PhP51

has shown a significant role in national FP program as it provided the biggest chunk of financing for FP at 60.28% of the total FP expenditures.

Households particularly out-of-pocket payments is also elevated at 19.19%. The figure follows the national health accounts wherein out-of-pocket payments is still relatively high, currently at 53.9% of the total current health expenditures.

For donors, the United States Agency for International Development (USAID) provided the most funding followed by the United Nations Population Fund (UNFPA).

Table 9. Total FP Expenditure by Financing Sources in USD, FPSA 2018

Financing Source	Amount	% Share
Public	**156,700,090**	**71.80**
National Agencies	25,136,108	11.52
Local Government Units	131,563,983	60.28
Private	**42,258,579**	**19.36**
Households	41,881,382	19.19
Employer	136,367	0.06
Non-profit/NGOs	172,157	0.08
For Profit - Local	68,673	0.03
International	**19,291,137**	**8.84**
USAID	15,534,562	7.12
UNFPA	3,059,823	1.40
Gates Foundation	447,568	0.21
Other International not-for-profit	249,182	0.11
TOTAL	**218,249,806**	**100.00**

3.3.1. National Government Expenditure

Public sector expenditures at the national level were gathered from the government agencies that were mandated by the RPRH Law and EO 12 to implement the policies that govern the National Family Planning Program.

Table 10. FP Financing from National Government Agencies in USD, FPSA 2018

Financing Source	Amount
Department of Health (including Centers for Health Development (CHDs) and Retained Hospitals)	13,803,573
Commission on Population and Development (including its Regional Offices)	5,679,854
Department of the Interior and Local Government	4,707

National Economic and Development Authority	11,045
Philippine Statistics Authority	21,987
Department of Social Welfare and Development	4,772,667
Various Government Agencies	842,273
TOTAL	**25,136,108**

The Department of Health (DOH) is the biggest source of FP financing among all government agencies followed by POPCOM and DSWD. Various government agencies also provided financing indirectly through their contribution to the national health insurance program of the country. In general, the disbursements of the government agencies with major FP expenditures relative to their respective mandates are:

A. Department of Health (including Centers for Health Development (CHDs) and Retained Hospitals) – The Department leads the implementation of the National Family Planning Program (NFPP) by providing policy direction, setting of standards and capacity building, ensuring access to modern family planning (FP) methods, augmentation of medical providers thru deployment program, and infrastructure development.

B. Commission on Population and Development (including its Regional Offices) – As the co-manager of the NFPP, the Commission leads in the demand generation for family planning by providing financial and technical support to LGUs and program implementers.

C. Department of the Interior and Local Government – As the mandated agency that has general supervision to local government agencies, the Department provides technical assistance to LGUs to enable them to effectively implement FP program and services. DILG also monitors the compliance of LGUs in delivering services to its constituents as mandated by the Local Government Code and the Responsible Parenthood and Reproductive Health Law.

D. National Economic and Development Authority – Achieving demographic transition through a decreased fertility is one of the major strategies adopted for the over-all national development. Thus, NEDA strongly advocates for the adoption of policies supportive of family planning including the Executive Order on Attaining Zero Unmet Need for Modern FP and the RPRH Law.

E. Philippine Statistics Authority – In 2017, the PSA conducted the National Demographic and Health Survey. Implementation of the project spilled over until 2018.

F. Department of Social Welfare and Development – The Department implements the Conditional Cash Transfer (CCT) Program to support poor Filipino families by investing in their health and education. Attendance of the beneficiaries to the Family Development Session (FDS) Module 2.2 on Responsible Parenthood and Family Planning is one of the conditionalities to receive the health grant.

3.4. FP Expenditure by Financing Agents

Relative to decision-making on how the funds are to be spent such as on what items and categories of expenditures will be made, it is the financing agent that make such determinations. As such, it is also very important to know who the major decision-makers for FP expenditures were in 2018.

Table 11. Total FP Expenditure by Financing Agents in USD, FPSA 2018

Financing Agents	Amount	% Share
Government	**156,855,370**	**71.87**
National Agencies	23,954,446	10.98
Socialized Health Insurance	1,336,941	0.61
Local Government Units	131,563,983	60.28
Private	**43,353,650**	**19.86**
Households	41,493,669	19.01
Non-profit/NGOs	1,791,308	0.82
For Profit - Local	68,673	0.03
International	**18,040,786**	**8.27**
TOTAL	**218,249,806**	**100.00**

The study learned that the government mainly made the decisions on how the family planning funds will be spent in 2018. Particularly, the local government units decided on how the 60% of the total FP funds were to be spent. The national government managed around 10% of the total FP funds for the country. International partners channeled around eight percent of the total funding for FP activities and services.

Donor funds (e.g. USAID) where managed by their contracting agencies which are mostly international organizations.

3.5. FP Expenditure by Service Providers

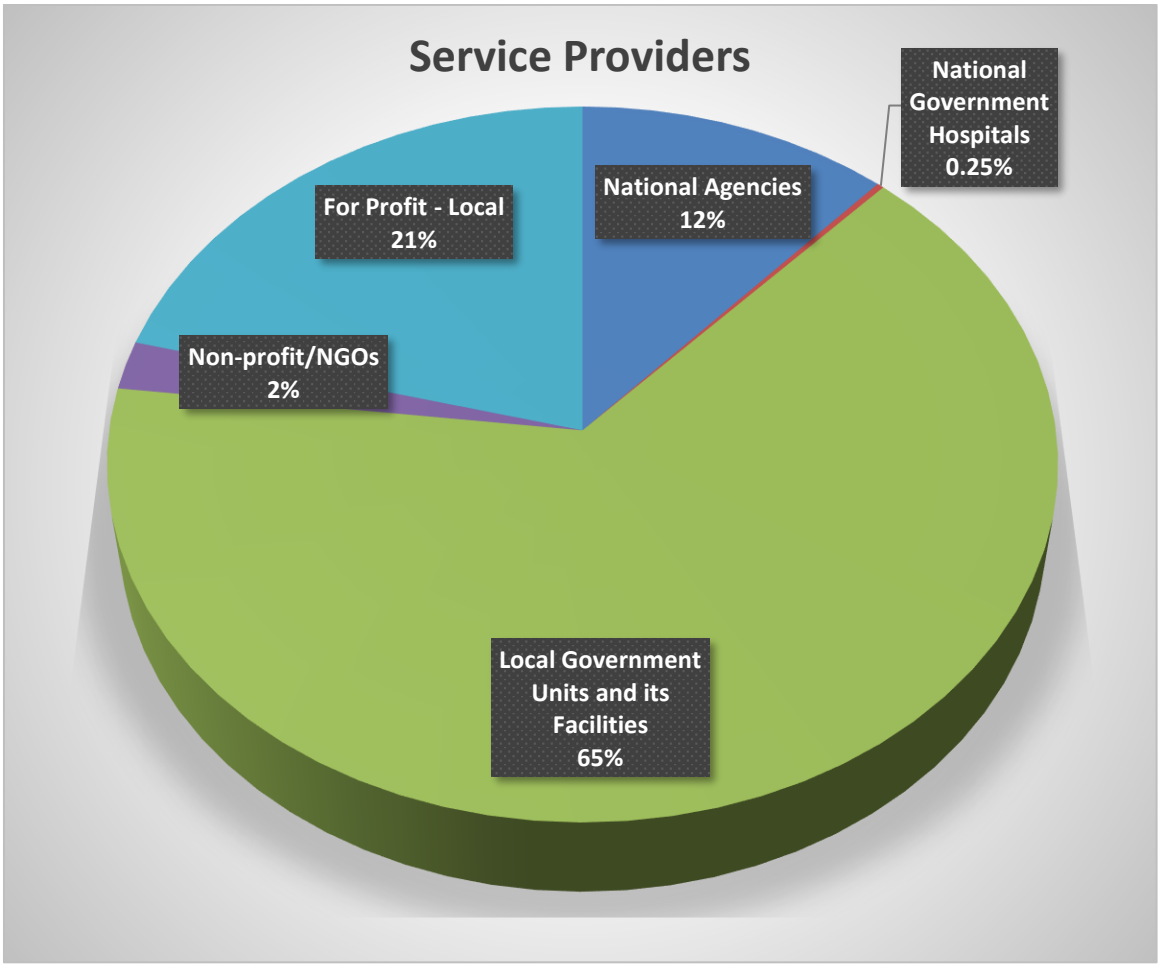
There were a number of FP service providers identified for 2018. Some were direct respondents of the study while others were identified by the financing sources and

agents as recipients of the FP funds and providers of FP services.

The family planning service providers are composed of the public sector (government agencies, hospitals, primary health care units, etc.) and the private sector (non-profit and for-profit facilities and institutions).

The total amount of FP expenditure by service providers (USD 202,715,243) does not include the USAID funds (USD 15,534,562) which were aggregately reported and were not broken down into service providers.

Figure 5. Total FP Expenditure by Service Providers, FPSA 2018



Again, the LGUs are the main providers of FP services at around two-thirds of the total FP expenditures. Private sector for-profit institutions took 20% of the total FP expenditures. These are mainly the providers of services and goods, particularly contraceptives, to households that availed of FP services through out-of-pocket payments including pharmacies, hospitals and other health facilities. Estimated total FP expenditures by service providers is shown in Table 11.

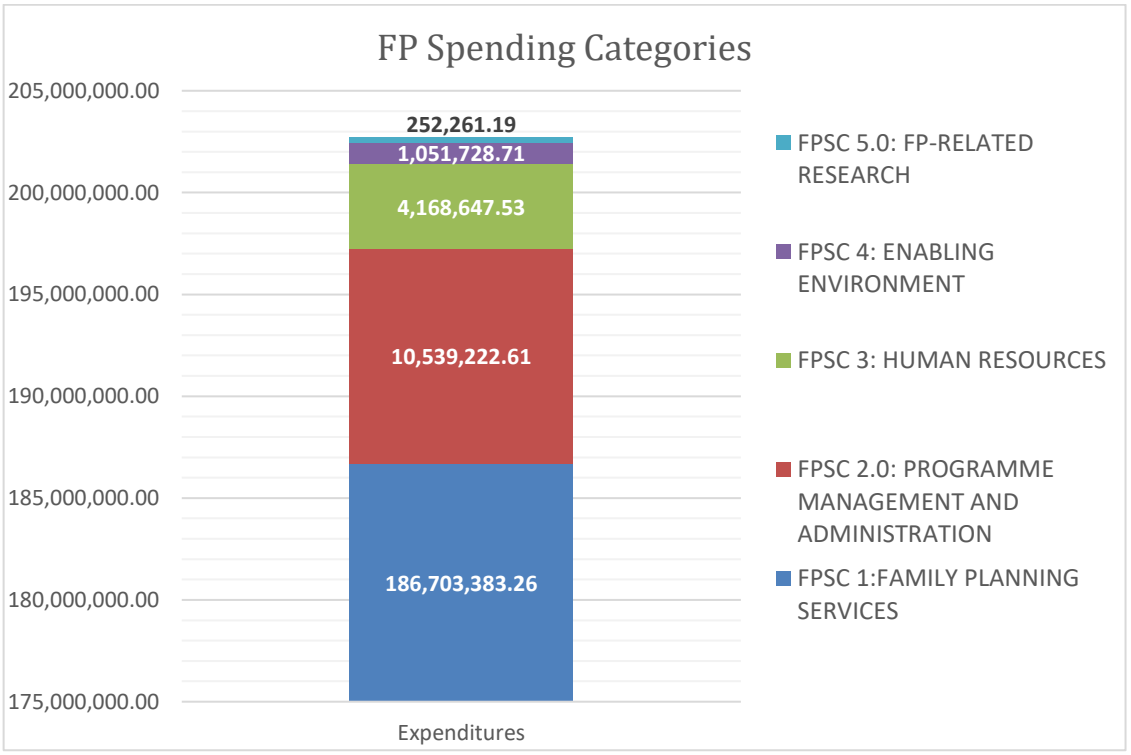
Table 12. Total FP Expenditure by Service Providers in USD, FPSA 2018[2]

Service Providers	Amount	% Share
Public Sector	**155,906,592**	**76.91**
National Agencies	23,616,240	11.65
National Government Hospitals	514,432	0.25
Local Government Units and its Facilities	131,775,920	65.01
Private Sector	**46,808,651**	**23.09**
Non-profit/NGOs	4,404,479	2.17
For Profit - Local	42,404,172	20.92
TOTAL	**202,715,243**	**100.00**

3.6. FP Expenditure by FP Spending Category

FPSA categorizes total FP expenditure into five major spending categories namely: a) family planning services including contraceptives, consumables and its relative services; b) programme management and administration; c) human resources particularly the development of capacities; d) enabling environment; and e) FP related research. Figure 6 and Table 12 demonstrate the findings of total FP expenditures under these spending categories.

Figure 6. Total FP Expenditure by FP Spending Categories in USD, FPSA 2018[3]



[2,3] The total amount of FP expenditure by service providers and spending category (USD 202,715,243) does not include the reported USAID funds.

The study found that almost all of the FP expenditure went to direct FP services at 92%, followed by program management and administration (5.2%), and human resources (2.06%). Provision of pills comprised 20% of the total FP expenditures. However, about 60% of the FP service provision cannot be dis-aggregated to specific FP methods. IEC activities also registered almost 10% of the total expenditure. Majority of these are expenses by the Conditional Cash Transfer program (4Ps) where beneficiaries are required to attend a family planning session once a year to be able to avail of the monetary assistance given to them. Training and capacity building registered some two percent of the total FP expenditures.

In terms of utilization of funds by the public and private sector according to spending category, it is notable that they have the same pattern of spending where the highest expenses went to FP services followed by programme management. The provision of pills reported mainly came from the public sector at 19%, representing the out-of-pocket payments made by client to procure their own contraceptives.

Table 13. Total FP Expenditure by FP Spending Category in USD, FPSA 2018

Spending Category	Public Sector Provider		Private Sector Provider		TOTAL
	Amount	% Share	Amount	% Share	
FPSC 1: Family Planning Services	142,798,661	70.44	43,904,723	21.66	186,703,384
FPSC 2.0: Programme Management and Administration	8,581,565	4.23	1,957,658	0.97	10,539,223
FPSC 3: Human Resources	3,815,935	1.88	352,713	0.17	4,168,648
FPSC 4: Enabling Environment	678,620	0.33	373,109	0.18	1,051,729
FPSC 5.0: FP-Related Research	31,812	0.02	220,449	0.11	252,261
TOTAL	**155,906,592**	**76.91**	**46,808,651**	**23.09**	**202,715,243**

Again, the total amount of FP expenditure by spending category (USD 202,715,243) does not include the USAID funds (USD 15,534,562) which were aggregately reported and were not broken down into spending categories.

3.7. FP Expenditure by Production Factors

Specific budget line items where funds were spent on are categorized as production

factors. Factors of production further categorized between recurrent and capital outlay.

In 2018, staff cost took the largest amount of expenditure. This is comprised of staff cost for direct FP service provision, indirect service provision, management cost and aggregated staff cost which were not broken down further.

Other recurring expenses that were not broken down by type represented the other 45% of the total expenses. It includes the estimation of out-of-pocket expenditures using the CGA tool which did not identify if expenses are for goods (contraceptives and other consumable materials), staff cost or administrative expenditures such as utilities, etc. It also includes expenditures of LGUs which cannot be broken down further into specific production factors.

If summed up, the staff costs and other recurring costs that were not broken down, comprised almost 99% of the FP spending. Only one percent can be categorized into capital outlay. This however is part of the limitation of the study since following the National Health Accounts, capital outlay is not reported in the yearly expenditures.

Table 14. Total FP Expenditure by FP Production Factors in USD, FPSA 2018

Production Factor	Amount	% Share
FPPF 1.1.1: Direct FP service provision staff cost	8,482,478	4.18
FPPF 1.1.2: Indirect FP service provision staff cost	1,500	0.00
FPPF 1.1.3: Management staff cost	2,681,198	1.32
FPPF 1.1.98: Staff cost not disaggregated by type	87,165,374	43.00
FPPF 1.1.99: Staff cost not classified above	359,705	0.18
FPPF 1.2: Contraceptives and consumables	4,412	0.00
FPPF 1.2.1: Pills	882,353	0.44
FPPF 1.2.2: Injectables and related consumables	1,557,706	0.77
FPPF 1.2.4: Implants and related consumables	417,254	0.21
FPPF 1.2.6: Consumables for vasectomy	1,471	0.00
FPPF 1.2.7: Male condoms for FP	196	0.00
FPPF 1.2.9: Beads	180,108	0.09
FPPF 1.2.99: Contraceptives and consumables not classified	92,932	0.05
FPPF 1.4: FP promotion	496,784	0.25
FPPF 1.4.1: IEC materials	183,253	0.09
FPPF 1.4.2: Print media	11,423	0.01
FPPF 1.4.3: Electronic media	588	0.00
FPPF 1.4.98: FP promotion not disaggregated	54,107	0.03
FPPF 1.4.99: FP promotion not elsewhere classified	4,772,667	2.35
FPPF 1.5.1: Rent	433,178	0.21
FPPF 1.5.2: Utilities	65,421	0.03
FPPF 1.5.3: Repairs and maintenance	169,598	0.08

FPPF 1.5.4: Transportation and travel expenses	79,889	0.04
FPPF 1.5.98: Administrative costs not disaggregated by type	906,751	0.45
FPPF 1.5.99: Administrative costs not classified	316,440	0.16
FPPF 1.6: Consulting services	59,810	0.03
FPPF 1.7: Meetings and workshops	464,969	0.23
FPPF 1.8: Financial intermediation services	13,117	0.01
FPPF 1.9: Training	527,924	0.26
FPPF 1.22: Transportation, and distribution	137,705	0.07
FPPF 1.98: Current expenditure not broken down	92,056,569	45.41
FPPF 1.99: Current expenditure not elsewhere classified	17,818	0.01
FPPF 2.2: Equipment	172	0.00
FPPF 2.2.1: Vehicles	112,447	0.06
FPPF 2.2.2: Information technology	4,049	0.00
FPPF 2.2.99: Equipment not elsewhere classified	3,880	0.00
TOTAL	**202,715,243**	**100.00**

USAID funds amounting to USD 15,534,562 which were aggregately reported and were not broken down into FP production factors were excluded from the data.

3.8. Comparison with Estimated Resource Requirements in the CIP

The National Family Planning Costed Implementation Plan provided a four-year guide on the resource requirement of the national program to be effective and to realize the objective of the National Family Planning Program "to provide access to FP information and services to all WRA belonging to the poorest 60% quintile to reaching a total of 60,588,862 WRA" by the end of the plan.

Table 15. National Family Planning Costed Implementation Plan 2017-2020 in PhP, DOH 2017

Target area	Costed Budget Requirement (% of total for the year)				
	2017	2018	2019	2020	Total
Leadership & Management	**245,678,539 (17.41)**	**228,727,421 (9.74)**	**193,758,020 (8.84)**	**201,751,552 (7.79)**	**869,915,534 (10.19)**
Family Planning Unit	4,647,506	5,544,952	6,087,581	6,695,290	22,975,330
Systems	195,819,480	188,596,427	155,957,460	161,901,985	702,275,352
Monitoring and Evaluation	45,211,553	34,586,042	31,712,979	33,154,277	144,664,852
Supportive Environment	**889,936,993 (63.07)**	**1,861,249,716 (79.25)**	**1,792,691,365 (81.77)**	**2,230,303,283 (86.16)**	**6,774,181,357 (79.32)**
Contraceptive security	337,584,933	1,112,722,944	1,242,427,937	1,762,661,246	4,455,397,060
Provision of FP	153,189,760	310,888,483	105,592,664	28,017,264	597,688,171

grants					
Nurse Deployment Program	377,843,900	391,239,275	415,281,125	430,734,500	1,615,098,800
Purple Ribbon Award	3,468,400	35,049,014	15,039,639	40,273	53,597,326
PhilHealth	17,850,000	11,350,000	14,350,000	8,850,000	52,400,000
Social Marketing	**275,384,000 (19.52)**	**258,500,000 (11.01)**	**206,000,000 (9.40)**	**156,500,000 (6.05)**	**896,384,000 (10.50)**
FP Social and Behavioral and Change Communication Strategy	275,384,000	258,500,000	206,000,000	156,500,000	896,384,000
GRAND TOTAL	**1,410,999,532**	**2,348,477,137**	**2,192,449,385**	**2,588,554,835**	**8,540,480,891**

The study attempted to compare the resource requirements identified in the CIP for 2018 and the actual expenditures reported for the public sector only at the national level. The target areas of the CIP were matched with the major spending categories for these purposes. Although the attempt did not yield a perfect match of categories, the comparison can somehow provide an impression of how the plan is being funded by the national government.

Table 16. 2018 CIP and Actual FP Expenditures in USD

Target Area	CIP for 2018	Spending Category	2018 Actual Expenditures
Leadership and Management	**4,484,851**		**3,866,517**
Family Planning Unit	108,725	FPSC 2.1: Planning, coordination, and programme management	3,334,917
Systems	3,697,969		
Monitoring and Evaluation	678,158	FPSC 2.3: Monitoring and evaluation	531,600
Supportive Environment	**36,495,092**		**11,182,282**
Contraceptive security	21,818,097	FPSC 1: Family Planning Services/FPPF 1.2: Contraceptives and consumables	2,620,166
Provision of FP grants	6,095,853	FPSC 4.2: FP-specific institutional development	3,589
Nurse Deployment Program	7,671,358	FPSC 1: Family Planning Services / FPPF 1.1.1:	8,474,004

		Direct FP service provision staff cost.	
Purple Ribbon Award	687,236	FPSC 4.1: Advocacy	84,522
PhilHealth	222,549		
Social Marketing	**5,068,627**		**5,320,064**
FP Social and Behavioral and Change Communication Strategy	5,068,627	FPSC 1.23: Information, education and communication for FP	5,320,064

The study found out that over-all, the funding requirement of the CIP is not responded by the national government allocation. Of the three major target areas, only one, social marketing, is fully funded. Leadership and management had about 86% funding while supportive environment, in general, is under-funded with only about 7% budget allocation.

In terms of contraceptive security, the expenditure is just 10% of the projected resource requirement. Procurement of contraceptives was made difficult by legal barriers that were imposed to DOH. It must be noted that it was only in the latter part of 2017 when the DOH was allowed to procure contraceptives by the Supreme Court (SC) which ruled that contraceptives must undergo re-certification with the Food and Drug Authority (FDA). As such, by the time of the actual procurement, stock-outs of pills were already reported in many health facilities. The difficulty is coupled by the unsupportive legislative bodies that pushes for the lowering of the budget allocation for procurement of commodities.

Funding for advocacy activities also fell short in 2018 wherein only 12% were funded, while funds to support the provision of FP grants to LGUs was also limited.

Among the target areas that were fully funded or where expenditures were almost at the level of the proposed budgetary requirement were: nurse deployment program for direct FP service provisions, IEC activities, and monitoring and evaluation activities.

4. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1. Summary

The study estimated that total family planning expenditure in the Philippines for 2018 amounted to USD 218,249,805.72 (PhP 11,130,740,091.93). The estimated FP expenditure was 1.39 percent of the total health expenditure reported in 2018.

Public-domestic was the main source of financing for FP services, contributing about 72% of total FP expenditure followed by Private-domestic (19%) and completed by International sources (9%). Particularly, local government units provided the biggest portion of funding at 60%. Out-of-pocket payments is also substantial at 19%.

Compared to the 1998 level of family planning financing where about 25% of funds were sourced from donor agencies, the country has considerably moved to become self-sufficient relative to family planning funding.

The combined local government spending from the provinces, cities and municipalities for the delivery of family planning services and conduct of other FP related activities is estimated to be around 12.15% of their total Health, Nutrition and Population Control budget. This is lower than the earlier estimate of UNFPA, based on their study of the Province-wide Investment Plans for Health (PIPH), which assigned about 25% of the HNPC budget to be FP expenditures (Reyes, 2013).

In terms of service providers, the public sector constituted the highest share (76.9%) of total FP spending as well. This is broken down into: national agencies (11.65%), national government hospitals (0.25%), and local government units and its facilities at 65%. Private sector service provision resulted to some 23% FP expenditure mostly by for profit facilities.

Disaggregated analysis of the family planning expenditures showed that among the activities (spending categories), expenses for direct FP services accounted to 92% of the total expenditures followed by program management at 5%. This level of FP expenditures per activity is both applicable to the public and private sector.

In terms of production factors, staff cost accounted for the highest share with 43% of total FP spending followed by FP promotion (2.73%). However, there is still a large portion of expenditures that were not dis-aggregated to specific budget line items amounting to about 45% of the total reported expenses for family planning in 2018.

The study also did a comparison of the funds projected in the National Family Planning Costed Implementation Plan 2017-2020 over the actual reported FP spending. In 2018, the CIP indicated the resources required for an effective national FP program at USD 46,048,571 (PhP 2,348,477,137). Side by side comparison to reported expenditures to the appropriate spending activities (categories) or production factor (line items) found that expenditures is lower than the resource requirement. It is most notable in the procurement of contraceptive supplies which is only 10% funded in 2018.

4.2. Conclusions

The results of the study showed that family planning services is largely a function of the local government units. LGUs provide the funds to provide the services and they, through their health facilities, also provide the actual FP services to the Filipinos. However, service provision of the LGUs for family planning is limited to its support to the personnel providing the services. They have limited funds for procurement of goods and supplies despite the call of the national government for contraceptive self-reliance at the local level, (DOH Administrative Order DOH AO 2010-0027 - Guidelines for Contraceptive Reliance Strategy). Thus, LGUs are still heavily dependent to the national government in terms of providing for free contraceptives and supplies.

Family planning services in the government hospitals is very limited. Thus, extending the FP services at the hospitals, may contribute to increasing the FP coverage among Filipinos. The NFPP effort to strengthen DOH Department Memorandum No. 2014-0312 on the guidelines for setting up family planning (FP) services in hospitals is quite timely.

Out-of-pocket expenditure for FP services is already high at 20%. This is largely attributed to the procurement of contraceptives and supplies from the private sector. However, considering that there is still an 18.1% unmet need for modern contraceptives among currently married women aged 15-49 years old from the lowest quintile (NDHS, 2017), provision of free FP services will support these women in realizing their reproductive health needs.

This study now provides concrete evidence on how funds for family planning is spent in the country. The findings in this study will help various FP program implementors: from the national government down to the local governments; the development partners (donors) and other relevant institutions including the civil society organizations, working on population management and family planning to identify the gaps and access financial resource flows for FP. This will be critical in developing

policies, programs and targeted action on family planning to reach the national goals of attaining and sustaining zero unmet need for modern contraceptives for all Filipinos.

4.3. Recommendations

a. FP expenditure is still underestimated. There are still many institutions who have refused to provide their information for various reasons. There must be a government policy to direct the program implementers to completely provide their financial data. Stakeholder's commitment including public, private, and donors to report any spending related to family planning for better understanding of resource flow in the country is needed.

b. FP expenditure must be further dis-aggregated. Non-compliance of respondents to provide dis-aggregated data has affected the final results of the research where you can see high amounts not broken down to specific budget items or categories.

c. Further studies specifically for the local governments are needed. More samples must be included in the research to give variation in spending patterns of family planning programs between regions and stratification of LGUs so that they can better represent national spending.

d. Household expenditure (out-of-pocket payments) on family planning should be further reviewed. It will be critical to analyze total household spending and the specific items of expenses on FP.

e. Institutionalize financial flows tracking of FP services to inform policy, planning and budgeting.

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Annex A: List of Respondent Government Agencies

A. National Government Agencies
   1. Commission on Population and Development (including its Regional Offices)
   2. Department of Health (including Centers for Health Development (CHDs) and Retained Hospitals)
   3. Department of the Interior and Local Government
   4. Department of Social Welfare and Development
   5. National Economic and Development Authority
   6. Philippine Health Insurance Corporation
   7. Philippine Statistics Authority

B. Local Government Units
   1. Antipolo City
   2. Akbar, Basilan
   3. Binan City
   4. Binangonan, Rizal
   5. Cotabato City
   6. Iloilo City
   7. Ormoc City
   8. Province of Albay
   9. Province of Palawan
   10. Puerto Princesa City
   11. San Jose City
   12. San Juan City
   13. Tacloban City
   14. Upi, Maguindanao
   15. Victoria, Tarlac

Annex B: List of Respondent Non-Government Organizations

A. Civil Society Organizations
   1. Bisdak Pride
   2. Catholics for Reproductive Health (C4RH)
   3. Cooperative Movement for Encouraging NSV (CMEN)
   4. Employers Confederation of the Philippines (ECOP)
   5. Family Planning Organization of the Philippines (FPOP)
   6. FriendlyCare Foundation, Inc.
   7. Health Action Information Network (HAIN)
   8. International Development Leadership and Learning Corporation (IDLLC)
   9. Institute for Reproductive Health (IRH)
   10. Philippine Center for Population and Development (PCPD)
   11. Philippine Legislators' Committee on Population and Development (PLCPD)
   12. Philippine Society for Responsible Parenthood (PSRP)
   13. Roots of Health
   14. The Forum for Family Planning and Development, Inc. (FORUM)
   15. Women's Health Care Foundation, Inc. (WHCF)

B. Development Partners
   1. United Nations Population Fund (UNFPA)
   2. U.S. Agency for International Development (USAID)