



# PAY FOR PERFORMANCE FOR WOMEN’S HEALTH TEAMS AND PREGNANT WOMEN IN THE PHILIPPINES

Glenda Gonzales, Rena Eichler, and Alix Beith

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*Supply-side and demand-side pay for performance (P4P), consisting of payments to Women’s Health Teams (WHTs) and to pregnant women, is being implemented in the Philippines with the goal of supporting facility-based childbirths and increasing the role of skilled attendance at delivery among disadvantaged women. Funded through the Department of Health and municipal local government units, the P4P scheme was designed to encourage women to deliver in an appropriate health facility within the mother’s catchment area and to encourage WHTs to track and counsel all women within their catchment area. Key features of this program include direct payment to WHTs to identify pregnant women in their catchment area and rewards to ensure that women are directed to and deliver in basic emergency obstetric and newborn care provider facilities for uncomplicated births. This case study provides an example of public sector incentives to scale up outreach to disadvantaged women with the aim of improving maternal health.*





## ABOUT THE P4P CASE STUDIES SERIES

**P**ay-for-performance (P4P) is a strategy that links payment to results. Health sector stakeholders, from international donors to government and health system policymakers, program managers, and health care providers increasingly see P4P as an important complement to investing in inputs such as buildings, drugs, and training when working to strengthen health systems and achieve the Millennium Development Goals (MDGs) and other targets that represent better health status for people. By providing financial incentives that encourage work toward agreed-upon results, P4P helps solve challenges such as increasing the quality of, as well as access to and use of health services.

Many developing countries are piloting or scaling up P4P programs to meet MDGs and other health indicators. Each country's experience with P4P is different, but by sharing approaches and lessons learned, all stakeholders will better understand the processes and challenges involved in P4P program design, implementation, evaluation, and scale-up.

This Health System 20/20 case study series, which profiles maternal and child health-oriented P4P programs in countries in Africa, Asia, and the Americas, is intended to help those countries and donors already engaged in P4P to fine-tune their programs and those that are contemplating P4P to adopt such a program as part of their efforts to strengthen their health system and improve health outcomes.

Annexed to each case study are tools that the country used in its P4P program. The annexes appear in the electronic versions (CD-ROM and Health Systems 20/20 web site) of the case study.

Rena Eichler, Ph.D.

Technical Advisor, Pay for Performance  
Health Systems 20/20 Project

## ACRONYMS

BEmONC	Basic Emergency Obstetric and Newborn Care
CEFBC	Certificate of Eligible Facility-based Childbirth
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
DOH	Department of Health
LGU	Local Government Unit
P4P	Pay for Performance
PhilHealth	Philippine Health Insurance Corporation
PHP	Philippine Peso
RHU	Rural Health Unit
RRA	Rapid Results Approach
WHSMP2	Women's Health and Safe Motherhood Project 2
WHT	Women's Health Team



# INTRODUCTION

In the Philippines, the government included performance-based grants as part of their recently introduced Women’s Health and Safe Motherhood Project 2 (WHSMP2). The goal of this six-year project (2006–12) is to improve women’s health by focusing on interventions in areas that will have the greatest impact on reproductive health problems. The project works in selected sites in five provinces to develop models that increase access for disadvantaged women to high-quality reproductive health services. It is part of the Department of Health’s (DOH’s) effort to establish a core knowledge base that can be replicated elsewhere in the country.

Three different performance-based grant mechanisms are currently being tested under the WHSMP2 project: (1) support to facility-based childbirth, (2) commodity swaps; (3) and enrollment in the sponsored program of the Philippines Insurance Corporation, or PhilHealth (the Philippines’ social health insurance program). This case study focuses on (1) support to facility-based childbirth and its role in increasing skilled attendance at delivery among disadvantaged women.<sup>1</sup>



**Performance-based grants were used to emphasize facility-based childbirth in order to increase the rate of skilled deliveries and decrease maternal mortality**

<sup>1</sup> Given that the P4P scheme described in this case is only a small part of the bigger WHSMP2, other factors (such as the presence of new or improved basic emergency obstetric and newborn care (BEmONC)/comprehensive emergency obstetric and newborn care (CEmONC) facilities in a given area) may affect the number of facility-based deliveries. For example, starting in November 2009, PhilHealth raised its payment for claims for the normal spontaneous delivery package and maternity care package increased from Philippine peso (Php) 4,500 to Php6,500



## WHAT DROVE THE DECISION TO IMPLEMENT P4P IN THE PHILIPPINES?

Concern about high maternal mortality and associated low rates of skilled deliveries, especially among the poorest women, led the DOH to use incentives to motivate community-level teams to help underserved women obtain skilled reproductive health services. The WHSMP2 project was designed to focus on interventions that have the most impact on reproductive health problems: maternal and newborn health, family planning, adolescent health, and control of sexually transmitted infections and HIV prevention. The P4P portion of the project was developed in-country as a potential solution to quality and performance problems, in particular to address the low rate of deliveries by skilled birth attendants (see Table 1), the low number of births taking place in hospitals (see Table 2), and the high maternal mortality rate of 162/100,000 live births in 2006. Indeed it is estimated that every 24 hours approximately seven Filipino women die from pregnancy-related causes (NSO 2006).

**TABLE 1: ASSISTED DELIVERIES BY TYPE OF PROVIDER IN SORSOGON AND SURIGAO PROVINCES, 2005**

Place of Deliveries	Child delivered by professional (MD, RN, midwives)	Child delivered by non-professional (TBAs: trained or untrained; others)
Sorsogon	53.4%	46.53%
Surigao del Sur	47.4%	52.64%
Philippines	68.4%	31.60%

Source: DOH Field Health Service Information System (FHSIS) 2005 and 2007



Note: DOH FHSIS data for 2008 and 2009 are still unavailable. TBA=traditional birth attendant. Sorsogon and Surigao del Sur provinces are where the program was first piloted, starting in 2006.)

**TABLE 2: NORMAL DELIVERIES BY TYPE OF FACILITY IN SORSOGON AND SURIGAO PROVINCES, 2005**

Place of Deliveries	Home	Hospital	Others
Sorsogon	67.8%	30.0%	2.2%
Surigao del Sur	81.1%	17.9%	1.0%
Philippines	64.6%	29.7%	5.7%

Source: DOH FHSIS, 2005 and 2007

Note: DOH FHSIS data for 2008 and 2009 are still unavailable.

The project advocates for a paradigm shift from a “risk approach” (which focuses on identifying women at high risk of complications during the prenatal period) to a “Comprehensive Emergency Obstetric Care approach” (which considers all women at potential risk for such complications) and thus calls for facility-based delivery as a strategy to save as many mothers’ lives as possible as it ensures skilled health professional care. It also recommends antenatal care use and promotes family planning, screening for newborn survival, and prevention of sexually transmitted infections. The 2008 National Demographic and Health Survey registered 16 neonatal deaths per 1,000 live births. Although the percentage of births delivered at home decreased from 66 percent in 1998 to 61 percent in 2003 and to 56 percent in 2008, there are still large disparities in home births between urban and rural populations (40 percent and 70 percent). The P4P portion of the WHSMP2 project aims to target those women most in need: rural, poor women.

The P4P program centers around the Women’s Health Team (WHT), of which there is at least one in every *barangay*.<sup>2</sup> A rural health unit (RHU) midwife heads the WHT and is assisted by barangay health workers<sup>3</sup> and TBAs. A RHU doctor supervises each WHT within a given catchment area. As stated in the WHSMP2 project implementation plan (DOH 2007?), each WHT:

<sup>2</sup> The barangay is the smallest administrative division in the Philippines and means “village”, “district,” or “ward” in Filipino (<http://en.wikipedia.org/wiki/Barangay>)

<sup>3</sup> Barangay health workers are people who have undergone a training program in an accredited government or non-government organization and who voluntarily renders primarily health care services in the community after having been accredited by the local health board in accordance with the guidelines promulgated by the Philippines DOH. Barangay health workers provide information, education, and motivation services for primary health care, maternal and child health, child rights, family planning, and nutrition. They also administer immunizations and regularly weigh children.



- Tracks every pregnancy using a pregnancy tracking protocol
- Assists women in developing a birth plan and monitoring compliance at each prenatal visit
- Refers women to an appropriate facility for prenatal, childbirth, and postnatal care
- Records prenatal visits findings and advice on birth plan in health facilities
- Counsels pregnant women
- Refers clients to the appropriate health facility
- Organizes outreach activities for family planning, blood collection, adolescent health, etc. and provides counseling on appropriate behavior
- Provides family planning services
- Serves as a resource on women's health issues in the community
- Reports maternal and newborn death occurring in the community

The WHT is considered part of the BEmONC team, as the WHT midwife assists primarily during childbirth and the RHU doctor and nurse are “on call” if complications arise



## WHY INCENTIVES FOR WHT MEMBERS WERE CONSIDERED SO IMPORTANT

**A Woman's Health Team (WHT) consists of a midwife, health workers, a Rural Health Unit (RHU) doctor, and a nurse**

The maternal care paradigm shift in the Philippines encourages delivery in health facilities. This resulted in changes in duties and responsibilities for the midwives, the barangay health workers, and the TBAs. Because TBAs can influence mothers' decisions on where to deliver their babies, including TBAs on the WHT was important. As team members, TBAs cease to be direct providers of childbirth services. However, they continue to provide supportive care to the mother and newborn,

which includes encouraging delivery in a health facility. Including TBAs in the WHT also provides an opportunity to link them to the health care system.

Financial incentives for the WHT seemed to be the most viable solution to achieve the goal of facility-based childbirth. The opportunity to earn financial incentives helped convince TBAs, barangay health workers, and midwives to join the WHTs. The incentives compensated TBAs for income forgone from performing traditional births and increased retention of barangay health workers and midwives by reducing the appeal of better-paying jobs in bigger cities or abroad.





# START-UP: SYSTEMS AND PERSONNEL INVESTMENTS NEEDED TO GET P4P UP AND RUNNING

The WHT P4P scheme was conceived at WHSMP2 start-up, when the project was conducting a facility mapping and needs assessment exercise. The mapping and assessment were done to (1) identify strategically located facilities for upgrading to B/CEmONC standards based on a 30-minute travel time criterion; (2) assess necessary inputs for these facilities i.e., infrastructure, equipment, and human resources; and (3) determine the cost of health investments. While conducting the human resource needs assessment under the second objective, the idea of the WHT was conceived.

## ORGANIZING THE WHTS

Organizing the WHT within a municipality comprises eight steps.

1. Carry out an inventory of midwives, barangay health workers, and TBAs – This is to determine the adequacy of members versus the number of WHTs that need to be organized and to define the geographic dispersion of the teams.
2. Determine the WHT selection criteria – The municipal health officer together with the RHU staff and other stakeholders decide on the qualification criteria for WHT membership.
3. Determine the number of WHTs to be organized – One WHT per barangay is the minimum required.



4. Call for an orientation meeting – This venue provides information about the WHT and solicits commitments to join a WHT.
5. Enlist the members and meet the WHT regularly – This is to ensure that all teams are appropriately deployed so that all women in the community have easy access to a WHT member.
6. Train the WHTs on their functions – This ensures that every team member knows her role and responsibilities.
7. Orient the WHTs to understand their incentives – Because incentives are what encourage joining the team, they should be clear to all members.
8. Build team spirit and teamwork through team-building exercises – Because one member cannot function well without the other members, teamwork is necessary.

## TRAINING THE WHT

WHTs are required to undergo training that is focused on their roles and responsibilities in activities such as the following:

1. Pregnancy tracking
2. Birth planning
3. Organizing outreach activities
4. Maternal death reporting.

These training courses are continuously developed and updated as those responsible for curriculum and course design learn from the implementation process. The DOH Health Human Resource and Development Bureau is in charge of human resource management and development that includes recruitment, deployment, career development, and training. The National Center for Disease Prevention and Control is responsible for assessing training needs and design of training packages. The Dr. Jose Fabella Memorial Hospital serves as the main training organization.



# P4P SCHEME DESIGN: THE WHOS AND HOWS

## WHOS OF DESIGN

The national government (i.e., DOH including PhilHealth), local government units (LGUs) (provinces, cities, or municipalities) including their respective health facilities (hospitals, RHUs, barangay health units), and local health experts designed the P4P scheme within the overall WHSMP2 project.

## HOW THE INCENTIVES WORK

The P4P scheme was designed to encourage women to deliver in an appropriate health facility within the mother's catchment area and to encourage WHTs to track and counsel all women within their catchment area. The WHT receives PhP1,000 (\$21.73) for every delivery by a poor mother (whether or not enrolled in PhilHealth) that it refers to and assists during delivery at a health facility; the mother is given PhP500 (\$10.87) to cover childbirth-related expenses such as transportation to the facility and medicines, medical supplies, and food during her facility stay.

**The P4P program gives WHTs incentive to monitor and advise each woman as they are rewarded per delivery done at a health facility**





## INDICATORS THAT ARE USED

Two key indicators that the WHSMP2 project uses to measure WHT performance are the following (DOH 2008):

- Percentage of facility-based deliveries
- Number of pregnant women who delivered with birth plan

However the incentive payment is only tied to facility-based delivery. Other indicators being collected for the WHSMP2 for monitoring purposes are listed in Annex A, Quarterly Monitoring Report Tools..



## P4P PAYMENT MECHANISM

When the WHT refers the woman to a health facility for delivery, the WHT becomes eligible to receive a P4P payment. However payment is not received until delivery occurs (at a facility) at which time the WHT completes a Certificate of Eligible Facility-Based Childbirth (CEFBC) Form signed by the health facility manager. The form contains the following information: (1) the name of the referring or attending WHT midwife or doctor; (2) the mother's name, (3) place of residence, and (4) confirmation of poor (indigent) status; (5) if the woman is a PhilHealth member, her PhilHealth identification card number and confirmation that the health facility has completed a reimbursement request and submitted it to PhilHealth; (6) the mother's obstetrical condition or diagnosis; and (7) the name, type, and address of the service facility. For every delivery, The B/CEmONC facility manager or authorized senior officer signs the CEFBC, which then is submitted by the WHT to the LGU accountant, treasurer, or cashier, who pays the incentives. Payment may be in the form of a check or in cash. To facilitate record-keeping, a cumulative monthly payment is made to WHT members when possible.

Mothers' payments are made along with the WHT's payment. Because the project is trying to direct uncomplicated pregnancies to BEmONC facilities, it does not pay the financial incentive if a mother expected to have an uncomplicated delivery goes to a CEmONC facility unless that mother happens to live in the CEmONC catchment area. It also makes the payment if the case is an actual emergency referral.



The DOH Project Management Team has established overall guidelines for payment distribution among WHT members. The Centers for Health Development (regional offices of the DOH) and provinces ensure dissemination of and compliance with the guidelines. However, provinces have some flexibility with the payment amount breakdown among WHT members. For example, in Sorsogon Province, the PhP1,000 incentive is distributed exclusively to the WHT, as follows: 60 percent goes to the TBA, 20 percent to the midwife, and 20 percent to the barangay health worker. In Surigao del Sur, the PhP1,000 is also shared with the health or birthing facility, the doctor, and the nurse that assist the birth: 20 percent goes to the facility, the remaining 80 percent is shared by the doctor (PhP100), nurse (PhP100), and WHT members (PhP200 each) (Rapid Assessment Study 2009).

## CONTRACTING

There is no formal contract between the WHTs and LGUs. Health facilities have an updated list of accredited WHTs in their respective catchment areas. Accreditation is done at the end of each WHT training session given by health facilities. The list identifies the member(s) from each WHT who is authorized to collect the incentives on behalf of the team and specifies the pre-agreed sharing arrangement for each team.



## P4P SCOPE AND SCALE

**D**uring the 2006–0 period, the P4P intervention is being piloted in five provinces before a likely roll-out nationwide. The project consists of two batches of pilot project sites: Sorsogon (700,000 people) and Surigao del Sur (500,000 people) provinces started in 2006. Albay (1.2 million people), Masbate (770,000 people), and Catanduanes (220,000 people) provinces started in 2009

**Mothers are more likely to receive proper care before, during, and after delivery with WHT performance based grants.**





## STRENGTHENING THE SCHEME: REVISIONS REQUIRED POST-IMPLEMENTATION

During the implementation of the scheme in the first two pilot provinces in 2006, the provincial governments passed provincial ordinances intended to prevent home deliveries: In December 2008, Sorsogon passed an ordinance that prohibits TBAs from performing assisting deliveries at home and without the immediate and direct supervision of a skilled birth attendant. Surigao del Sur passed a similar ordinance but its ordinance added penal provisions for TBAs as well as for pregnant women who violate the ordinance.



## FINANCING THE SCHEME

The main sources of financing for the P4P scheme are LGU and the national government budget appropriations, reimbursements from PhilHealth, and user fee revenues collected at LGU hospitals. All these sources contribute to the supply-side (WHT) and demand-side (women's) incentive payments. The P4P payment (PhP1,500) is channeled through the DOH (PhP1,000) and the municipal LGUs (PhP500).



advocacy camp for pregnant mothers in Lingig

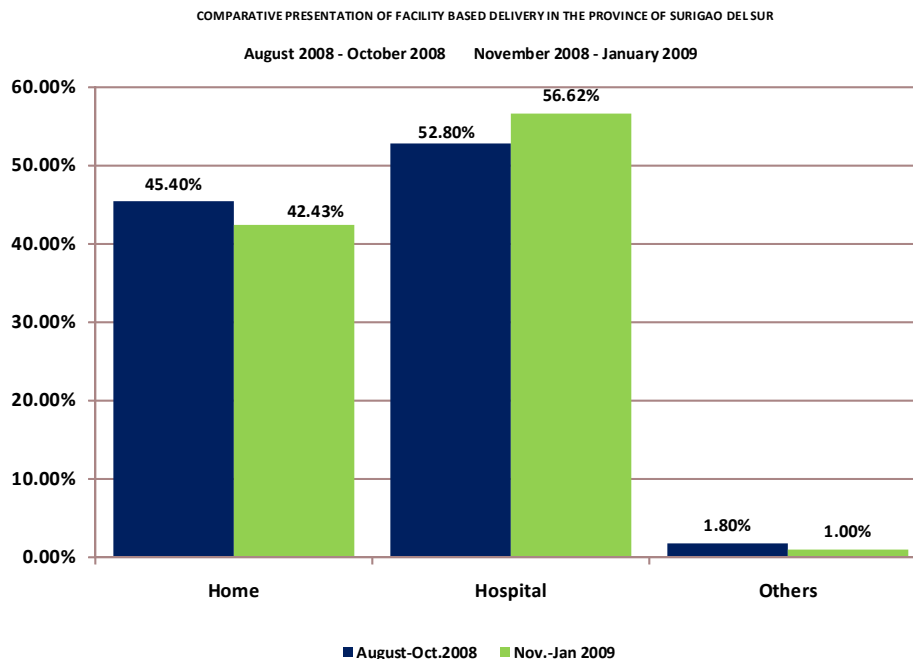


## FROM THEORY TO EVIDENCE

The WHSMP2 has been carrying out a regular rapid results approach (RRA) every 100 days since implementation began, to evaluate the program and plan accordingly. Although evidence available to date is not sufficient to determine whether the P4P scheme increases the number of facility-based deliveries, a presentation by the Government of Surigao del Sur on one 100 Day RRA period (November 2008–January 2009) estimated a 7.6 percent increase from the previous period (November 2008–January 2009). In tracking 50 percent of the eligible population of pregnant women, they found that hospital-based deliveries had increased, from 52.80 percent to 56.62 percent, and home-based deliveries had decreased, from 45.40 percent to 42.43 percent (Figure 1).



**FIGURE I: CHANGE IN NUMBER OF FACILITY-BASED BIRTHS VS. HOME-BASED BIRTHS, SURIGAO DEL SUR PROVINCE**



A rapid assessment study<sup>4</sup> conducted in 2009 to describe the processes of implementing the performance-based grants in the Philippines, including the facility-based deliveries P4P component, identified several important issues. For example, on the operational side, the assessment reported delays in the release and disbursement of the project funds to a few LGUs; this meant that incentive payments for WHTs and mothers earned in 2007 were not paid until 2008 or 2009. It also determined that some TBAs still prefer to assist at-home deliveries, because these deliveries pay more than the incentives they receive for referring pregnant women to a health facility (PhP1,000 and PhP1,500 per delivery at home vs PhP600 in Sorsogon and PhP200 in Surigao del Sur for referral to and ultimate delivery in a facility). However, some TBAs recognize a financial risk in making this choice – since the mothers they serve are poor, most of them cannot pay the TBA immediately and take months before they can pay, and some never pay. Finally the assessment found that the other WHT members, the midwives and the barangay health workers, are satisfied with the incentive payment, although they receive less than the TBA, as they already receive honoraria as barangay employees.

<sup>4</sup> Results from this study are mainly descriptive and do not constitute a formal evaluation



## KEY CHALLENGES AND LESSONS LEARNED

It is the choice of mothers whether to give birth at home or in a health facility. This choice is affected by demand-side barriers (direct and indirect costs of treatment, knowledge of the available health services, perceived quality of care, and socio-cultural characteristics) and supply-side barriers (cost of treatment, availability of birthing facility, quality of care). The Philippine WHT P4P scheme addresses demand-side barriers as well as supply side barriers. The Php500 paid to mothers who deliver at a health facility covers the indirect costs of treatment. WHTs counsel mothers regarding the services available to them, such as pre-pregnancy, pre-natal, delivery, and postpartum and postnatal care. WHTs also encourage mothers to deliver at the closest birthing facility and educate them regarding the importance of delivering at these facilities.

The primary challenge is P4P scheme financial sustainability, which depends largely on funding from PhilHealth reimbursements and user fee revenues collected by the facility. The LGUs in Sorsogon and Surigao del Sur have already made local policies to enroll the poor in PhilHealth in order to qualify for the reimbursements, and to collect user fees from non-poor clients using a socialized pricing scheme.



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Health Systems 20/20 | [www.healthsystems2020.org](http://www.healthsystems2020.org)  
Abt Associates Inc. | [www.abtassociates.com](http://www.abtassociates.com)  
4550 Montgomery Lane  
| Suite 800 North | Bethesda, MD 20814 | USA  
E-mail: [info@healthsystems2020.org](mailto:info@healthsystems2020.org)