



Charging for FP-MCH Commodities and Services: Mid-term Evaluation

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Executive Summary

The findings of the mid-term evaluation indicate that the first phase of the "Charging for FP-MCH Commodities and Supplies" intervention was going well. Revenues were being collected regularly, most users, including low-income users, believed that the fees for contraceptives were reasonable, and most users were paying the fees for contraceptives rather than deferring payment. Record-keeping also improved in the intervention unions, and the gap between the CAR (GoB MIS) and the CPR decreased significantly in the intervention unions.

Significant reductions in wastage of pills were found in the intervention unions, probably due to better accountability of supplies associated with the collection of revenues. Although the percent of total users that were pill users increased, and contraceptive prevalence did not change in these two unions, approximately Tk.3,300 and Tk.1,720 were saved per month from the previous years through a reduction in distribution of oral pills in Rajghat and Dhum unions respectively. These findings suggest tremendous potential for savings through reductions in wastage.

One problem that was found was the users' inadequate knowledge of the contraceptive pricing structure. Although the respondents could state the correct prices for methods distributed at the home, knowledge of prices at the SC and H&FWC (in Mirsarai) was poor. The implication of this latter finding is that additional information, education and communication activities need to take place, so that users as well as their husbands become better informed of contraceptive fees.

The second part of the evaluation examined the effect of pricing on contraceptive-seeking behaviour. Contrary to initial fears, the contraceptive prevalence in the intervention unions did not decrease, rather it increased in Mirsarai thana. In addition, the contraceptive method mix was not affected by the introduction of prices. While no effect of pricing was found on contraceptive prevalence, some effect was found on provider choice. In

both the intervention unions, the use of SCs to obtain family planning methods doubled. In addition, at the intervention union in Abhoynagar thana, the use of the H&FWC increased. These findings suggest that the choice of provider can be influenced by pricing signals.

An unexpected finding was observed at the intervention union in Mirsarai thana - the use of the services of the FWA increased, instead of decreasing while the use of the H&FWC and pharmacy decreased. The likely explanation is that the contact of the FWA with the clients has increased due to the increased regularity required to collect revenues. This effect will be monitored as the intervention continues to determine whether it is a temporary artifact of the intervention or due to the introduction of pricing.

A survey on health care-seeking patterns for children and women of reproductive ages was also conducted to prepare for the second phase of the intervention when charges for selected MCH services will be introduced. The results of the survey indicated that curative care for children aged ten years and less and MWRA was obtained primarily through the private sector. However, the public sector (SC, H&FWC, and THC) was also used to some extent.

The majority of the respondents indicated that they were willing to pay as much as Tk. 6 to receive curative care for themselves or for their children at the SCs and H&FWCs. The clients also indicated considerable willingness to pay for EPI services.

Decision-making patterns and willingness to pay differed between Abhoynagar and Mirsarai thanas. In Abhoynagar, the wife, not the husband, was more often the principal decision-maker on child curative care, but not for decisions on her own care. In Mirsarai, the wife was more likely to be the decision-maker on whether to seek care for the child or for herself, but her husband was more likely to decide where to seek care. In addition, the respondents were more willing to pay for curative care and EPI services in Abhoynagar (88%) than in Mirsarai (76%). The differences between the two thanas suggest that it would be useful to consider variations in designing phase two of the pricing intervention at each of the two areas.

Introduction

The National Family Planning Programme has reached a stage of maturity when it can be concerned with objectives other than creating consumer demand for family planning methods. Policy-makers and programme managers are increasingly focusing on improving the financial sustainability of the programme through improving its efficiency and cost-effectiveness and introducing financing schemes that recover costs.

One mechanism to increase the cost-recovery of the programme is to introduce user fees for MCH-FP commodities and supplies. As part of its operations research, the MCH-FP Extension Project (Rural) introduced prices for contraceptives in GoB facilities in two unions in rural Bangladesh: in August 1996 at Rajghat union in Abhoynagar thana and in September 1996 at Dhum union, Mirsarai thana.

After six months, the intervention was evaluated to determine how well the process of implementation was proceeding. This paper presents the findings of the mid-term evaluation.

Background

The National Family Planning Programme has been tremendously successful in raising the country's contraceptive prevalence rate (CPR) from 7 percent in 1975 to 49.2 percent in 1996-1997 [1]. While the programme needs to continue its efforts to raise the CPR to reach the replacement fertility level, it also needs to focus on its rising costs. The costs of providing commodities and services are increasing, due to continuing population growth (2%) and rising contraceptive prevalence levels.

The National Family Planning Programme is also heavily dependent on donor funds; external contributions fund over 60 percent of the population sector [2]. The dependency in the population sector is much higher than in the health sector, where the use of external funds is only

about 17 percent. The GoB needs to develop strategies to fill the gaps in its financing, as external funds are gradually being withdrawn.

Part of the reason that the National Family Planning Programme is so costly is due to its labour-intensive strategy of delivering services at the homes of married women of reproductive ages (MWRA). While this strategy may have been necessary to generate demand for family planning services in the early stages of the programme, considerable demand for contraceptive services has now been generated and sustained over the last decade. In addition, women have become more mobile than they were during the early stages of the programme. The programme is now at a stage when it may shift its strategy from door-step delivery to deliver services at the fixed clinics.

The door-step delivery of contraception is costly and also results in a high dependence on short-term methods: the oral contraceptive pills and the condoms, which are less use-effective and costlier than long-term methods. In addition, while these methods are appropriate for women when they are young and wish to space but not limit their fertility, long-term methods, such as IUD and sterilization, are more suitable for women who have completed their desired level of childbearing and wish to have no more children. For this reason, a shift toward the increased use of long-term methods for women who wish to limit their fertility should take place if the programme is to become more cost-effective. The shift toward long-term methods will only take place if the quality of services improves, and women and men who have completed their childbearing are encouraged to use methods, such as IUD and sterilization, through appropriate information, education, and communication.

Cost Recovery

There are two mechanisms for addressing the high cost issue of increasing costs: 1) services can be made more cost-effective and efficient, requiring fewer resources to deliver a unit of service than before; and 2) funds can be generated through judicious application of user fees at the GoB service-

delivery points. One advantage of the latter is that selective pricing can also be used for improving equity and encouraging clients to use outlets appropriate for contraceptive methods. Ideally, both these mechanisms should be addressed simultaneously.

At present, the GoB is offering family planning and MCH services at little or no charge to consumers. The reason behind the present pricing structure is two-fold: 1) family planning methods are considered to be public goods, i.e. their use is thought to benefit the larger society by lowering population growth, and 2) there was insufficient demand for family planning methods when the programme began.

There are several negative consequences of not charging fees for family planning and MCH services and supplies [3]. One consequence is that clients pay for services in the cost of their time, rather than in cash prices. That is, although clients do not pay for services (or pay only a small amount), they may have to wait for services. The waiting time may be long when services are over-used because of low prices, or when the client's time is considered to be of low value to health personnel, since they are not paying for services. In this case, the waiting time may become the allocative device rather than cash prices.

Another consequence of negligible prices is that the quality of service may be low, since resources are limited. In addition, the quality of services may be driven down, because clients have low expectations about services which are free. A third consequence of not charging fees is that customers may begin to seek differential access to the service, based on their personal connections or position. An advantage to having user charges is that the efficiency of health service use increases, since they eliminate economic losses that occur with other allocation methods, such as queues. That is, a client can borrow money to use services from another individual, but not the time necessary to wait in line at a clinic¹. Thus, initiating user charges is a more efficient allocative mechanism.

¹ The assumption made here is that the waiting time for service providers will decrease when the over-use of services due to negligible pricing declines, or as service providers become more attentive to client needs.

Prices can also be used for sending signals to clients about priorities in the health and population programmes. They may be used for indicating higher priorities for preventive rather than curative care. They may also be used for signaling to clients that the use of long-term family planning methods by women who wish to limit their fertility is considered more appropriate than short-term methods, through charging more for short-term methods.

Quality and Equity Effects

Two aspects need to be considered for any cost-recovery initiative: quality of care of services and equity. International experience shows that clients are highly resistant to paying fees unless there is some incentive for them to do so. For example, the clients will be more willing to pay fees if the quality of services increases or if a special service is offered, such as new operating hours.

In addition to quality considerations, in charging prices in developing countries, it is important to consider its effects on low-income groups, since these groups are likely to be most sensitive to changes in prices.

Quality Effects

When clients are asked to pay user fees for services which were previously free, they usually expect that the quality of service delivery will increase simultaneously. Some of their expectations are likely to include the following: services offered regularly, availability of contraceptives and drugs, clean facilities, and attractive waiting areas. If these expectations are not met, there will be a substitution effect as clients are discouraged from using the public sector and may switch over to the private sector or stop using the service altogether.

Some empirical evidence suggests the importance of improving quality when user fees are introduced. Longitudinal studies, conducted in Africa on the effect of user fees on health-care service use, have found reduced use in places where there had been few improvements in quality [4]. On the other hand, when user fees were combined with quality improvements in a province of Cameroon, there was increased use of services. Akin *et al* [5] found that the usage rates in Nigeria increased significantly as quality improved.

Equity Effects

One consideration is whether a government should use its scarce resources to subsidise health care at all. The distinction typically made in considering this question is whether the services offered are public or private goods. That is, whether the services affect only the individual (private good) or whether they benefit the larger society (public good). Under this definition, a private good might be treatment for a non-communicable disease, such as heart disease. A public good might be an immunization that would decrease the transmission of a communicable disease. Family planning and maternal and child health (FP-MCH) goods and services usually constitute a mix of public and private goods. That is, individual couples receive benefits from having smaller families, while society as a whole benefits from having a slower growing population.

While the society clearly benefits from subsidising FP-MCH services, it is also a private good. So, while the GoB has a justification for subsidising free services, it can also consider family planning services partially a private good and charge fees to those who can afford to pay. Two equity effects of user fees need to be examined when considering the application of user fees: (1) how clients within the same income group are treated, and (2) how clients in different income groups are treated.

If prices are equal for clients in the same income group, the effect is likely to be more equitable than charging no fees. The reason is that the cost of a free service may differ for people depending on their use patterns

and access to scarce resources. Under a free system, infrequent users will be subsidising more frequent users, since they pay the same taxes for public services. Also, people using personal connections will have more access to scarce resources than will other people.

Another issue is how user fees affect people from different income groups. User fees may differentially affect clients, depending on their income group. It is likely that people with more disposable income (from higher income groups) will be more likely to buy FP-MCH services/supplies than will people with very little disposable income. On the other hand, a user fee service is likely to have the potential to improve the targeting of the poor. Exemptions can be designed for individuals who are unable to pay, but those who can afford to pay should.

A user fee system has the potential to be more equitable than a pricing structure that charges no fees for services, particularly if the quality of services improves. It is important to carefully design the pricing structure to take equity considerations into account.

Previous Experience in Charging Prices for Family Planning and Other Services

Evidence from family planning studies indicates that individuals are not very sensitive to prices (i.e. the price elasticity of demand is low). This finding makes sense intuitively, since the cost of raising a child is quite large compared to the price of contraception. Studies conducted in Thailand, the Philippines, Jamaica, and other less-developed countries [6,7,8] have found that the demand for contraceptives is relatively insensitive to changes in the price of contraception. Schwartz *et al.* [6], however, found that while demand for most methods (pills, IUDs, injectables, and sterilization) was not sensitive to an increase in price, it was sensitive to an increase in price for condoms. Demand may also be more sensitive to prices in lower income households. In these cases, use may increase if prices are decreased [7].

Barkat-e-Khuda *et al.* [9] conducted a study to investigate the effect of prices on contraceptive use in one union of Monohardi Thana in Bangladesh. In this study, GoB Family Welfare Assistants (FWAs) charged fees for pills and condoms in one union for one year, while no fees were charged for these contraceptives in a comparison union.

The contraceptive pricing study had mixed results. On the positive side, the contraceptive prevalence in the intervention union did not decline, but instead, increased slightly. On the other hand, recovery of user fees was low, since the FWAs were unable to collect the fees for approximately one-half of pills and one-third of condoms that they distributed. This inability to collect fees was related to the generally limited access to cash, and the fact that FWA visits were not regular.

On the other hand, the NGOs seem to have had more success in experience in charging fees for services in Bangladesh. A majority of NGO contraceptive clients (80-90%) pay fees (personal communication, Abdur Rouf, FPSTC, 1996). Table 1 gives the range of prices that are charged by NGOs offering MCH-FP services, disaggregated by urban and rural location:

Table 1. Median and range of prices charged for family planning services by Asia Foundation Non-Government Organizations in Bangladesh (Prices are in Taka)

NGO Sites	Pill	Condom	Injectable	IUD	Registration Fees	
					1st Visit	Re-visit
Rural (n = 68)	0.5 (0-2.0)	0.5 (0.5-1.0)	1.0 (0.0-10.0)	0.0 (0.0-20.0)	2.0 (0.0-10.0)	2.0 (0.0-10.0)
Urban (n = 28)	1.0 (0.0-2.0)	1.0 (0.0-3.0)	0.0 (0.0-5.0)	0.0 (0.0-5.0)	5.0 (0.0-10.0)	2.0 (0.0-5.0)

Source: TAF, 1995

Note: Some NGOs are also charging fees for MCH services.

Methodology of the Pricing Intervention

As part of its efforts to improve the sustainability of GoB services, the MCH-FP Extension Project (Rural), in collaboration with the Family Planning Directorate of the Ministry of Health and Family Welfare (MOHFW) has been implementing an experiment in two treatment unions of Jessore and Chittagong districts. The unions are Rajghat of Abhoynagar thana in Jessore and Dhum of Mirsarai thana in Chittagong. Siddipassa and Mayani have been selected as comparison unions for Rajghat and Dhum unions, respectively. The intervention started in Abhoynagar and Mirsarai beginning August 1, 1996 and September 1, 1996 respectively.

The contraceptive-pricing intervention has two phases. In the first phase, fees are introduced for short- and medium-term contraceptive methods (pills, condoms and injectables). Clients will not be charged for the use of long-term methods (IUDs and sterilization), since the family planning programme wishes to promote the increased use of these methods. During the second phase, user fees will be introduced for selected MCH services at the satellite clinics (SCs) and Health and Family Welfare Centres (H&FWCs). Lower fees for contraceptives are being charged at outlets which require the clients to leave their homes (Table 2). The prices at the SC are half of those at the doorstep. Contraceptives are provided free of charge at the H&FWC to offer a safety net to the clients who are unable to pay cash for contraceptives. These women or their husbands will, instead, be asked to pay with the opportunity cost of their travel time to the H&FWC.

Prior to the implementation of this pricing intervention, the MCH-FP Extension Project (Rural) carried out a comprehensive survey which addressed the issues related to clients' ability and willingness to pay, and direct and indirect (travel and waiting) prices associated with contraceptive use. Since the intervention began, a second survey was conducted in March 1997 to compare the process and outcome indicators after the intervention has begun with the baseline.

Table 2. Pricing structure in intervention unions during the first phase

Service delivery point	Charge prices		Charge prices for services	
	Yes	No	Charge*	No Fee
Doorstep	+		1 cycle pills- Tk. 1 12 condoms- Tk. 1 1 doze injectable- Tk. 2	NA
Satellite Clinic/Cluster	+		1 cycle pills- Tk. 5 12 condoms- Tk. 5 1 doze injectable- Tk.1	IUDs
FWC		+	NA **	pills, condoms, injectables, IUDs

*NA = not applicable

**Although in the original design, condoms were to be given free at the H&FWC, the MOHFW decided to continue charging Tk. 0.5 per dozen at this outlet, since prices were already in effect.

Evaluation Objectives and Methodology

In this section, the evaluation objectives and methodology of the “Charging for FP-MCH Commodities and Supplies” intervention are discussed.

Objectives of the Evaluation

The first objective of the evaluation was to assess how well the intervention was proceeding on two levels: (1) the process, and (2) impact on contraceptive-seeking behaviours, i.e. contraceptive use, method mix, provider choice. A second objective was to examine health-care-seeking behaviours and willingness-to pay for health care at the SCs and H&FWCs to prepare for the introduction of pricing for selected MCH services.

Methodology of the Mid-term Evaluation

Three sets of findings of the “Charging for MCH-FP Commodities and Supplies” intervention are presented in this paper: (1) process indicators, (2) effect of introducing pricing on contraceptive-seeking behaviours, and 3) baseline findings on child and women’s curative care-seeking patterns and use of EPI services.

The process indicators were evaluated by analyzing data from the monthly monitoring reports and bimonthly intervention-specific Sample Registration System (SRS) reports. For example, the patterns of total monthly revenues collected were examined, as well as problems and constraints of record keeping, and reductions in wastage of contraceptives. Other indicators examined included the users’ valuation of current contraceptive prices and percent of users paying for contraceptives.

The second part of the evaluation investigated was the effect of introducing pricing on contraceptive-seeking behaviours by analysing data from a mid-term evaluation survey undertaken in March 1997. In this survey, the respondents from SRS households from the intervention and comparison unions were interviewed on their contraceptive-seeking behaviours.

The third part of this paper examines health care-seeking behaviours for women and children and respondents’ willingness to pay for curative care as well as EPI services at the SCs and H&FWCs. The analysis investigates the median expenditures on children aged ten years or younger and women’s curative care in rural areas, sources of care, and decision-making patterns. Contingent valuation was used for assessing willingness to pay among the respondents. Using this technique, the respondents were asked about their willingness to pay for services at government facilities under a hypothetical fee/quality improvement programme.

Data to address the quality issue were not available for this study, but the issue of equity was investigated. The effect of introducing prices on

contraceptive-seeking behaviours for different wealth groups was examined in the analysis.

Sampling Procedure

The unions where the contraceptive pricing survey was carried out are part of the SRS of the MCH-FP Extension Project (Rural). The SRS is a data collection system; it gathers demographic, health and contraceptive use longitudinal data every two months. For this analysis, the same households in the SRS sample were surveyed during the baseline data collection, so that the information already available on these households could be supplemented with the data from the pricing survey.

The total sample of the contraceptive-pricing survey consists of 2727 eligible married women in the age group 15 - 49 years. The sample selection was based on a systematic household-sampling procedure whereby every sixth household in Rajghat and Siddipassa at Abhoynagar thana and every fourth household in Dhum and Mayani at Mirsarai thana were selected. All eligible women residing in those sample households were selected. The sample sizes of the intervention and treatment unions were 848 in Rajghat, 730 in Siddipassa, 538 in Dhum, and 611 in Mayani.

To increase the number of contraceptive users for the survey, additional respondents who were users of what were added to the survey; lists of users by method were obtained from the FWA registers. In the intervention union at Abhoynagar, where the number of users was higher due to higher contraceptive prevalence, an additional 93 condom users and 22 injectable users were interviewed. In the intervention union at Mirsarai, where the number of users is smaller, 46 condom, 154 pill, and 241 injectable users were added.

In the modules on child or women's curative health care, the respondent was asked to answer questions on the child's last illness episode if the youngest child had been ill within the last two months. In

addition, she was asked about her own illness episode if she had been ill within the last two months.

Findings

In this section, the findings of the study are presented. The section, 4.1 presents the change in process indicators over time, where the Section 4.2 presents the change in contraceptive-seeking behaviours over time, and the Section 4.3 the findings on health-seeking patterns and willingness to pay for health services.

Process Indicators

The first indicator examined was the amount of revenues collected each month. Figure 1 shows that a much higher amount of revenues was collected in the intervention union at Abhoynagar than that in the intervention union at Mirsarai. The difference is due to the higher contraceptive prevalence and larger population in the Abhoynagar union than that in the Mirsarai union. The revenues ranged between Tk. 1,100 and 1,300 at the intervention union at Abhoynagar and Tk. 300 and 450 at the intervention union at Mirsarai. Some fluctuations occurred in the revenues, probably because more injectable doses were given in some months than in others.

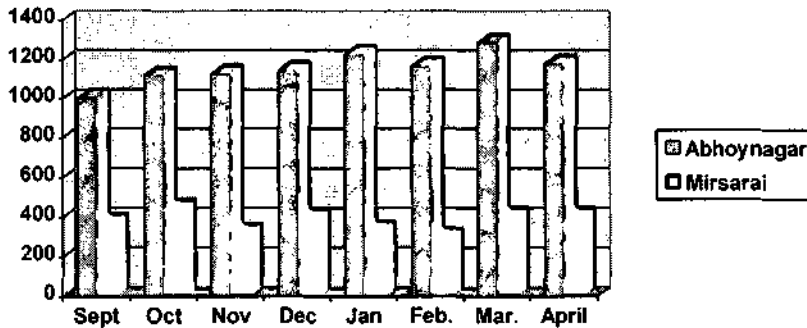


Fig. 1. Total monthly revenues collected in intervention unions

The record-keeping system required to record the revenues for the pricing was also examined. The use of the monthly one-page form developed to record the revenues received by the FWAs and FWVs at the intervention union was reviewed. It appeared from the monitoring reports that the FWAs and FWV kept the records satisfactory, although it needed to be checked regularly by the Family Planning Inspector (FPI). In addition, discussion with the FWAs and FWVs indicated that they perceived the time required to complete the forms to be short.

One indicator that recordkeeping on client use of contraceptives has improved is a change in the gap between the Contraceptive Prevalence Rate (CPR) and the Contraceptive Acceptance Rate (CAR). Previous studies [10] found wide gaps between the CAR reported by the GoB MIS and CPR reported in surveys. Because the FWAs needed to be more accurate about the number of supplies they distributed when they charged for contraceptives, the gap between the CAR (from the GoB MIS) and the actual CPR decreased in the intervention unions. The gap should be lower in the intervention unions than in the comparison unions. Figure 2 indicates that the CAR-CPR gap was reduced to about 5 percent in the

intervention unions compared to the gaps of 10 - 15 percent in the comparison unions.

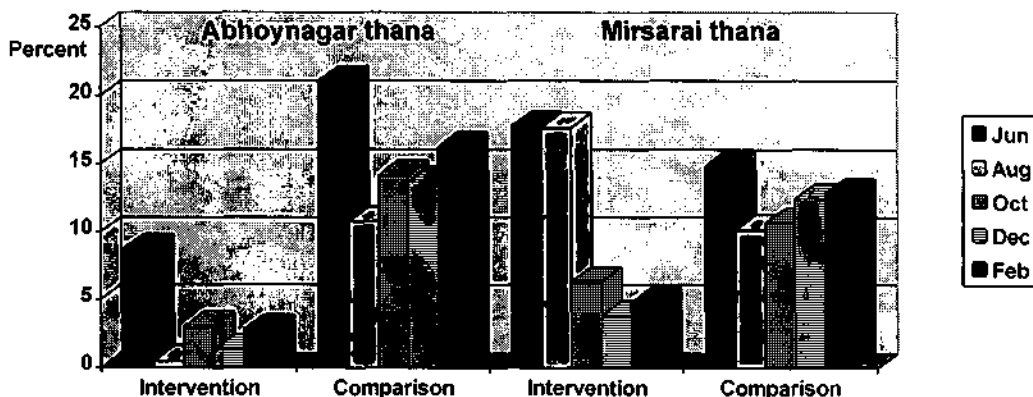


Fig. 2. CAR-CPR gap in intervention and comparison unions, June 1996-February, May 1997

Another indicator, the percentage of users paying for pills, condoms, and injectables was examined because the findings of other studies [9] showed that contraceptives were often given on credit (deferred payment) rather than paid for in cash. Figure 3 shows that most users purchased their contraceptives rather than obtained them through credit, probably due to the intervention policy to tell clients who do not wish to pay for traveling to the H&FWC instead. A small percentage (approximately 10%) obtained their contraceptives at outlets where there was no charge (H&FWC or THC).

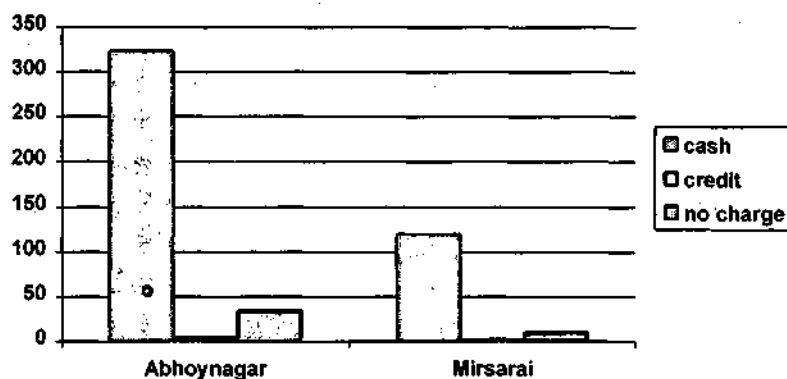


Fig. 3. Number of users by type of payment for contraceptives in intervention unions, February 1997

When users were asked whether they felt the user fees were reasonable, most stated that they were (Table 3). Among the users that felt the fees were not reasonable, most stated that it was because the fees were too high or due to lack of cash, and the reasons differed by thana. In the intervention union in Abhoynagar thana, most users stated that lack of cash was the problem, whereas in the intervention union in Mirsarai, the respondents more often stated that the fees were unreasonable because they considered them too high.

Table 3. Valuation of pricing structure and knowledge of correct prices by current contraceptive users, February 1997 (%)

	Rajghat, Abhoynagar (n = 330)			Dhum, Mirsarai (n = 117)		
Reasonable	86.1			81.2		
Not reasonable because:						
Fees too high	2.1			10.3		
Lack of cash	11.8			7.7		
Percent of users that know correct price by outlet:	Home	SC	H&FWC	Home	SC	H&FWC
Pill	80	32	98	71	3	19
Condom	25	4	98	9	2	18
Injectable	87	48	98	47	2	17

Source: SRS

Although a large percentage of pill, condom and injectable users stated that the fee structure was reasonable, the percentage of users that knew the correct prices of contraceptives at each outlet was low. It is likely that users knew the prices best for the methods that they used themselves. The percentage of users that knew the correct prices was higher in the high-performing Abhoynagar union than in the low-performing Mirsarai union.²

The percentage of users who stated that the fee structure was reasonable was also disaggregated by wealth groups³ to ascertain if the lowest income group was more affected by the price structure. Table 4 shows that the majority of low-income users felt that the fees were reasonable.

Table 4. Valuation of pricing structure by wealth group

Wealth group	Reasonable	Not reasonable	Total
1	51 (86.4)	8 (13.6)	59 (100)
2	37 (75.5)	12 (24.5)	49 (100)
3	80 (78.4)	22 (21.6)	102 (100)
4	70 (94.6)	4 (5.4)	74 (100)

* Wealth Groups range from a low of 1 to a high of 4.

Another issue that was examined was whether reductions in wastage of pills and injectables⁴ occurred after the intervention began. Table 5 indicates that, although the share of pill use increased among users during the six months since the intervention was introduced (Section 4.2) and

² The low percentage of users that knew the correct prices at the SC may be due to overall low use of the SCs at Mirsarai thana.

³ The wealth groups were differentiated on the basis of number of assets that were in the household.

⁴ Since prices already existed for condom, this method was not examined for reduced wastage.

contraceptive prevalence either remained the same or increased,⁵ the number of cycles that were distributed, on an average, decreased significantly. The reduction was probably due to the increased accountability of supplies associated with revenue collection. On an average, the number of pill cycles distributed decreased by 40 percent in the intervention union at Abhoynagar and 50 percent in the intervention union at Mirsarai.⁶ The savings per month at Abhoynagar and Mirsarai unions were Tk.3300 and Tk.1716 respectively, and were higher than the total revenues received from user fees.

There was also some reduction in distribution of injectables at Abhoynagar, but not at Mirsarai where the proportion of injectable users is increasing. On an average, there was a reduction of 18 vials of injectables each month in the intervention union at Abhoynagar, or a savings of Tk.619 (Appendix Table A-1). In Mirsarai, the distribution of supplies increased instead, and there were no savings.

Some hypothetical estimation of the savings from reductions in pill wastage if pricing were to be extended to the entire country of Bangladesh were undertaken and are shown in Appendix Table A-2. It shows the projection of the estimated savings in US dollars that can be generated from reduced wastage of oral pills at various rates of savings. It also shows that between an amount of US\$ 2.4 - 4.1 million could be saved annually through reductions in wastage of oral pills.

⁵ It should also be noted that the use of private sources to obtain contraceptives only increased slightly in Rajghat and decreased in Dhum, and could not account for the reduction in supplies distributed.

⁶ These percentage changes were similar to the divisionwide gap rates found in a study on the pill gap done in 1994 [11].

Table 5: Total number of pill cycles distributed in intervention unions before and after introduction of pricing (% in parentheses)

Month	Abhoynagar thana				Mirsarai thana			
	Total cycles distributed per month year before pricing began	Total cycles distributed per month after pricing began	Difference in amount distributed before and after pricing (in cycles)	Monthly savings in taka	Total Cycles distributed per month year before pricing began	Total cycles distributed per month after pricing began	Difference in amount distributed before and after pricing (in cycles)	Monthly savings in taka
August	1415	570	845 (60)	5577	NA	NA	NA	NA
September	1018	569	449 (44)	2963	636	202	434(68)	2864
October	1274	687	587 (46)	3874	484	314	170(35)	1122
November	1230	747	483 (39)	3188	514	218	296(58)	1954
December	1282	851	431 (34)	2845	421	254	167(40)	1102
January	1063	796	267 (25)	1762	527	235	292(55)	1927
February	1337	993	344 (26)	2270	410	176	234(57)	1544
March	1453	969	484 (33)	3194	486	215	271(56)	1789
April	1454	852	602 (41)	3973	509	238	271(53)	1789
May	NA	NA	NA	NA	448	186	262(58)	1729
Total	11526	7034	4492(40)	29647	4435	2038	2397(54)	15820
Average/ month	1281	782	499	3294	492	226	266	1756

NA = Not Available

Effect of the Introduction of Pricing on Contraceptive-seeking Behaviour

The effect of pricing on contraceptive-seeking behaviour was also investigated, and the results are presented in this section.

Although initially fears were expressed that contraceptive prevalence would decline with the introduction of prices, the CPR either remained the same or increased slightly during the first six months of the intervention (Fig. 4). The CPR in the intervention unions followed similar trends as those in the comparison unions.

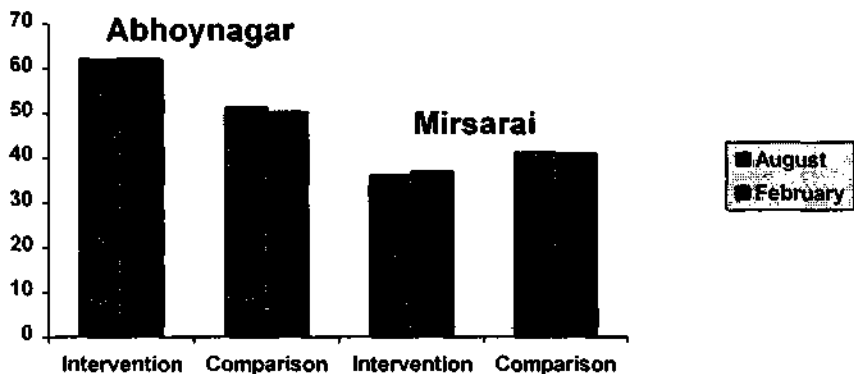


Fig. 4. Contraceptive prevalence rates in intervention and comparison unions

When the contraceptive method-mix at baseline in the intervention and comparison unions was compared with the mid-term findings, no significant differences were found (Table 6), and oral pills and injectables continued to be the most frequently used methods in all the unions.

Table 6: Contraceptive method mix at Abhoynagar and Mirsarai thanas (%)

	Abhoynagar thana				Mirsarai thana			
	Intervention		Comparison		Intervention		Comparison	
	BL*	MT**	BL	MT	BL	MT	BL	MT
Pill	26.0	31.0	34.3	41.9	34.0	35.2	26	28.3
Condom	8.0	8.4	7.3	5.9	9.0	5.7	4	5.7
Injectables	28.6	29.6	28.5	29.8	22.0	24.9	30	25.1
IUD	10.0	8.8	4.6	2.7	11.0	10.4	7.6	6.9
Tubec./Vasec.	18.0	16.1	13.9	11.4	17.0	13.5	25.0	24.0
Traditional	9.0	5.7	11.0	8.3	8.0	10.4	7.0	10.5

*BL = Baseline findings **MT = Mid-term findings

Some behavioural changes in use of sources of contraceptives have occurred, however. More clients obtained their contraceptives from the SCs than did before the intervention (Fig. 5). In the intervention union at Abhoynagar, clients increased their use of the H&FWC as well.

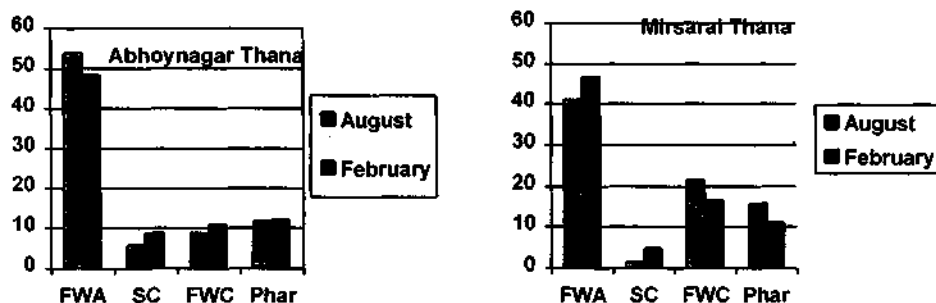


Fig. 5. Source of contraceptives in intervention unions, August 1996 and February 1997

One effect of the intervention that was unexpected was the increased use of the services of the FWA in the Mirsarai union. It is likely that this occurred because of the increased regularity of the FWAs in this union when pricing was introduced. That is, the FWA contact rate, the percentage of MWRA that were visited by FWAs during the last two months, increased from 10.8 percent before the intervention to approximately 25 percent after the intervention began. Since clients were more likely to be visited at their homes and asked to pay prices lower than those found in the pharmacy, they were more likely to obtain their supplies through the FWA.

The percentage of MWRA using a particular provider was also disaggregated by wealth group to determine whether pricing had differential effects on contraceptive-seeking behaviours by wealth groups. Appendix Table A-3 and A-4 show that the introduction of pricing did not affect the users' choice of providers of contraceptive differentially by wealth group in Abhoynagar, although there were differences in Mirsarai. In Abhoynagar, the use of the FWA declined for three of the four wealth groups, and the use of the satellite clinic and/or private sector increased. In Mirsarai, users of the lowest wealth group were less likely to use the service of FWA and more likely to use the satellite clinic. However, in the other wealth groups, the use of the FWA and satellite clinics increased, while the use of the H&FWC and private providers declined.

Health Care-seeking Patterns

Since user fees for curative health care and possibly EPI services will be introduced in the second phase of the intervention, health care seeking patterns were examined to determine the sources of care respondents have used during illness episodes, how much they have been paying and who makes the decisions to pursue treatment and which source will be used. The willingness of the respondents to pay for services at the SCs and H&FWCs was also examined.

Child Curative Care

The first type of health care-seeking patterns examined were those of curative care for children aged ten years or younger. Health care-seeking patterns were investigated for this age group, since they are one of the principal groups receiving curative care from the SCs and H&FWCs.

Private sector providers were the main source of child curative care used by the respondents (Table 7). Providers who were cited most often were village doctors who subscribe to allopathic medicine, followed by homeopaths. Public sources (SCs, H&FWCs, and THC) were used less frequently - about 10% of the time in Abhoynagar⁷ and 3% in Mirsarai. The public source that was most commonly used was the H&FWC.

The most common illnesses reported for children were fever, cough/cold, scabies, and diarrhoea.

Table 7. Number of Visits to Providers of Child Curative Care (% in parentheses)

Source of care	Abhoynagar thana		Mirsarai thana	
	Rajghat (n=325)	Siddipassa (n=297)	Dhum (n=291)	Mayani (n=336)
Self-care	74 (20.2)	96(30.4)	39(12.3)	70(20.4)
Pharmacy	6 (1.6)	0 (0.0)	39(12.3)	16 (4.7)
Shop	0 (0.0)	0 (0.0)	4 (1.3)	5 (1.5)
SC	10 (2.7)	4 (1.3)	1 (0.3)	1 (0.3)
H&FWC	22 (6.0)	18 (6.1)	8 (2.6)	6 (1.7)
THC	16 (4.4)	4 (1.3)	3 (0.9)	5 (1.5)
Private doctor	19 (5.2)	16 (5.1)	25 (8.0)	10 (2.9)
Village doctor	130 (35.5)	105 (33.2)	125 (40.1)	131 (38.2)
Kabiraj	20 (5.5)	17 (5.4)	17 (5.4)	14 (4.1)
Homeopath	64 (17.5)	52 (16.5)	51 (16.3)	82 (23.9)
Other	5 (1.4)	4 (1.3)	0 (0.0)	3 (0.9)
Total No. of visits	366 (100.0)	316 (100.0)	312 (100.0)	343 (100.00)

Note: In some cases, multiple providers were used.

⁷ In the intervention union in Abhoynagar, there are 24 rather than 8 SCs offered each month.

Table 8 indicates that while most clients did not pay registration fees for child health care, about 40 percent paid consultation fees, and most paid for drugs. The median total expenditure (Tk.35) was lower in Abhoynagar thana than that in Mirsarai thana (Tk. 57).

Table 8. Median total expenditure and percent of respondents paying for child curative care (Taka)

	Abhoynagar thana		Mirsarai thana	
	Rajghat (n = 172)	Siddipasa (n = 126)	Dhum (n = 191)	Mayani (n = 163)
Total median expenditure	36.5	35	55	60
Registration: 0	91.8	91.3	98.4	98.8
1-2	5.1	3.2	0.5	0.6
3+	3.2	5.6	1.0	0.6
Consultation: 0	58.6	66.7	55.5	52.1
5-10	28.4	23.8	5.8	10.4
15-20	8.6	6.3	22.0	30.1
20+	4.3	3.2	16.7	7.4
Drugs: 0	16.3	8.7	1.6	0.0
1-20	20.3	32.5	19.9	22.7
21-50	38.4	38.1	34.6	32.5
50+	25.0	20.6	44.0	44.7

When the decision-making process on child curative care was examined, decision-making patterns were found to differ between the thanas (Table 8). In Abhoynagar, the mother or both parents were most

likely to take the decision to seek health care for a sick child, whereas in Mirsarai thana, the mother took the decision herself most of the time.

Table 9: Principal decision-maker on child curative care at Abhoynagar and Mirsarai (%)

Method	Abhoynagar thana		Mirsarai thana	
	Rajghat	Siddipassa	Dhum	Mayani
<u>Child-care treatment</u>	(n = 208)	(n = 167)	(n = 363)	(n = 291)
Self	31.3	35.3	51.2	60.5
Husband	22.6	28.7	30.9	18.6
Both	33.2	28.7	9.9	14.1
In-laws	13.0	7.2	8.0	6.9
<u>Child-care source of Treatment</u>	(n = 205)	(n = 168)	(n = 359)	(n = 342)
Self	30.2	34.5	29.5	35.7
Husband	29.8	29.8	47.9	47.8
Both	26.8	25.6	7.5	5.8
In-laws	13.2	10.1	15.0	10.7
<u>Person accompanying the child</u>	(n = 177)	(n = 141)	(n = 200)	(n = 170)
Self	48.6	58.2	24.5	29.4
Husband	22.6	21.3	49.0	38.8
Both	16.4	7.8	2.5	3.5
In-laws	12.4	12.8	23.5	28.2

The second decision, where to take the child for health care, was equally decided upon by the mother or by the father in Abhoynagar thana, but more often by the father in Mirsarai thana. The person who accompanied the child was most often the mother in Abhoynagar and the father in Mirsarai.

Most respondents stated that they were willing to pay for child curative care at the SC or H&FWC. In Abhoynagar, 90.9 percent and 85.4 percent of the respondents in Rajghat and Siddipasa, respectively were

willing to pay for services, whereas in Mirsarai, 82.6 percent and 69.1 percent of the respondents in Dhum and Mayani respectively were willing to pay for services.

When the respondents were asked about the amount that they were willing to pay (Tk. 2, 4, or 6) for child curative care, most indicated that they were willing to pay Tk. 2 (Fig. 6), particularly in Abhoynagar thana. However, the percentage was lower in Mirsarai thana (75% and 85%). The percentage of the respondents willing to pay Tk. 4 was lower by 5 - 10 percent, and the percentage of the respondents willing to pay Tk. 6 was only slightly lower.

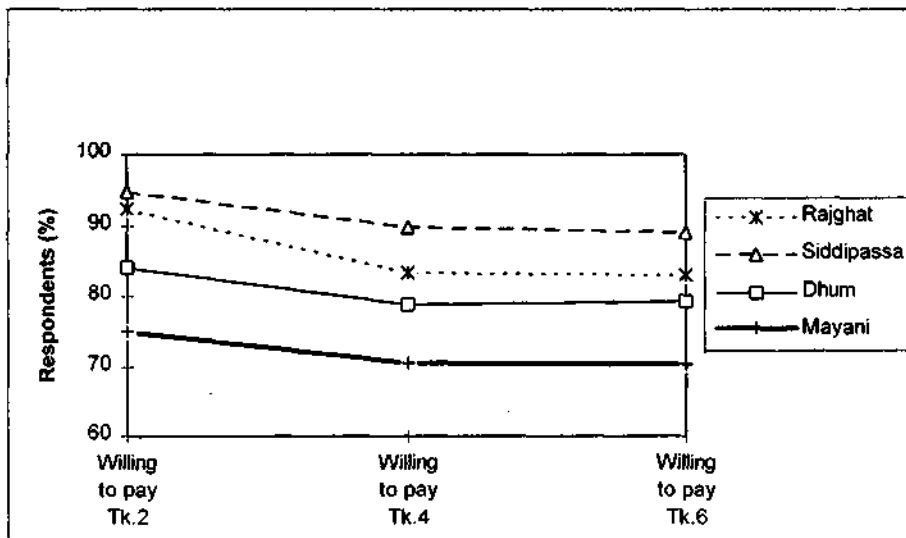


Fig 6. Willingness to pay for Child Curative Care at different prices at Abhoynagar and Mirsarai thanas

Women's Curative Care

The second type of curative care-seeking behaviour that was investigated was that of married women of reproductive ages. This service is the other most frequently provided service at the SC and H&FWC.

The respondents indicated that they were more likely to use the private sector over the public sector providers to obtain their curative care (Table 9), as in the case of children. The most frequently cited source was the village doctor, followed by the private doctor, homeopath (in Abhoynagar thana), and pharmacy (in Mirsarai thana). The symptoms cited most often for women using these sources were dizziness, cough, fever, stomach pain, aches, and weakness.

Table 10. Most recent source of health care for women (% in parentheses)

Source of health care	Rajghat (n = 433)	Siddipasa (n = 323)	Dhum (n = 337)	Mayani (n = 386)
Self-Care	151 (31.0)	127 (39.3)	80 (22.9)	127 (32.3)
Pharmacy/shop	17 (3.5)	3 (0.9)	66 (18.9)	29 (7.4)
SC	8 (1.6)	2 (0.6)	1 (0.3)	2 (0.5)
H&FWC	21 (4.3)	7 (2.1)	6 (1.7)	17 (4.3)
THC	23 (4.7)	4 (1.2)	3 (0.9)	8 (2.0)
Private Doctor	52 (10.7)	30 (8.8)	47 (13.4)	26 (6.6)
Village Doctor	124 (25.5)	109 (32.0)	124 (35.4)	147 (37.4)
Kabiraj	34 (7.0)	16 (4.7)	7 (2.0)	8 (2.0)
Homeopath	51 (10.5)	39 (11.4)	15 (4.3)	22 (5.6)
Other	6 (1.2)	4 (1.2)	1 (0.3)	7 (1.8)
Total	487 (100.0)	341 (100.0)	350 (100.0)	393 (100.0)

Note: Multiple sources are possible.

A small proportion of the clients used the public sector. About 7 percent and 5 percent of the respondents used the public sector (SC, H&FWC, and THC) in Abhoynagar and Mirsarai thanas respectively. The most common symptoms cited by clients using public sources differed slightly from clients using private sources and included chest pain, fever, stomach ache, and weakness.

Health care-seeking behaviours differed between the two thanas. In Abhoynagar, women were more likely to use the homeopath during an illness episode than in Mirsarai. In Mirsarai, women were more likely to

obtain drugs through a pharmacy than in Abhoynagar, perhaps because of the more limited mobility of the women⁸ in this area and/or the household's greater access to cash.

The median expenditure on health care for women was greater than that spent on children, with Tk. 52 and Tk.90 spent per visit in Abhoynagar and Mirsarai thanas respectively (Table 10). The expenditure was higher per visit in Mirsarai than that in Abhoynagar thana, perhaps because the households have greater disposable income there.

Table 11. Median total expenditure and percent of respondents paying for Women's curative care

	Abhoynagar thana		Mirsarai thana	
	Rajghat (n = 204)	Siddipasa (n = 148)	Dhum (n = 232)	Mayani (n = 213)
Median expenditure (taka)	50	54.5	80	100
Registration: 0	90.1	92.7	98.7	98.1
1-2	7.8	0.7	1.3	1.9
3+	2.1	6.7		
Consultation: 0	54.5	50.7	60.3	46.9
1-20	34.3	42.6	17.2	38.0
21-40	7.8	2.7	7.3	5.2
41+	3.4	4.1	15.1	9.9
Drugs: 0	15.8	5.4	0.4	1.4
1-20	22.5	26.4	25.4	20.7
21-50	20.1	23.0	14.2	15.5
50-100	17.2	21.6	19.0	18.3
100+	24.4	29.1	40.9	44.1

⁸ Women who have limited mobility are more likely to send their husband or in-laws to buy medicine at a pharmacy than visit a service provider when they are ill.

Patterns of decision-making were somewhat different for women's curative care than for children's curative care (Table 11). In Abhoynagar thana, either the wife or the husband made the decision for her to seek care when she is ill. In Mirsarai thana, however, the wife made the decision. In deciding where to seek care, the husband was more likely to make the choice in both areas and accompany the wife to seek care.

Most respondents were willing to pay for services at the SC or H&FWC, although the percentage was lower in Mirsarai than in Abhoynagar. At Abhoynagar, 89.3 percent and 84.9 percent of the respondents were willing to pay for services in Rajghat and Siddipassa, respectively, whereas at Mirsarai, 80.8 percent and 67.9 percent of the respondents were willing to pay for services.

Table 12. Principal decision-maker on women's curative care

	Abhoynagar thana		Mirsarai thana	
	Rajghat (n = 259)	Siddipassa (n = 192)	Dhum (n = 401)	Mayani (n = 342)
<u>Women's Health Care</u>				
Self	32.8	34.4	50.1	55.9
Husband	35.9	35.9	36.9	28.1
Both	18.5	19.8	28.1	7.3
In-laws	12.7	9.9	7.7	8.8
<u>Women's care source of treatment</u>	(n = 258)	(n = 191)	(n = 401)	(n = 339)
Self	29.0	31.4	30.9	36.3
Husband	38.0	41.4	51.1	44.5
Both	17.1	15.7	4.0	3.5
In-laws	15.9	11.5	14.0	15.6
<u>Person accompanying the wife</u>	(n = 219)	(n = 153)	(n = 242)	(n = 229)
None	21.5	28.1	9.9	18.3
Husband	44.3	40.5	54.5	43.7
In-laws	31.0	29.4	33.1	36.7
Other	1.2	2.0	2.5	0.3

Most respondents were willing to pay Tk. 2 for women's health care (Fig. 7). However, the percentage was lower at Mirsarai (80%) than that at Abhoynagar (93.3%). The percentage willing to pay Tk. 4 was lower by 5-10 percent. Little difference was found between the percentage willing to pay Tk. 4 and Tk. 6 for women's curative care.

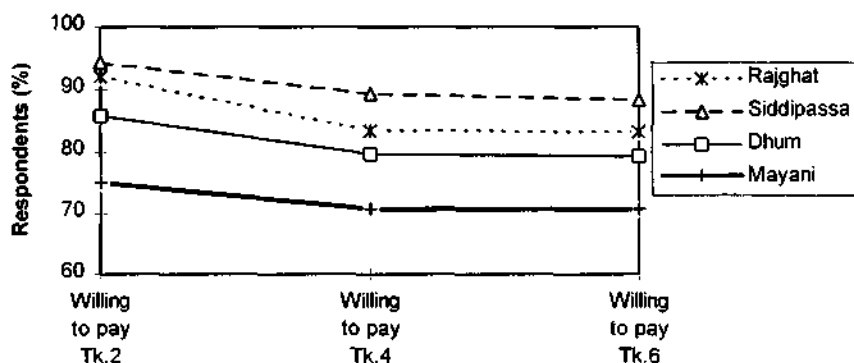


Figure 7. Willingness to pay for Women's Care at different prices at Abhoynagar and Mirsarai thanas

EPI Services

Decision-making on and willingness to pay for EPI services were also investigated. When decision-making patterns were examined on whether and where to immunize a child, the respondents cited that they themselves often made the decision (Table 12), but they did not always accompany the child. Instead, the in-laws/relatives often accompanied the child.

Table 13. Principal decision-maker on use of EPI services

	Rajghat	Siddipasa	Dhum	Mayani
<u>Immunizing child</u>	(n = 299)	(n = 242)	(n = 169)	(n = 108)
Self	66.2	63.2	90.5	88.0
Husband	7.0	7.0	3.0	4.6
Both	23.1	25.6	1.8	1.9
In-laws	3.7	4.1	4.7	5.6
<u>Place of immunizing child</u>	(n = 223)	(n = 169)	(n = 121)	(n = 67)
Self	64.6	71.6	86.0	76.1
Husband	7.6	7.1	5.8	10.5
Both	22.4	16.6	1.7	3.0
In-laws	5.4	4.7	6.6	10.5
<u>Person accompanying the child</u>	(n = 341)	(n = 281)	(n = 239)	(n = 263)
Self	61.9	65.1	30.5	30.8
Husband	6.2	2.1	3.8	5.7
Both	1.5	0.3	1.3	0.4
In-laws	30.5	32.4	64.4	63.1

A similar pattern was found for willingness to pay for EPI services as for the other services. MWRA were more willing to pay for EPI services in Abhoynagar thana than in Mirsarai thana - 93% and 88% for Rajghat and Siddipasa Unions in Abhoynagar, respectively and 85% and 71% in Dhum and Mayani in Mirsarai respectively. When MWRA were asked about paying for TT immunization, a similar percentage of women were willing to pay.

As in the case of curative care services, most respondents were willing to pay Tk. 2 for services, and 5-10 percent fewer were willing to pay Tk. 4 or Tk. 6 (Fig. 8).

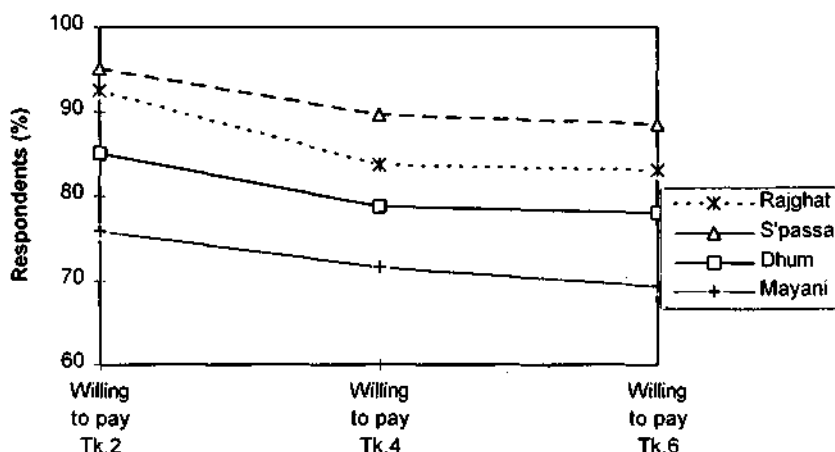


Fig. 8 Willingness to pay for EPI at different prices at Abhoynagar and Mirsarai thanas

Discussion, and Policy and Programmatic Implications

The findings of the mid-term evaluation indicate that the first phase of the "Charging for FP-MCH Commodities and Supplies" intervention is going well. Revenues are being collected regularly. Most users believed that the fees were reasonable, and the majority of users were paying the fees for contraceptives rather than deferring payment.

An important finding was the significant reduction in wastage occurring in the intervention unions, particularly for pills. Although the proportion of pill users increased and contraceptive prevalence did not change, approximately Tk. 300 and Tk. 1,720 were saved per month

through a reduction in distribution of oral pills in the intervention unions in Abhoynagar and Mirsarai respectively. These findings suggest that there is a tremendous potential for savings through reductions in wastage.

Another finding was that the record-keeping system has improved in the intervention unions, probably because the service providers need to be more conscientious to record accurately the distribution of supplies to clients. The gap between the CAR (GoB MIS) and the CPR has decreased significantly in the intervention unions.

One problem that was found is the users' inadequate knowledge of the contraceptive- pricing structure. Although the respondents could state the correct prices for methods distributed at the home, knowledge of prices at the SC and H&FWC (in Mirsarai) was poor. The implication of this latter finding is that additional IEC activities need to take place, so that users and their husbands can become better informed of contraceptive user fees.

The second part of the evaluation examined the effect of pricing on contraceptive-seeking behaviour. Contrary to initial fears, the contraceptive prevalence in the intervention unions did not decrease, rather it increased in Mirsarai thana. In addition, the contraceptive method-mix was not affected by the introduction of prices.

While no effect of pricing was found on contraceptive prevalence, the findings indicate some effect on provider choice. In both the intervention unions, the use of SCs to obtain family planning methods doubled. In addition, at the intervention union in Abhoynagar thana, the use of the H&FWC increased. These findings suggest that the choice of provider can be influenced by pricing signals.

An unexpected finding was observed at the intervention union in Mirsarai thana - the use of the services of the FWA increased, instead of decreasing, and the use of the H&FWC and pharmacy decreased. The likely explanation is that the contact of the FWA with the clients has increased due to increased regularity required to collect revenues.⁹ This effect will be monitored as the intervention continues to determine whether

⁹ A second explanation is that the FWA increased their regularity with increased monitoring.

it is a temporary artifact of the intervention or due to the introduction of pricing.

The results of the survey on curative care seeking patterns indicated that curative care for children aged ten years and below, and MWRA was obtained primarily through the private sector. However, the public sector (SC, H&FWC, and THC) was also used to a smaller extent.

The respondents indicated that they were currently paying between Tk. 30 and Tk. 50 per visit to a provider for children and between Tk.45 and Tk.110 per visit to a provider for themselves, mostly for drugs rather than consultation fees.

The majority of the respondents indicated that they were willing to pay as much as Tk. 6 to receive curative care for themselves or their children at the SCs and H&FWCs. The clients also indicated their considerable willingness to pay for EPI services.

The findings also indicated that even though the respondent was often the principal decision-maker in deciding to treat an illness, she often did not decide where to seek care, particularly for herself. In addition, she often did not accompany the child for curative care or to be immunized, rather the father or in-laws performed this function. The implication of the important role that the father/husband plays is that he will need to be targeted as well as the MWRA in introducing prices for curative care at the SCs and H&FWCs. This will be particularly true in designing IEC messages to inform clients of the introduction of new user fees.

Decision-making patterns and willingness to pay differed between Abhoynagar and Mirsarai thanas. In Abhoynagar, the wife, not the husband, was more often the principal decision-maker on whether and where to seek child curative care, but not for decisions on her own care. In Mirsarai, the wife was more likely to be the decision-maker on whether to seek care for the child or for herself, but her husband was more likely to decide where to seek care. In addition, the respondents were more willing to pay for curative care and EPI services in Abhoynagar (87% and 90%) than in Mirsarai (75% and 78%). The differences between the two thanas suggest that it would be useful to consider variations in designing phase two of the pricing intervention at each of the two areas.

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Appendix

Table A-1: A comparison of total distribution of injectables from different sources at Rajghat union in Abhoynagar thana with previous year

Month	Abhoynagar thana				Mirsarai thana*			
	Total cycles distributed per month year before pricing began	Total cycles distributed per month after pricing began	Difference in amount distributed before and after pricing (in cycles)	Monthly savings in taka	Total cycles distributed per month year before pricing began	Total cycles distributed per month after pricing began	Difference in amount distributed before and after pricing (in cycles)	Monthly savings in taka
August	345	309	36	1238	NA	NA	NA	
September	329	365	-36	-1238	126	112	14	482
October	372	414	-42	-1445	94	150	-56	-1926
November	395	377	18	619	82	94	-12	-413
December	332	341	-9	-310	108	110	-2	-69
January	443	385	58	1995	117	94	23	791
February	373	323	50	1720	52	90	-38	-1307
March	433	405	28	963	97	110	-13	-447
April	426	370	56	1926	NA	NA	NA	NA
Total	3448	3289	159	5470	676	760	-84	-2890
Average/ month	383	365	18	608	96	109	-13	-413

- The increased distribution of injectables in Mirsarai is likely to be due to the increasing share of injectables as a method, as well as the increasing contraceptive prevalence in this area.

Note: NA = Not available

Table A-2. Estimated savings from reduction in wastage after introducing contraceptive prices for pill throughout the country

Division	MWRA living in rural areas	No. of women using FP*	No. of Pill users	Savings if 10% wastage (US\$)	Savings if 20% wastage (US\$)	Savings if 30% wastage (US\$)	Savings if 40% wastage (US\$)	Savings if 50% wastage (US\$)
Barisal	1,506,947	744,432	314,895	62,110	124,220	186,331	248,441	310,550
Chittagong	3,979,782	1,480,479	626,243	123,520	247,042	370,563	494,084	617,600
Dhaka	5,725,362	2,851,231	1,206,071	237,887	475,774	713,661	951,548	1,189,435
Khulna	2,378,650	1,472,384	622,819	122,846	245,691	368,537	491,382	612,730
Rajshahi	5,179,722	3,035,317	1,283,939	253,246	506,492	759,738	1,012,984	1,266,230
Sylhet	1,417,550	284,928	120,524	23,772	47,545	71,317	95,090	1,118,860
Total	20,188,013	9,868,771	4,174,491	823,382	1,646,764	2,470,146	3,293,529	4,116,930

*Number based on % of women contracepting by division from the Bangladesh Demographic and Health Survey 1996-97.

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Table A-3. Source of contraceptives before and after contraceptive pricing begun by wealth group in Abhoynagar thana

Wealth group	% use FWA at baseline	% use of FWA after pricing begun	% use of SC at baseline	% use SC after pricing begun	% use of H&FWC at baseline	% use of H&FWC after pricing begun	% use of private sector at baseline	% use private sector after pricing begun
1	54.4	52.3	3.8	11.1	10.1	8.9	11.4	12.1
2	51.9	56.6	8.5	3.3	5.4	3.3	4.6	3.3
3	53.2	50.5	3.4	9.6	7.8	7.8	9.9	12.7
4	55.7	54.9	6.2	2.8	9.4	10.6	16.1	17.6

Table A-4. Source of contraceptive pricing before and after contraceptive pricing begun by wealth group in Mirsarai thana

Wealth group	% use FWA at baseline	% use of FWA after pricing begun	% use of SC at baseline	% use of SC after pricing begun	% use of H&FWC at baseline	% use of H&FWC after pricing begun	% use of private sector at baseline	% use of private sector after pricing begun
1	55.6	46.8	0	8.5	15.6	10.6	11.1	12.8
2	37.9	42.9	1.5	2.0	21.2	20.4	10.5	4.1
3	51.5	50.0	0	4.2	21.2	14.6	12.1	8.3
4	37.0	44.8	0	3.5	18.7	10.3	44.4	27.6