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# A Study of the Feasibility and Impact of Pricing Scheme for Condoms and Oral Pills

## Final Report

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# PREFACE

Bangladesh has a large family planning program with a target population of over 20 million eligible women. The government conducts the major part of the program, although non-governmental organizations (NGOs) and the Social Marketing Company (SMC) also play an important role.

The government and NGO programs are almost exclusively based on free distribution of contraceptives, which has been made possible because of donor assistance. To eventually become self-reliant and reduce some of the wastages associated with free distribution of contraceptives, the government had been considering the possibility of introducing pricing, and effective July 1990 started charging for condoms nationwide.

Another intervention, designed to charge for both oral pills and condoms, was implemented in one union of an upazila in the country, where charging for condoms began in July 1990 and that for oral pills in September 1990. An operations research study was undertaken to assess the effects of pricing on oral pills and condoms on contraceptive prevalence and use patterns. Results of this study can be used in deciding whether the pricing intervention, as implemented in the study area, should be continued in its present form, modified, or altogether discontinued. Several research activities were undertaken as part of this study, and this is the final report highlighting the key findings from all research activities undertaken.

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# EXECUTIVE SUMMARY

## 1 Background

Bangladesh has a relatively large family planning program with a target population of over 20 million eligible women. The government conducts the major part of the program, although non-governmental organizations (NGOs) and the Social Marketing Company (SMC) also play an important role. The SMC operates a subsidized retail sales network. Except for condoms which have recently become priced, both the government and NGO sectors are largely based on a free community-based distribution of contraceptives.

This system of free distribution is financially supported by donor agencies, and it can exist only so long as these agencies continue to supply contraceptives free of cost. Although donor agencies have been generous with their assistance, the cost of supplying contraceptives to Bangladesh will rise in the future because of the growing size of the number of couples in the reproductive age group and also because of the increasing proportion of these couples who use contraception to space or terminate births. To achieve greater self-reliance, the program must come to depend less on donor assistance by raising its own revenue.

One way to achieve this goal is to charge a modest fee for contraceptives. Experience in other countries have shown that the introduction of contraceptive pricing does not necessarily result in any major decline in the Contraceptive Prevalence Rate (CPR). Indeed, the CPR may even rise if clients believe that they obtain better product or service value by paying a price. Additionally, price introductions may lead to program savings by reducing supply wastage. It is appropriate, however, to determine whether this experience can be replicated in Bangladesh where rural households may have little disposable cash and where women may have little authority to make independent decisions about spending money.

## 2 Study Design and Objectives

URC/Bangladesh designed an operations research project to test the feasibility and impact of government Family Welfare Assistants (FWAs) charging a modest fee for pills and condoms in one union of the country. The government set the price and some of the details of fee collection and accountability. The primary purposes of this study were to: (1) investigate the viability of this fee and collection system and the constraints to its implementation, and (2) evaluate its impact on contraceptive use patterns. The study should help policy makers determine whether prices can be introduced and collected by fieldworkers using the present study design or whether this design should be modified or altogether scrapped.

## 3 Methodology

This study used the standard three phases of an OR study : problem analysis, solution development, and solution validation.

The Problem Analysis Phase identified factors needed to design a contraceptive pricing project -- (1) feasible prices for condoms and pills, and (2) support systems (accounting, record-keeping, supervision, staff training, etc.). A multidisciplinary team held discussions with representatives of various agencies, went on field trips to talk to relevant family planning experts and officials, and collected and reviewed literature on contraceptive pricing. Based on the information gathered in this phase, a 'working model' was developed in the Solution Development Phase, which was reviewed and finalized with the MOHFW and USAID/Dhaka. In the Solution Validation Phase, URC/Bangladesh and USAID/Dhaka examined the effects of contraceptive pricing on contraceptive use patterns, including continuation, switching, and supply source using data from the baseline and follow-up surveys, service statistics, and three rounds of in-depth interviews.

The study followed a quasi-experimental design. It was conducted in Monohardi Upazila in Narsingdi District. After detailed consideration of available information, Lebutala was selected as the experimental union and Ekduaria as the control union. The experimental and control areas were matched in terms of several areal characteristics.

## 4 Findings

The control and experimental unions were roughly similar to each other demographically and programmatically, but differed from the national average in having higher levels of female education, and fieldworker visitation coverage, and lower contraceptive use. Economically both areas were better off than the national average but were by no means affluent. Economic comparisons were difficult to make because of differences between the two areas, with the experimental union being a traditional agrarian economy with greater land ownership and the control union located in closer proximity to a main road and having higher non-agricultural employment. However, based on a scale of number of household consumer items, no significant differences in wealth emerged between the two unions.

Women in the control union were considerably more likely to have been employed than women in the intervention union. This greater involvement could indicate either greater economic distress (women traditionally in purdah being forced to work) or economic opportunities in the non-agricultural sector. Women in the control area also had greater authority to spend their own money, although the vast majority of women in both unions required prior approval from their husbands to spend their earnings

In both unions, over one-quarter of married women currently use a modern method and about a third currently use any method. The largest number of current users use the pill (about 10 percent of all married women) in both unions, and many nonusers and current users of other methods express their intention of adopting this method in the future. Compared with women in the intervention union, women in the control union are considerably more likely to use clinical methods than pills and condoms. This propensity for greater clinical method use may be influenced by the relatively close proximity of the control union to the Upazila Health Center and the relatively high use of control union women to use motorized transportation.

Three quarters of women in the intervention union and 85 percent of women in the control union claimed that they were willing to pay for pills or condoms. In both unions, three-fifths of those resistant to paying stated that they were not interested in using these methods rather than they were not able to afford the price. However, over three-fifths of the women reported that they did not always have disposable cash to buy pills or condoms during unannounced fieldworker home visits. Most women claimed that they could pay the fieldworkers when cash was readily on hand, implying a need for supply by credit.

The number of condoms distributed declined considerably in the intervention union after prices were introduced in July 1990. This decline was not as apparent in the control union where prices were introduced in July 1990 but withdrawn the following September. It may in part be explained by a government policy decision to give clients fewer condoms per visit which was independent of the price introductions.

The distribution of pills in the intervention union showed only a modest drop after price introduction. As soon as pricing was introduced, monthly pill distribution stopped increasing in this union and then after some fluctuations registered a slow, steady decline that only reversed itself during the last months of the study. This short term decline in the number of pill cycles distributed may have been unrelated to the pricing intervention, because there was also a decline in the other unions in the same upazila. Nevertheless, the experimental union which had average pill distribution before the pricing intervention had less than an average distribution after the pricing intervention.

The most plausible explanations for reductions in pill and condom distribution are: (1) payment of a price reduced contraceptive wastage, (2) fieldworkers faced with debt collection kept more accurate records, and (3) project managers exerted closer supervision and monitoring over field personnel during the study. In the case of condoms, changes in the government distribution policy also affected distribution.

The effect of pricing on pill and condom use appears to be quite different than its effect on distribution. In the intervention union, pill use increased by five percentage points and all modern method use by seven percentage points between the baseline and follow-up surveys, with condom use remaining almost unchanged. In the control union, however, there was little or no change in modern method use, including pills and condoms. According to a contraceptive history, much of the pill use increase in the experimental union occurred in the last two months of the study.

The most plausible explanations for increased pill use in the intervention area after pill introductions were: (1) fieldworkers visited clients more often to maintain their targets or to collect bad debts, and (2) project managers exerted closer supervision and monitoring over field personnel during the study.

The pill continuation rate was higher in both the experimental and control unions than the national rate, and it was higher in the intervention than control union.

Fieldworker home visitation improved among pill, condom, and other modern method users in the intervention union after pricing was introduced. Fieldworkers explained that this better coverage was necessary to improve sales and also to collect money owed to them for supplies given on credit. Visitation, however, also increased in the control union which had no fees, suggesting that the study itself may have motivated fieldworkers to visit regularly. According to in-depth interviews with the dropouts of pills and condoms, fieldworker home visitation worsened among them. During such visits, the fieldworkers were mainly interested in promoting their adoption of free clinical methods.

About one-third of condoms and one-half of pills were provided on credit. The proportion buying condoms on credit remained virtually unchanged after pricing was introduced, except in May 1991, the last month of the study, when condom sales increased considerably. A large part of this increase is accounted for by credit sales. The proportion buying pills on credit increased from September 1990 to February 1991. However, with a decline in the volume of sales in March and April, the proportion buying pills on credit also declined. The trend was reversed in May with a rise in the volume of sales. In general, the volume of sales is associated with the proportion of sales given on credit. This relationship suggests that fieldworkers with higher sales are willing to take higher risks than their compatriots. FWAs can thus push sales of condoms and pills, provided they can supply these methods on credit.

About one-fifth of condoms and about one-third of pills sold on credit accumulated into bad debts, and the fieldworkers ended up shouldering the costs of these debts. The amount foregone by the fieldworkers as a result constituted less than one percent of their annual salary. Because of their need to meet monthly government method-mix targets, the fieldworkers continued to supply their clients with credit, in full knowledge that a sizeable proportion of them would be unable to realize this credit.

Despite the high proportion of respondents in the baseline survey who reported a willingness to pay for pills and condoms, a lower proportion expressed this willingness for either themselves or their husband after actually being confronted with this payment. The findings from the three rounds of in-depth interviews showed that the majority of the women did not have cash at their disposal, and among those who had cash most could not spend it without prior consent from their husbands or in-laws. Even among those women with cash and the authority to spend it, most claimed that using it on contraceptives was a low priority because of other pressing household needs. Indeed, most of the dropouts interviewed in the in-depth interviews said that they dropped out because they could afford to pay for contraceptives.

In a country where paying for services is not normatively ingrained, clients accustomed to receiving free supplies may resist a government decision to introduce contraceptive prices. Nevertheless, at the end of the intervention year, at least some clients had come to feel that prices were justified to reduce wastage and that prices should be applied to those who could afford to pay them. However, the vast majority still felt that prices discriminated against the poor and those who used pills and condoms rather than the clinical methods.

The fieldworkers had a negative attitude toward the pricing intervention when it was first introduced. First, it made their everyday work more difficult; and second, some clients had the erroneous idea that the fieldworkers pocketed the sale proceeds. Over the course of the intervention period, however, some fieldworkers felt that they had overcome client suspicions by holding group meetings. They felt the need for more of such meetings and stressed that a national media campaign on the issue would be helpful in order to reassure clients that they did not pocket the proceeds. Many also felt that with the passage of time and effective IEC campaigns, many clients would switch from dependence on free contraception to greater self-reliance. These views were echoed quite strongly by the Deputy Director/Family Planning, Narsingdi District, and the Upazila Family Planning Officer/Monohardi, who felt that the lack of any national media campaign seriously affected fieldworker credibility.

Estimation of revenue generation by instituting a FWA-based pricing scheme indicated that each fieldworker, on average, collected roughly Tk.75 for condoms over a ten-month period and Tk.195 for pills over a nine-month period. Extrapolated nationwide, revenue generation for pill and condom sales would be roughly Tk.10.7 million, one-fifth of which would be bad debts borne by the fieldworkers. Further estimation indicated that revenue generation from pill and condom sales by fieldworkers would cover only less than 3 percent of their salaries, a negligible amount.

Estimation of condom wastage reduction based on the results of this study indicated that approximately Tk.14.5 million could potentially be saved as the result of a pricing intervention. It is important to note, however, that the decline in condom distribution in the intervention area was related not only to the pricing intervention but also in the change in government distribution policies. It is impossible to disentangle the relative contribution of these two effects.

## 5 Lessons Learned

There have been several important lessons learned from this study:

(i) Instituting a payment program for pills and condoms is difficult, given that few women have access to, or authority over, disposable cash. Even though many women state a willingness to pay, it is clear that this response is hypothetical and not in line with their capability of paying.

(ii) Because women lack disposable income and also because they often do not know the timing of fieldworker visits, they are forced to use credit to buy their pills and condoms.

(iii) A significant part of this credit will never be repaid, and the fieldworkers under the current system will be forced to shoulder the cost of this bad debt. Their willingness to bear this cost is directly related to their need to meet monthly contraceptive targets. Although this study indicated that this loss only represents a small fraction of their salaries, it is plausible that it would cause resentment and a possible loss of morale over the long term.

(iv) Those unable to pay may feel that fieldworkers visit them less and recommend unsuitable contraceptive methods.

(v) Payment for condoms and pills should discourage wastage, although given a policy directive to reduce condom distribution during the course of the study and better fieldworker record-keeping and supervision by project managers, it is difficult to isolate this effect because of a policy directive to reduce condom distribution and better record-keeping and supervision during the course of the study.

(vi) It is difficult to infer from this study the degree to which payment will discourage contraceptive use. Contrary to expectation, pill use rose in the intervention union after price introductions, and this rise may have been caused by greater program effort in this area.

(vii) The financial benefit to the program, both through direct revenue and wastage reduction, is modest. Given administrative, training, and IEC costs necessary to make this kind of cost recovery program successful, there appears to be few, if any, cost savings in institutionalizing it.

## 6 Conclusions and Recommendations

The results of this operations research study suggest that the fieldworkers should not implement a community-based pill and condom pricing at this time. Women generally do not have access to disposable income, and for this reason, many are unable to purchase contraceptives except by receiving credit. In cases where clients are unable to pay fieldworkers frequently give credit, and if the clients are unable to repay the credit, the fieldworkers take the loss out of the own pockets, something they are willing to do to meet their targets. Although this loss only represents a small fraction of their salaries, it is likely that this kind of system will over the long run lead to a loss of fieldworker morale and the underserving or misserving of clients unable or unwilling to pay.

This study was not able to establish in a definitive way the degree to which contraceptive use would increase or decrease after price introductions, but it is likely that from all plausible calculations cost savings from institutionalizing an FWA-based cost recovery program would be quite minimal.

Despite these findings, alternative strategies described below are recommend to the Government of Bangladesh to help recover costs. Any effort to recover costs should be accompanied by operations research supported by strong IEC activities.

(a) URC/Bangladesh developed a model for the Social Marketing Company (SMC) to sell contraceptives, ORSaline, and safe delivery kits by utilizing Community Sales Workers (CSWs) who receive a small honorarium plus commission on sales. An operations research study is being conducted by URC/Bangladesh to assess the effectiveness of the model. Should the model prove cost-effective, it could, then, be replicated by others.

(b) Fieldworkers could carry both free and priced contraceptives. The priced contraceptives would be cheaper than the upscale brands carried by the Social Marketing Company and appeal to women who could pay a modest fee for their contraceptives. This strategy could be complicated to introduce administratively and logistically, but may be feasible with proper preplanning.

(c) According to the 1989 Contraceptive Prevalence Survey, almost two-thirds of all condom users receive their supply through commercial sources. Because men are the primary customers of condoms, it is unclear the degree to which a female fieldworker distribution system is effective in promoting this method. In addition, condoms constitute only a small proportion of total contraceptive use and are unlikely to increase in popularity in the foreseeable future. It might thus be feasible for the Government of Bangladesh to eliminate condoms from its FWA-based distribution system, leaving them entirely in the hands of the private sector.

(d) Top priority accorded to the population sector should be reflected in increased budgettary allocations for the sector.

# SECTION 1
# BACKGROUND

## 1.1 Introduction

Bangladesh has a large family planning program with a target population of over 20 million eligible women. The government conducts the major part of the program, although non-governmental organizations (NGOs) and the Social Marketing Company (SMC) also play an important role. The SMC operates a subsidized retail sales network. Except for condoms which have recently been priced, both the government and NGO sectors are largely based on a free community-based distribution of contraceptives.

Because contraceptives are supplied free by the MOHFW and NGOs, some eligible couples may accept supplies from fieldworkers even though they do not actually practice family planning. They may do so to avoid admitting that they do not use contraception or because they find alternative uses for the commodity (e.g., condoms for balloons). This wastage could presumably be reduced by charging for community-based contraceptives.

Charging for pills and condoms, however, could have an adverse effect on the contraceptive prevalence rate (CPR) if couples who use them when distributed free stop using them and fail to switch to other methods after pricing is introduced. While no study has so far been conducted in Bangladesh empirically linking prices with method use, commercial sector sales of pills and condoms have steadily risen over time. Customers of these priced methods include not only the middle and upper classes, but also the poor and illiterate (Schellstede and Ciszewski, 1984). According to the 1989 Contraceptive Prevalence Survey, about 20 percent of pill users and two-thirds of condom users currently buy their contraceptives.

Evidence from other countries also indicates that contraceptive methods may not be overly sensitive to price. For example, based on data from the Philippines, Jamaica, and Thailand, Schwartz et al., (1986) found that prices for pills, IUDs, injections, and sterilizations were generally inelastic; they were, however, elastic for condoms in each of the three countries and for injectables in Jamaica. Lewis (1986), using data from several countries in Asia, Africa, and Latin America found that: (1) contraceptive demand is relatively inelastic and that in some instances where price was very low the demand curve for contraceptives was even backward-bending; (2) once parents perceive the marginal net cost of children as negative, savings from not bearing children far outweighs the costs of contraception; (3) free or too low priced contraceptives may discourage use because of psychological reasons; and (4) free services do not appear to be necessary.

Lewis also found, however,that contraceptive prices can be too high for low-income households, and that under these circumstances price reductions will have a positive impact on utilization. Also, evidence from Taiwan (Cernada, 1982), Korea (Chen and Worth, 1982), and Thailand (Knodel, et al., 1984) showed that a decline in prices or no fee for supplies and services can boost demand.

A recent Thai study on the impact of pricing on contraceptive method choice found that contraceptive price increases have generally had a minimal effect on utilization (Teera Ashakul, 1990). It concluded that:

i. an increase in the public-sector pill price resulted in a reduction of only 2.2 percent of total public-sector oral pill use; about 90 percent of women who discontinued pills switched to other contraceptive methods; and

ii. an increase in the public-sector injectable price resulted in a reduction of 8.4 percent of the total public-sector injectable use; about two-thirds of women who discontinued injectables switched to other contraceptive methods.

A recent study from Indonesia (Molyneaux and Diman, 1991) found that response to price increases varied by educational group. Whereas women with high education tended to shift to IUDs when confronted with higher pill prices, women with low education tended to stop use. When the average public-sector pill price approached that of the private-sector, contraceptive use among women with high education increased by 2.2 percentage points (because of method switching). By contrast, contraceptive use among women with low education plummeted 18 percentage points under the same conditions.

The above evidence, thus, suggests that the introduction of contraceptive pricing may not result in any major decline in the CPR. A moderate charge may even boost contraceptive demand if consumers perceive that a product's value is reflected in its price (Lewis, 1986; Chowdhury, 1988). However, Bangladesh is substantially poorer than the countries cited above and its women tend to operate outside a market economy. The Indonesian example is instructive in showing that price response may function differently for the poor than for the middle-class and rich.

## 1.2 The Intervention

The Bangladesh National Family Planning Program is largely funded through donor assistance which enables the MOHFW and NGOs to provide free commodities and services to eligible couples. Given the growth of the reproductive age group population, it will become increasingly onerous for donor agencies and the government to continue this free provision for the indefinite future. To eventually become self-reliant, the National Family Planning Program will need to reduce its dependence on donor assistance by raising revenue from within the country to help meet costs. This can be achieved by diverting resources from other sectors of the economy, improving program efficiency, and by charging for contraceptives (Khuda and Alam, 1990; Khuda and Barkat, 1991). This operations research project assesses the feasibility and impact of charging for contraceptives.

This study was conducted by the University Research Corporation (URC)/Bangladesh and funded by USAID. It occurred between May 1990 and May 1991. The intervention involved government Family Welfare Assistants (FWAs) charging for pills and condoms in Lebutala Union of Monohardi Upazila in Narsingdi District, with Ekduaria Union in the same upazila serving as a control area. During most of the study period, the MOHFW introduced a 50

paisa charge for condoms nationwide. Because this charge would have influenced findings in the control union, URC negotiated with the MOHFW not to introduce it in the control union for the duration of the study.

The essential elements of the intervention were:

(i) FWAs charged only for pills and condoms -- methods already incorporated into the government's community-based distribution program. FWAs continued to refer clients to clinics for IUDs, injectables and sterilization which remained free of charge.

(ii) Pills and condoms were no longer free in the intervention union. Instead, clients were asked to pay the government-recommended price of 50 paisha per dozen condoms and 50 paisha per pill packet. Distribution of both pills and condoms continued to be free in the control union. URC reimbursed the MOHFW for condoms distributed free in the control union after the government initiated nationwide condom charging.

(iii) Prices were adjusted during the study. On the basis of its initial findings, URC requested the MOHFW to reduce the price of condoms from Tk.1.0 per dozen to Tk.0.50 per dozen in November 1990.

(iv) IEC about the pricing intervention was conducted in the intervention union by organizing folk song sessions, group meetings with clients, prospective clients and local community leaders and through interpersonal communication.

(v) A financial accounting system was developed as follows:

- The FWAs reimbursed sale proceeds every month to the Upazila Family Planning Officer (UFPO) at the time of receiving their salaries, and the UFPO gave them a receipt. The proceeds were then checked against sales during the preceding month. The FWAs received fresh supplies of the contraceptives, depending on their unsold stocks plus expected needs for the month.

- The UFPO was responsible for the sale proceeds which were deposited in a bank account.

- URC/Bangladesh developed a simple financial accounting procedure and oriented the UFPO how to use it. Accounts of sale proceeds were maintained by the UFPO, who was assisted by the URC Project Officer.

- By the first week of every month, the UFPO prepared a financial statement showing the sale proceeds received from the FWAs, and the CPR by method. He sent a copy of this statement to the Joint Secretary/MOHFW, Director General, Family Planning (DG/FP), Deputy Director, Family Planning (DD/FP) Narsingdi, and URC/Bangladesh.

(vi) Sale proceeds of pills and condoms were authorized as follows:

- The sale proceeds were to be used to meet essential MOHFP expenses in the intervention union.

- Allowable expenses were specified by the MOHFW circular of August 27, 1990 as dry cell batteries for flashlights, kerosene for sterilization of surgical equipment, paracetamol, Dettol/Savlon, bags/umbrellas for FWAs, transportation of sterilized instruments and other materials to satellite clinics, and repairs and maintenance of tubewells. Purchase of other items required prior written permission of the Joint Secretary, Ministry of Health and Family Welfare.

- The UFPO was to authorize all expenses and maintain financial records and receipts of them. However, none of the sale proceeds were utilized during the intervention period.

(vii) URC/Bangladesh gave on-the-job training to all field personnel in the intervention union to explain the purpose of the intervention and how it was to be implemented. It also organized field trips for the DD/FP, UFPO, and fieldworkers from the intervention union to a nearby FPAB project site which charged for pills and condoms. These field trips enabled them to understand the accounting procedures, IEC, and utilization of sale proceeds in the FPAB areas.

(viii) FWA Registers were the primary source of record-keeping. The URC Project Officer also monitored these registers in neighboring unions to see if free pill supplies from the outside entered the intervention union. URC/Bangladesh developed a simple management information system to monitor pill and condom sales, the CPR, contraceptive method and switching patterns, continuation rates, sources of supplies, and uses of sale proceeds.

(ix) URC placed a full-time Project Officer in the intervention area to work as a counterpart to the local family planning personnel. He assisted the UFPO in implementing the intervention. He was responsible for the following activities:

(a) meeting with the UFPO regularly to review work progress and fieldworker problems;

(b) assisting the UFPO in preparing monthly performance reports, the FWVs with their financial reports, and the fieldworkers with their monthly field reports;

(c) holding group meetings with the FWAs, FWVs, and FPAs on a biweekly basis to review their progress and provide on-the-job training;

(d) accompanying fieldworkers to FPAB project sites in Ghorasal to familiarize them with pricing and apprising them of the problems faced by the Ghorasal fieldworkers in implementing their pricing intervention;

(e) accompanying the FWAs on their home visits to help them with client problems regarding the pricing intervention; and

(f) undertaking IEC activities (folk songs, group meetings in mosques, schools, youth clubs, and bazaars) to promote the pricing intervention.

## 1.3 Objectives

The objectives of this operations research project included:

1. developing and testing a viable pricing scheme for condoms and pills in one union in rural Bangladesh;

2. assessing its effects on contraceptive use patterns, including method continuation, switching, and source;

3. identifying management, training, and motivation needs of family planning workers and supervisors; and

4. determining fieldworker and client attitudes toward the pricing intervention.

## 1.4 Policy Implications

Results of this study will be used by the MOHFW to assess the viability of its nation-wide condom pricing scheme. They will address key issues of interest to the government about whether contraceptive pricing is feasible; and if so, the level at which it will be set and the equity of the scheme. The same issues apply to pill pricing. Finally, it can be used to develop alternate cost-recovery schemes, should price introductions by government female fieldworkers prove not feasible.

# SECTION 2
# METHODOLOGY

This study used the standard three-phase OR approach: problem analysis, solution development, and solution validation.

## 2.1 Problem Analysis

URC/Bangladesh selected a multidisciplinary team, comprising an anthropologist, a women-in-development specialist, a family planning program specialist, a marketing expert, and an accountant. This team conducted a literature review on: (1) the relationship between prices and contraceptive outcomes, and (2) procedures (accounting, record-keeping, staff training, supervision, and monitoring) needed to develop a successful pricing intervention. URC/Bangladesh and USAID/Dhaka held discussions with representatives of the Ministry of Health and Family Welfare, the International Center for Diarrhoeal Disease Research, the Social Marketing Company, and two NGOs which charged for pills and condoms -- the Family Planning Association of Bangladesh and the Pathfinder International -- to discuss the study design and management and to select the study site. The multidisciplinary team went on field trips to interview government officials, community leaders, and family planning clients and prospective clients about the same issues.

## 2.2 Phase 2: Solution Development

The multidisciplinary team analyzed the information collected in Phase I, developed a "working model," and then reviewed and finalized this model with the MOHFW and USAID/Dhaka.

## 2.3 Phase 3: Solution Validation

URC/Bangladesh and USAID/Dhaka assessed the effects of contraceptive pricing on contraceptive use patterns, including contraceptive continuation and switching and supply source. The assessment included the following activities:

a) a baseline survey;
b) project monitoring;
c) in-depth qualitative investigations; and
d) a follow-up survey.

The design is shown below, where O=observation and X=intervention:

| Intervention/ Control Area | Baseline Survey | Inter-vention | Monitor-ing (monthly) | In-depth, qualitative interviews | Follow-up Survey |
|---|---|---|---|---|---|
| Intervention Area | $O_1$ | $X_1$ | $O_2$ | $O_3$ | $O_4$ |
| Control Area | $O_1$ | | $O_2$ | $O_3$ | $O_4$ |

A baseline survey was conducted in June 1990. A monitoring system was designed in July 1990 to monitor project activities, including sales, acceptors, dropouts and method-switching; in-depth, qualitative interviews were conducted with selected current users and dropouts of pills and condoms, family planning providers at various levels in the system, and selected husbands and community leaders during November 1990-April 1991 to understand their perceptions about the intervention, problems encountered in implementation of the intervention, and their suggested solutions; and finally, a follow-up survey was undertaken in May 1991.

The following chart summarizes the principal study variables and their data sources:

| | Principal Variables | Data Sources |
|---|---|---|
| 1. | Willingness and ability to pay for condoms and pills; what clients were already paying for these methods at the time of the baseline survey; and what they paid at the time of the follow-up survey | $S_1$, I, $S_2$ |
| 2. | Contraceptive prevalence | $S_1$, M, $S_2$ |
| 3. | Contraceptive method and switching patterns | $S_1$, M, $S_2$ |
| 4. | Supply source | $S_1$, M, $S_2$ |
| 5. | Contraceptive continuation | $S_1$, M, $S_2$ |
| 6. | Sociodemographic and economic characteristics of MWRAs | $S_1$, $S_2$ |
| 7. | Perceptions about the intervention; problems encountered in its implementation, and suggested solutions | I |

**Key:** $S_1$ = Baseline Survey
M = Monthly Monitoring
I = In-depth, Qualitative Interviews
$S_2$ = Follow-up Survey

### 2.3.1 Selection of the Study Area

The project was designed to test the contraceptive pricing model in one union of an upazila which should have been relatively conservative, and relatively poor. It should also should have had a CPR between 20 and 30 percent, a good FWA Register system, and a receptive upazila staff. The reason for selecting an upazila with the first three criteria was that if the intervention could work in such an area it might very well work in more favorable settings. The fourth criterion would ensure reliable data quality, and the last criterion would ensure the cooperation of upazila leaders and staff.

In selecting the study site, the multidisciplinary team led by URC held discussions with ICDDR,B MCH-FP Extension Project representatives. The Extension Project had trained fieldworkers in record-keeping procedures in several upazilas in the country, including Monohardi Upazila in Narsingdi District. Given that the Extension Project had properly trained the fieldworkers, implemented a good FWA registry system, and gathered reliable data, Monohardi Upazila was selected for the study.

One union was selected as the intervention and another as the control union from Monohardi Upazila. The following items were considered in selecting these intervention and control unions:

a) number of eligible couples;
b) field and clinic staff vacancies;
c) experience and skills of the fieldworkers;
d) availability of Family Welfare Centers (FWCs);
e) transportation;
f) presence of NGO activities;
g) the sociocultural environment;
h) economic conditions; and
i) the contraceptive prevalence rate.

Table 2.1 shows data on Monohardi Upazila by union collected from secondary sources at the upazila level and also from discussions with the UNO and the UFPO and his colleagues. After detailed consideration of the available information, Lebutala was selected as the intervention union and Ekduaria as the control union.

TABLE 2.1 : SELECTED DATA ON MONOHARDI UPAZILA BY UNION

| Sl. No. | Union | Couple | FPA | FWA | Quality of FW | FWV | FWC | Transport-ation [1] | NGO | Religion [2] | Economy [3] | CPR [4] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01 | LEBUTALA | 3101 | 1 | 6 | C | 1 | FWC | N | | C | B | 25.3 |
| 02 | Chalakchar | 2868 | 1 | 5 | B | 1 | U.C | N | NGO | A | A | 27.7 |
| 03 | Chandanbari | 2995 | 1 | 6 | A | 2 | HQC | N | NGO | A | A | 29.0 |
| 04 | Khidirpur | 4105 | 1 | 6 | B | 1 | FWC | N | NGO | A | C | 45.6 |
| 05 | Charmandalia | 3655 | 1 | 6 | B | --- | U.C | W | NGO | A | C | 27.3 |
| 06 | Barachapa | 3793 | 1 | 6 | B | 1 | FWC | N | NGO | A | B | 52.3 |
| 07 | Kachikata | 3497 | 1 | 6 | A | 1 | FWC | N | NGO | C | B | 33.6 |
| 08 | Shukundi | 3527 | 1 | 6 | A | 1 | FWC | N | | A | A | 29.1 |
| 09 | EKDUARIA | 3485 | 1 | 6 | C | 1 | FWC | N | | A | B | 23.1 |
| 10 | Daulatpur | 2960 | 1 | 6 | A | 1 | U.C | W | | A | A | 41.2 |
| 11 | Gotashia | 3616 | 1 | 6 | A | 1 | FWC | W | | A | B | 36.2 |
| TOTAL | | 37602 | 11 | 65 | --- | 11 | --- | --- | --- | --- | --- | 34.1 |

1 N = Motorable in all seasons; W = Motorable in winter season
2 A = Average socio-religious condition; C = Conservative
3 A = High; B = Medium; C = Low
4 = As of February, 1990

### 2.3.2 Baseline Survey

The Associates for Community and Population Research (ACPR), on a subcontract from URC/Bangladesh, collected data in a baseline survey of both the intervention and control unions. This survey focused on: (1) sociodemographic and economic characteristics of married women of reproductive age, (2) contraceptive use patterns, (3) sources of supplies, and (4) willingness and ability of clients to pay for condoms and pills. Key findings of this baseline survey would later be compared to those of a follow-up survey.

URC/Bangladesh developed a sample design in which a 25 percent sample of MWRAs was drawn from both the intervention and control unions. The FWA register was used as the sampling frame. Separate listing of households was not considered necessary for preparation of the sampling frame on the assumption that there was reasonably accurate couple registration by Extension Project-trained fieldworkers in Monohardi Upazila.

Sample selection was done on the basis of probability proportionate to the number of MWRAs in each FWA coverage area. All the MWRAs within these unions were thus equally likely to be selected for inclusion in the sample. Table 2.2 shows that the sample comprised 1745 MWRAs -- 804 from the intervention union and 941 from the control union.

If a selected MWRA was not available for interview after three attempts, a substitute sample was randomly chosen from the same FWA coverage area. These substitutes constituted 2.9 percent of the total sample. The rationale for this substitution was to ensure the required number of successful interviews.

Data were collected during June 8-30, 1990, using a structured questionnaire developed by URC/Bangladesh (Appendix 1) . One interviewing team was deployed in each of the two unions. Each team consisted of one Team Leader, one Female Supervisor, and five Female Interviewers. Two Research Associates from ACPR monitored the teams. In addition, URC staff and USAID monitors undertook several field trips to monitor data quality. Finally, a URC field-based Project Officer provided guidance to the interviewing teams.

TABLE 2.2 : Sample Selection of the MWRAs in the Intervention and Control Unions in the Baseline Survey

| Unit No. of FWA | INTERVENTION (Lebutala) | | | CONTROL (Ekduaria) | | |
|---|---|---|---|---|---|---|
| | No. of MWRAs | No. of MWRAs selected | Percentage | No. of MWRAs | No. of MWRAs selected | Percentage |
| 1 (a) | 617 | 154 | 25.0 | 667 | 165 | 24.7 |
| 1 (b) | 500 | 125 | 25.0 | 514 | 129 | 25.1 |
| 2 (a) | 454 | 113 | 24.9 | 643 | 161 | 25.0 |
| 2 (b) | 722 | 180 | 24.9 | 673 | 169 | 25.1 |
| 3 (a) | 547 | 138 | 25.2 | 573 | 144 | 25.1 |
| 3 (b) | 376 | 94 | 25.0 | 691 | 173 | 25.0 |
| Total | 3216 | 804 | 25.0 | 3761 | 941 | 25.0 |

### 2.3.3 In-depth Investigations

URC/Bangladesh conducted three qualitative research rounds, the first in November-December 1990, the second in February 1991, and the third in April 1991 to gauge fieldworker and client response to the pricing intervention. In-depth interviews were held with current users and dropouts of pills and condoms, husbands, and community leaders in the intervention and control unions. Focus group discussions and in-depth interviews were held with the fieldworkers, and in-depth interviews with upazila and district family planning officials.

### 2.3.4 Follow-up Survey

ACPR conducted a follow-up survey in May 1991, eleven months after the baseline survey, using a structured questionnaire (Appendix 2). All of the respondents from the baseline survey were approached for reinterview, and interviews were completed with almost 95 percent of the original respondents. As can be seen from Table 2.3, less than 4 percent of the original respondents were not available, and less than 1 percent were either widowed or divorced in the previous year. One percent in the intervention union and 2 percent in the control union had moved out of the area.

TABLE 2.3 : Reasons for nonresponse among eligible respondents for the Follow-up Survey

| Outcome | Lebutala | | Ekduaria | |
|---|---|---|---|---|
| | % | N | % | N |
| Interview completed | 94.5 | 760 | 93.1 | 876 |
| Respondent not available | 3.5 | 28 | 3.3 | 31 |
| Respondent refused | - | - | 0.1 | 1 |
| Respondent died | 0.2 | 2 | 0.2 | 2 |
| Respondent moved | 1.0 | 8 | 2.0 | 19 |
| Respondent no longer married | 0.7 | 8 | 1.3 | 12 |
| TOTAL | 100.0 | 804 | 100.0 | 941 |

The Follow-up Survey asked all respondents about their contraceptive use in the previous year using a contraceptive calendar.[1] Initially, through a series of questions on childbearing and pregnancies, interviewers determined if the respondents had been pregnant at any time during the past year. Interviewers inquired about all pregnancies: current pregnancies, pregnancies which resulted in a live birth, and pregnancies which ended in other outcomes.

During the interview, women were reminded of the current contraceptive use status and method reported the year before and asked if this information was

1 *For more information about this approach, see Goldman, et al., 1989.*

correct: 97 percent of respondents from both unions agreed with their previous statements. Respondents were then asked if they were currently practicing contraception and, if so, using what method. Using the pregnancy history and contraceptive use status at the beginning and end of the contraceptive calendar, interviewers then probed for the timing of contraceptive use and marked on the contraceptive calendar when methods were started or abandoned, thus determining duration of use.

Pill and condom users were then asked to recall the months in which they received supplies; their source of supply; whether there was a charge, and if so, how much; and whether they paid in cash or received supplies on credit. Also, pill and condom users who terminated use during the year were asked their reasons for dropping out, with special emphasis on whether price was a factor for this termination.

As a result of an unexpected rise in pill use in the intervention union reported in the follow-up survey, URC/Bangladesh and USAID conducted a small post-enumeration quality check. A team of two female interviewers with extensive in-depth interviewing experience was sent to the intervention union one month after the initial follow-up survey was completed to reinterview selected current users of pills who did not report using the method at the time of the baseline survey but who reported using the method at the time of the follow-up survey. Out of 63 such women, 18 were reinterviewed, 3 from each of the six FWA units. The interviews were conducted using semi-structured checklists. Such reinterviews were not conducted after the follow-up survey in the control union nor in either of the unions after the baseline survey because of time and cost constraints.

### 2.3.5 Review of Service Statistics

URC/Bangladesh reviewed May 1989 through May 1991 pill and condom distribution service statistics for the intervention and control unions from the FWA Registers and the Monohardi Upazila Family Planning Office. These two-year service statistics cover the period of one year before and one year during the price intervention. Also, service statistics from the FWA Registers were compiled for the follow-up survey respondents and matched with corresponding follow-up survey data.

### 2.3.6 Other Experiences with Charging

URC/Bangladesh held focus group discussions and conducted in-depth interviews with fieldworkers and clients (both current users and drop-outs) in selected NGO sites to determine their reactions to price interventions. There was also a review of service statistics and other relevant documents in those areas.

# SECTION 3
# THE AREA SETTING

Family planning practice is influenced by demographic, social, economic, and programmatic variables. This section presents a brief description of the study area to enable comparison between the intervention and control unions. A comparison between these unions and the average for rural Bangladesh is made for selected social, economic, and demographic variables.

Table 3.1 is a summary table which gives both respondent and family planning program variables. The table shows that the control and intervention unions are similar to each other with respect to mean ages of the respondents, their husbands, and their youngest children, their mean number of living children, and the percentage of women currently pregnant. Although lower than the national level, the percentage with no schooling is higher among the respondents in the control than intervention area, with no difference between their husbands.[2]

Economic comparisons are difficult because of differences between the two areas, with the intervention union having a traditional agrarian economy with greater land ownership and the control union being located in greater proximity to a main road and having higher non-agricultural employment. Income is higher in the intervention than control union, although income is generally difficult to measure accurately in economies only partially monetized. Based on a scale of number of consumer items, no significant differences in wealth emerge between the intervention and control unions. The number of consumer items owned in both unions, however, is higher than the national average.

Almost a third more women have ever been economically active in the control than intervention union, which may indicate either economic distress (women traditionally in purdah being forced to work) or economic opportunities in the non-agricultural sector. Fewer women in the control union need the approval of their husbands to spend their earnings than in the intervention union, but this may simply reflect the fact that more women in the control union have earnings.

2 *More detailed description of the study areas is contained in Khuda, Larson, Hadi, and Barkat, 1990.*

TABLE 3.1 : Summary Table on Background Characteristics of the Respondents and key FP Program Variables

| CHARACTERISTICS | INTERVENTION | CONTROL | CPS Rural |
|---|---|---|---|
| 1. Background Characteristics | | | |
| Mean age | 27.4 | 27.3 | 27.0 [1] |
| Mean number of living children | 2.7 | 2.5 | 3.0 |
| Mean age of husband * | 36.7 | 38.3 | 39.0 |
| Mean age of youngest child (in mths) | 35.9 | 37.8 | |
| Percentage currently pregnant | 12.2 | 10.5 | 10.6 [3] |
| Percent with no schooling | | | |
| Respondents * | 45.3 | 52.3 | 66.8 |
| Husbands | 43.3 | 44.6 | 46.8 [2] |
| Percentage owning land * | 76.0 | 71.3 | 53.6 |
| Mean amount of land owned (in acres) among landowning households * | 1.79 | 1.34 | NA |
| Percent of respondents' husbands primarily engaged in agriculture | 48.1 | 39.0 | 44.2 |
| Mean family income | 29,001 | 25,833 | |
| Mean number of items owned | 3.5 | 3.6 | 2.1 |
| Percent of respondents ever economically active * | 53.0 | 69.1 | |
| Percent of respondents economically active during previous year * | 39.5 | 54.0 | |
| Percent of respondents requiring prior approval of husbands to spend their earnings * | 81.8 | 71.5 | |
| 2. FP Program Variables | | | |
| Date when FWC was set up | Apr 24, 1987 | Sep 23, 1985 | |
| Mode of transportation to Upazila Hospital | Rickshaw/walk | Bus/rickshaw | |
| Presence of FP NGO | No | No | |
| No. of pharmacy/shops selling contraceptives | Pharmacy : 13<br>Other (pan-shops, groceries) : 17 | Pharmacy : 13<br>Other )pan-shops, groceries) : 18 | |
| No. of eligible couples | 3,101 | 3,485 | |
| No. of FWAs in place | 6 | 6 | |
| Distance to Upazila hospital | 9 km. | 7 km. | |

* Significantly different at P <0.05.
1 Median age among ever-married women under 50 years of age.
2 Total, i.e., both rural and urban areas.
3 1985 CPS Rural.

Sources: *Baseline Survey Report; 1985 and 1989 CPS Reports.*

The distance to the Upazila Hospital is two kilometers closer in the control union than in the intervention union, and the usual mode of transportation to the Upazila hospital is by bus and rickshaw rather than by rickshaw and walking. The data appear to indicate that clinical methods may be more accessible for eligible couples in the control than intervention union.

The CPR is lower in the study unions than the rural average. This difference is largely attributable to low reported traditional method use in the study unions and is probably caused by underreporting of these methods in the fieldworker registration books. Pill and condom use is higher in the intervention than control union or the rural Bangladesh average. By contrast, clinical method use is higher in the control than intervention union (Table 3.2).

TABLE 3.2 : Contraceptive Prevalence Rates by Methods in the Intervention and Control Unions, February, 1990.

| Methods | INTERVENTION | CONTROL | 1989 CPS RURAL |
|---|---|---|---|
| Oral Pill | 10.0 | 7.5 | 7.9 |
| Condom | 4.1 | 1.7 | 2.4 |
| PILL and CONDOM | 14.1 | 9.2 | 10.3 |
| Injection | 0.7 | 1.3 | 1.0 |
| IUD | 2.2 | 3.3 | 1.5 |
| Tubectomy | 6.8 | 8.0 | 9.0 |
| Vasectomy | 0.1 | 0.3 | 1.6 |
| MODERN METHODS | 23.9 | 22.1 | 23.5 |
| TRADITIONAL METHODS | 1.4 | 0.7 | 6.8 |
| ALL | 25.3 | 22.9 | 30.3 |

Source: *Upazila Family Planning Service Statistics (based on Field Worker registration books).*

The intervention and control unions, while similar in some respects, are different enough in other respects to render them not strictly comparable. This drawback, however, is frequently encountered in quasi-experimental designs. It is doubtful that socioeconomic rather than programmatic changes in the unions caused changes in distribution and use patterns during the course of the study, because URC/Bangladesh had a constant field presence

during that time and observed no major changes. No socioeconomic data, however, were collected in the follow-up survey.

It is important to note that the intervention union appears to be more prosperous than typical unions in Bangladesh. If the pricing intervention turns out not to be feasible in this union because of payment problems, chances are it would not be feasible in other unions for similar reasons.

condoms distributed per month was not much lower than the level prevailing at the end of 1989 and the beginning of 1990. By contrast, monthly distribution in the other unions stabilized and then rose slightly from a level which was only one-third of that before condom prices were introduced.

The same situation can be observed between the two study unions. Condom distribution declined in Lebutala after price introductions, just as they had in the rest of the upazila (Figure 4.2). Although fieldworkers in Lebutala distributed many more condoms than in Ekduaria before the intervention, they distributed about the same amount for a few months after the intervention. Subsequently, distribution declined in Ekduaria relative to Lebutala, possibly reflecting a new government policy on the recommended number of condoms to be distributed per fieldworker home visit.

Condom distribution levels and trends are conspicuously different in Ekdauria than in the other unions in Monohardi Upazila. Ekdauria has lower condom distribution than those other unions despite prices essentially not being introduced in it. As discussed in Section 2, Ekdauria is located close to a main road and, compared with Lebutala, is closer to the Upazila Family Welfare Center and has higher use of clinical methods. Anomolous condom distribution rates may reflect this greater access to clinics and use of clinical methods. Women in Ekdauria may also waste fewer condoms than women in other unions, although this was not directly observed in this study. At any rate, it is important to note that union method-mix patterns may differ considerably, and that the impact of pricing will be higher on unions with high levels of pill and condom use compared with those which do not. This differential use has obvious equity implications.

Condom distribution nationwide declined moderately after the government price introduction (data not shown).

**Figure 4.1**
**Condoms distributed in Monohardi Upazila**

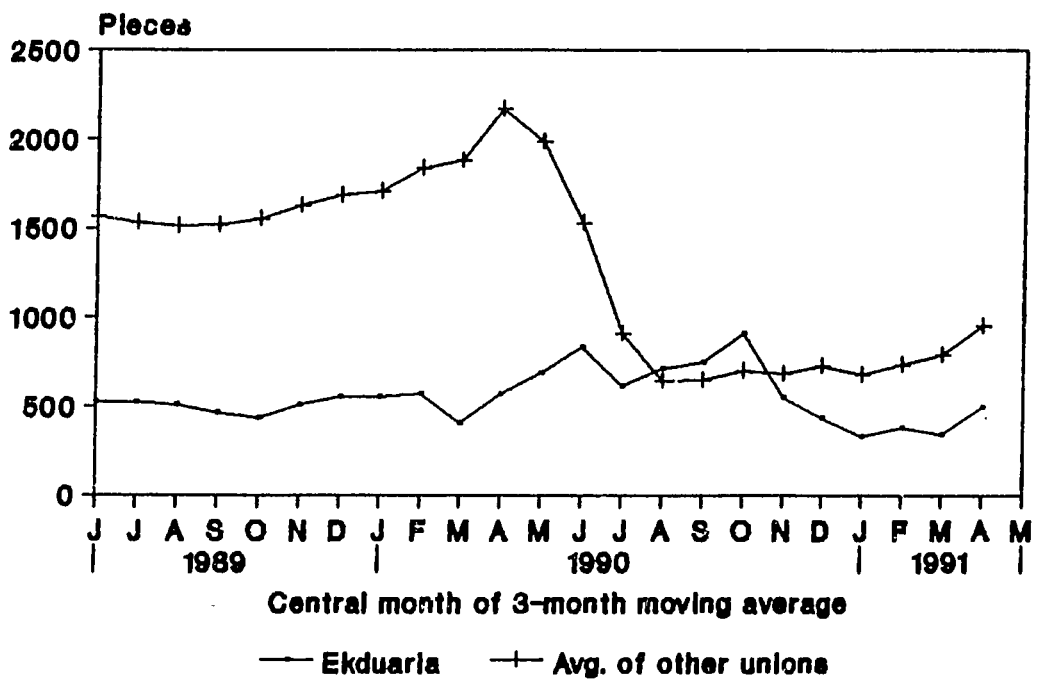
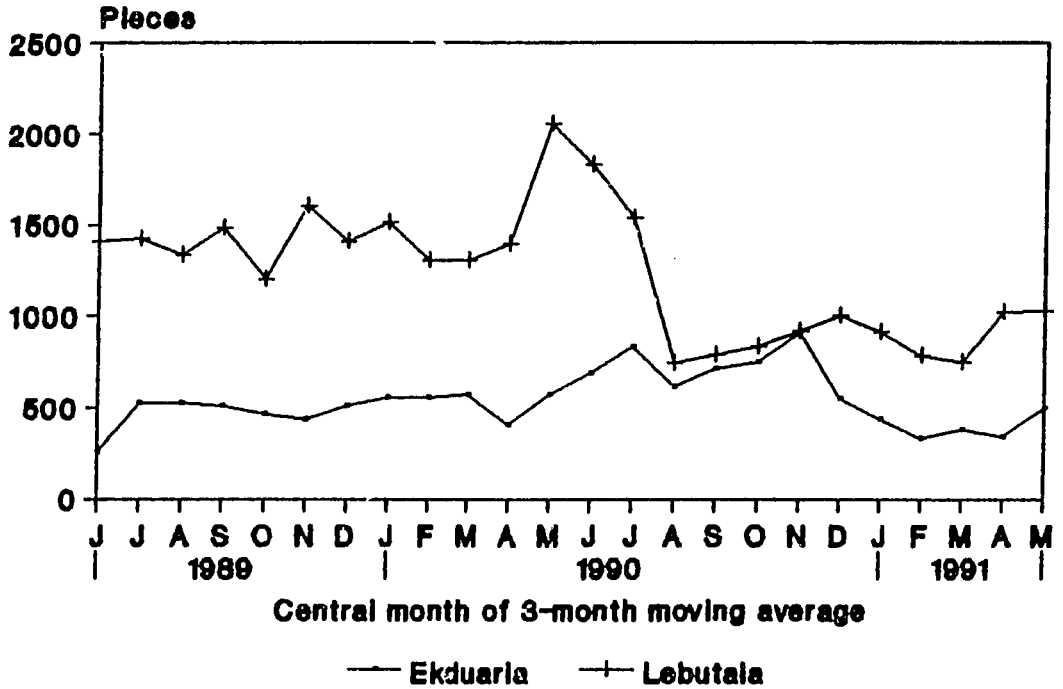


**Figure 4.2**
**Condom distribution in two study unions**




**Source: Monohardi Upazila service statistics.**

### 4.2.1 Number of condoms Distributed Per Client

The decline in the average number of condoms distributed in the unions which charged for condoms and the smaller decline in Ekduaria several months later can be at least partly explained by a policy decision independent of the price introductions.

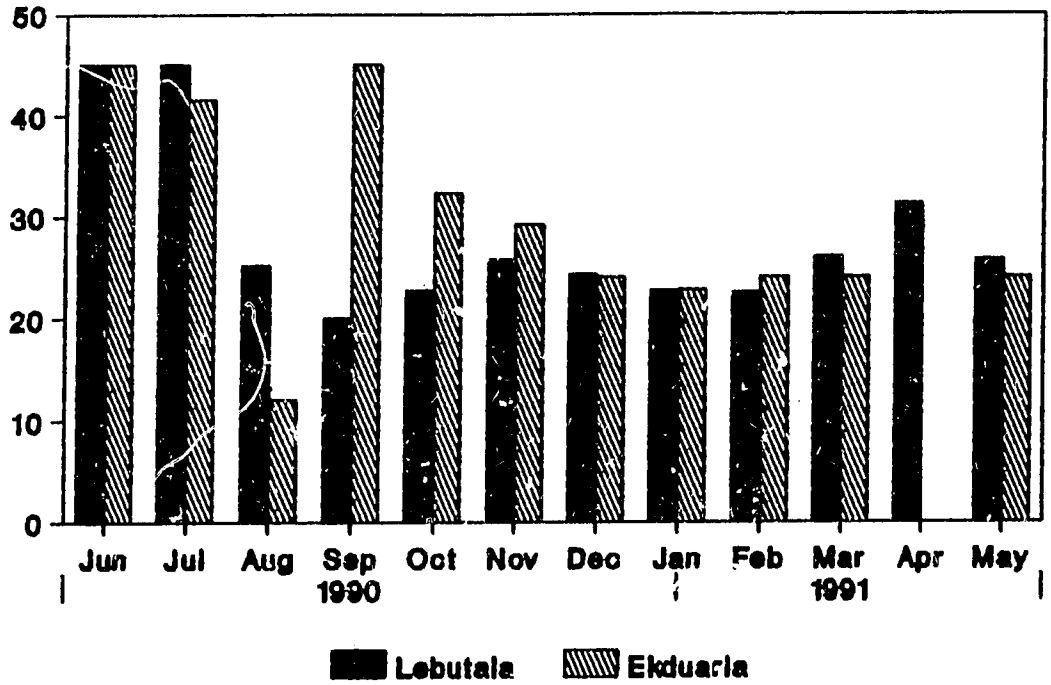
Before July 1990, the Ministry of Health and Family Welfare intructed fieldworkers to maintain a three-month visitation cycle. Clients who wanted condoms were given a three-month supply which was calculated at 45 pieces or 15 pieces per month. After pricing was introduced, fieldworkers were told to visit their condom clients every two months and provide two-month supplies to them. A month's supply was also redefined from 15 to 12 pieces which meant that fieldworkers supplied 24 rather than 45 condoms per visit.

Figure 4.3 gives the mean number of condoms distributed to clients per month during the June 1990-May 1991 period. The average client was given 45 pieces in June and July 1990. After the policy change, Lebutala fieldworkers distributed and charged for an average of 24 pieces per visit. In Ekduaria, fieldworkers were slower to alter their distribution routine. Clients received a

mean number of condoms higher than 24 until December 1990, probably because fieldworkers did not yet have to charge for them.

The decline in the number of condoms given per visit and the introduction of prices in Lebutala in July and introduced several months later in Ekduaria are probably the two principal reasons for the decline in the numbers distributed (Figure 4.3).

**Figure 4.3**
**Number of condoms distributed per client**




**Source: FWA registration book entries for respondents in the Follow-up Survey**

## 4.3 Number of Pill Cycles Distributed

Lebutala was the only union in Monohardi Upazila in which the fieldworkers charged for pills. Unlike the effect of pricing on condoms, there is no evidence of a large and sustained drop in the number of pills distributed after pricing was introduced. Some evidence suggests, however, that more pills would have been distributed had pricing not been initiated.

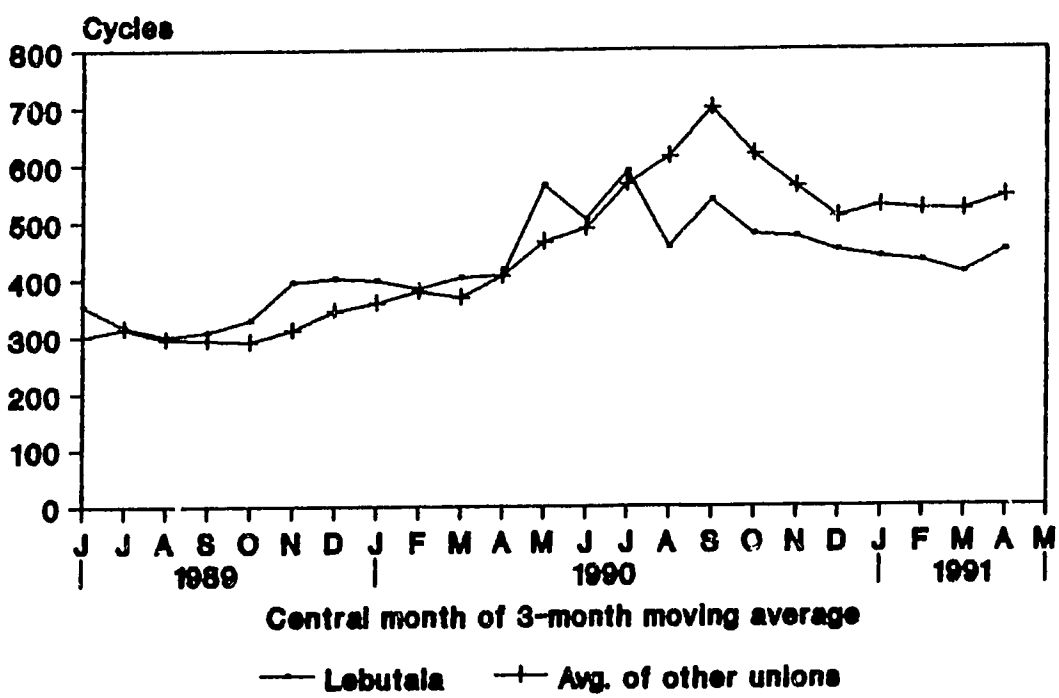
Table 4.2 gives the service statistics for pill distribution in Lebutala and Ekduaria Unions and Monohardi Upazila. These are illustrated in Figures 4.4 and 4.5. Both figures use three-month moving averages to smooth out short-term fluctuations.

TABLE 4.2 : Number of Oral Pill cycles distributed by month in Monohardi Upazila and the Unions of Lebutala and Ekduaria : May 1989 - May 1991

| Month | Monohardi Upazila | Lebutala Union | Ekduaria Union |
|---|---|---|---|
| 1989 | | | |
| May | 3,378 | 474 | 192 |
| June | 3,447 | 261 | 189 |
| July | 3,255 | 327 | 246 |
| August | 3,690 | 363 | 273 |
| September | 2,826 | 210 | 234 |
| October | 3,237 | 351 | 180 |
| November | 3,630 | 423 | 180 |
| December | 3,636 | 411 | 273 |
| 1990 | | | |
| January | 4,290 | 372 | 369 |
| February | 4,017 | 414 | 249 |
| March | 4,218 | 366 | 330 |
| April | 4,041 | 432 | 159 |
| May | 5,141 | 420 | 381 |
| June | 6,462 | 840 | 678 |
| July | 4,593 | 255 | 243 |
| August | 7,671 | 666 | 403 |
| September | 7,479 | 444 | 540 |
| October | 7,425 | 507 | 540 |
| November | 5,076 | 483 | 510 |
| December | 5,751 | 429 | 537 |
| 1991 | | | |
| January | 5,766 | 438 | 501 |
| February | 5,622 | 450 | 408 |
| March | 5,525 | 405 | 390 |
| April | 5,673 | 372 | 534 |
| May | 6,455 | 567 | 603 |

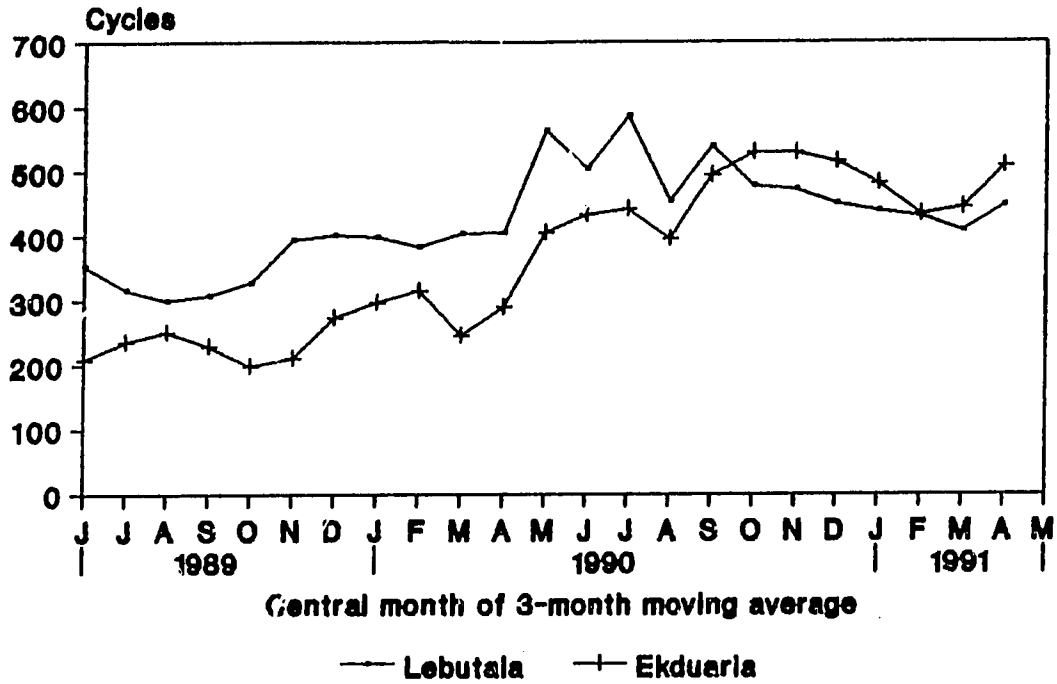
Source: *Service Statistics.*

**Figure 4.4**
**Pill distribution in Monohardi Upazila**




**Source : Monohardi Upazila service statistics.**

**Figure 4.5**
**Pill distribution in two study unions**




**Source : Monohardi Upazila service statistics.**

Figure 4.4, which compares Lebutala to the average of the other Monohardi unions, shows that during the previous year monthly pill distribution increased in Lebutala and elsewhere in the upazila. Lebutala fieldworkers distributed an average number of pill cycles a month. After pricing was introduced, monthly pill distribution stopped increasing in Lebutala and after some fluctuations entered a steady decline that did not reverse itself until the last months of the study. In the remaining unions, pill distribution started to decline two months later. The decline in the monthly number of pill cycles distributed in Lebutala may be unrelated to the pricing intervention, because declines also occurred in the other unions. Before the pricing intervention, however, there was an average number of monthly pill cycles in Lebutala; after the intervention, this number is less than average.

The surveys also provide evidence about pricing effects on pill distribution in Lebutala and Ekduaria. Figure 4.5 shows that like the rest of Monohardi Upazila pill distribution fell in both unions. The decline in pill distribution in Lebutala may thus not result from the pricing intervention. However, the

stability of Lebutala's distribution compared to the increase in Ekduaria's distribution suggests a possible dampening price effect in the intervention union. During the year before the intervention, Lebutala fieldworkers distributed more pill cycles per month than the Ekduaria fieldworkers. After pricing, there was higher distribution in Ekduaria, although the differences between the two unions are quite small. One possible reason for the decline in pill distribution in Ekdauria and other Monohardi unions subsequent to the decline in Lebutala is that word about pill pricing travelled between unions throughout the upazila.

As with condom distribution, pill distribution in Ekdauria is lower than the upazila average. The reasons may also be the same, the greater access of Ekdauria clients to clinical methods in the upazila headquarters or unobserved factors relating to wastage.

In summary, if there had been no pricing intervention in Lebutala, monthly pill distribution may still have declined. It is plausible, however, that pill distribution in Lebutala would still have approximated the upazila average and would have been higher than the distribution in Ekduaria.

## 4.4 Contraceptive Prevalence — Evidence From the Surveys

Table 4.3 compares the percentage of married women using various modern contraceptive methods at the time of the baseline and follow-up surveys in the intervention and control unions. Pill use increased by five percentage points and that of all modern methods by almost seven percentage points in Lebutala. Condom use, however, remained constant. There was little or no change in the percentage of married women using modern contraceptives in the control union.

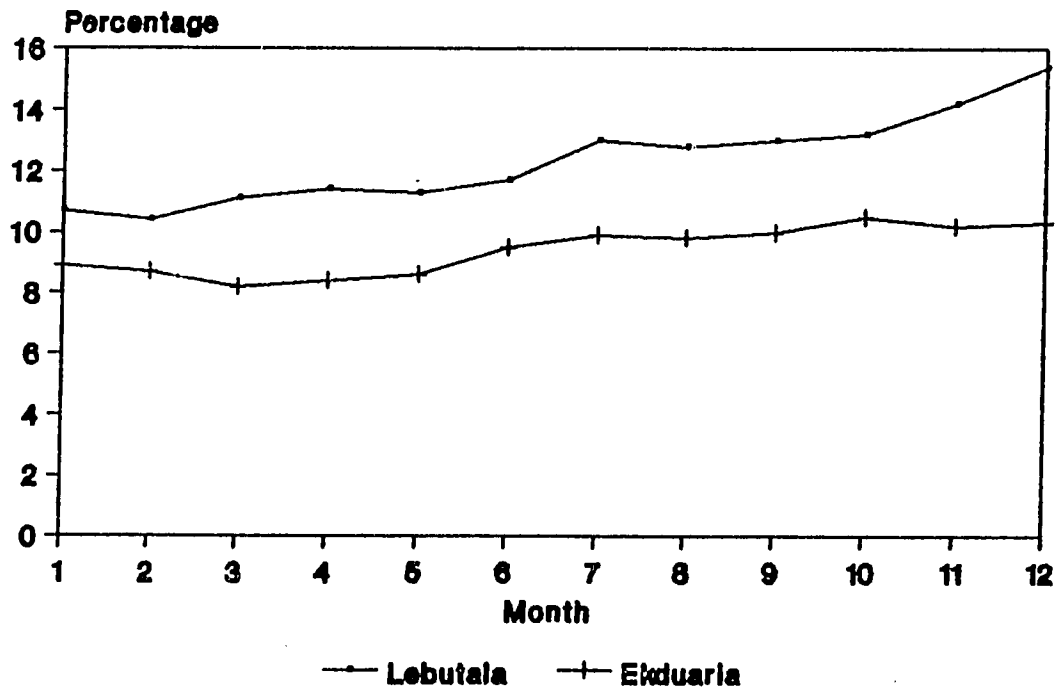
TABLE 4.3 : Percentage distribution of women reporting of specific modern methods in the Intervention and Control unions

| Modern methods | BASELINE | | FOLLOW-UP | |
|---|---|---|---|---|
| | Lebutala | Ekduaria | Lebutala | Ekduaria |
| Oral Pill | 10.4 | 9.8 | 15.4 | 10.3 |
| Condom | 3.1 | 2.0 | 3.2 | 2.1 |
| Injectables | 1.6 | 1.8 | 2.2 | 1.5 |
| IUD | 2.7 | 5.1 | 3.0 | 5.4 |
| Tubectomy | 8.1 | 7.5 | 8.8 | 8.2 |
| Vasectomy | - | 0.7 | - | 0.6 |
| TOTAL | 25.9 | 26.9 | 32.6 | 28.2 |
| N | 804 | 941 | 760 | 876 |

Source : Baseline and Follow-up Surveys.

Trends in pill use rates can be derived from the contraceptive calendar data collected in the follow-up survey. Figure 4.6 shows the percentage of married women who reported using pills in each month following the baseline survey. The rates increased slowly in both unions until the last two months, when pill use rose more rapidly in the intervention union and declined in the control union.

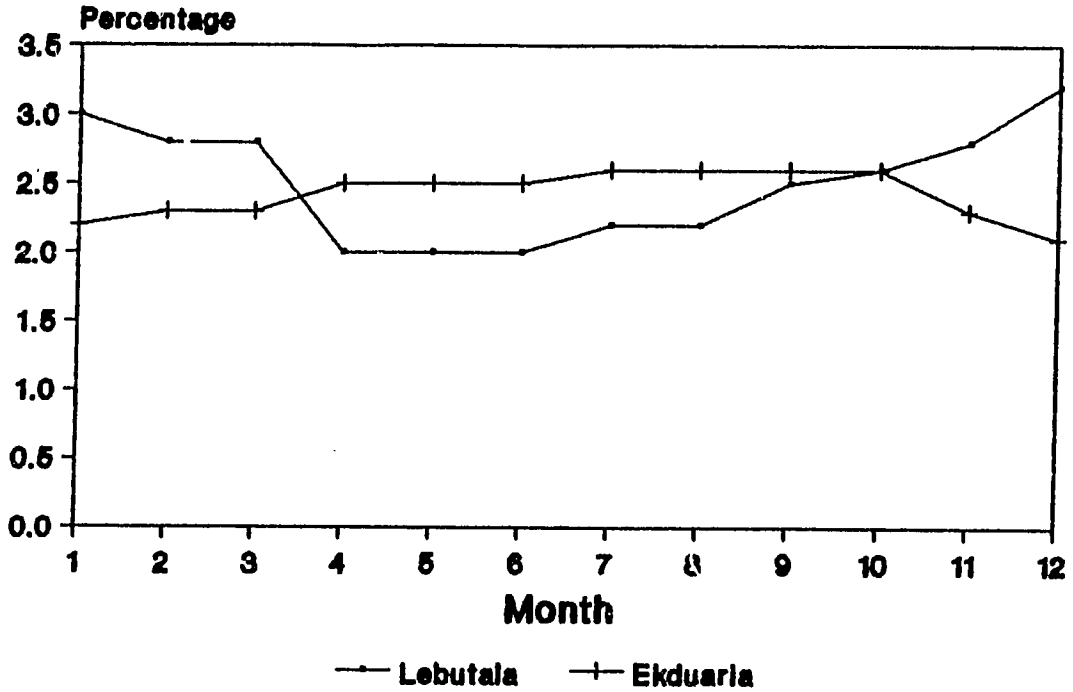
**Figure 4.6**
**Percentage of women using pills**




**Source : Follow-up Survey**

Trends in condom use rates shown in Figure 4.7 indicate that couples in the intervention union were initially more likely to use condoms than couples in the control union, but that immediately after the price introduction condom use dropped in the intervention union and rose slightly in the control union. In the last month of the study, condom use rose even above the pre-study level in the intervention union and declined slightly below this level in the control union. These trends may have been the result of random fluctuations unrelated to the pricing intervention. In no month was there considerable difference in use rates between the two study unions.

**Figure 4.7**
**Percentage of women using condoms**




**Source : Follow-up Survey**

In conclusion, the evidence provided by the baseline and follow-up surveys shows that pill use increased in the intervention union after price introduction, and that this increase may have been related to price introduction itself, the operational effect of a new intervention being implemented in an area, or an unobserved and thus unmeasured influence. There was no corresponding increase in condom use in the intervention union after price introductions.

### 4.4.1 Eliminating possible reasons for the survey results

The results from the surveys are surprising in that they indicate use patterns that differ from distribution patterns. In the intervention union, condom use should have declined if it reflected actual reductions in distribution. The pill use increase in the intervention union after price introductions are also not reflected in the stable distribution statistics.

Two possible explanations for the rise in pill use in Lebutala are unlikely. First, women in Lebutala were not more likely to have intended pill adoption at the time of the price introductions than their Ekduaria counterparts. Findings

of the baseline survey show that in both unions about two-thirds of women who did not use contraception expected to adopt it in the future, and roughly equal proportions expected that their method of choice would be the pill.

Second, women in the intervention union, when faced with prices for previously free contraceptives, did not start obtaining supplies from shops. In fact, the opposite occurred. Whereas in Ekduaria 77 percent at the time of the baseline survey and 78 percent at the time of the follow-up survey received their last supplies from a fieldworker, the percentage getting supplies from the fieldworker increased in Lebutala from 81 percent to 91 percent. This increase in fieldworker-supplied pills may indicate that fieldworkers made a greater effort to promote pill use after pricing was initiated. It may also indicate that clients willing to pay for contraceptives shifted to the most convenient source of supply.

### 4.4.2 Results of reinterviews of recent pill adopters

One possibility which had to be addressed was that the follow-up survey respondents claimed to be pill users when they were not and that this inflated the level of pill use in Lebutala. As previously mentioned, a final interviewing team was sent to Lebutala to reinterview women who reported adopting pills between the time of the baseline and follow-up surveys. The purpose was to determine the following: whether they had indeed told the follow-up interviewers that they used pills; whether they were, in fact, using pills at that time; what had made them decide to adopt pills during the past year; if they had paid for the cycles; and their experiences with payment.

The final interview team found that out of 18 women reinterviewed, three were not using pills at the the time of the follow-up survey. This is an extremely high proportion of false reports of contraceptive use. It is sufficiently high to explain the large gain in pill use in the intervention union during the study period. However, there is no reason to expect that the same kind of inflation did not characterize reporting in the control union. The results of the reinterviewing showed that women who reported using pills in the follow-up survey who were found not to be using at the time of the reinterview either intended to use or had considered themselves users who had only stopped temporarily in the earlier period. These reinterviews did not show that fieldworkers had encouraged pill use misreporting in the intervention union in order to meet their targets.

### 4.4.3 Individual Consistency Between Service Statistics and Survey Data

Service statistics are management tools for fieldworkers and their supervisors to keep track of services provided and to organize work plans. They are an imperfect measure of actual contraceptive use. In trying to reconcile trends in pill and condom distribution data with reports from contraceptive histories based on the follow-up survey data, it is important to note that on an individual level the reports do not match very closely.

Table 4.4 compares respondents' reports of their current use status with the most recent use status fieldworkers recorded. In Lebutala 72 percent of the women fieldworkers recorded as pill users (91 out of 127) said that they used during the follow-up survey and 63 percent recorded as condom users (17 out of 27) were later surveyed as using. It is possible that fieldworkers was not up-to-date on clients' use status. However, only 8 of 36 women with conflicting reports said that they had used pills at any time during the previous year. In the control union, respondents' reports and the fieldworkers' records were even more inconsistent. Only 52 percent of women recorded as pill users were later interviewed as such, and only 57 percent of couples recorded as condom users were later interviewed as such. Another 15 women said they had used pills during the previous year but were not current users.

TABLE 4.4 : Comparison of respondents' report of current contraceptive use with the most recent use status recorded in fieldworkers' registration book

| Contraceptive status according to fieldworker records | Respondents' reported status at Follow-up Survey | | | | |
|---|---|---|---|---|---|
| | Oral Pill | Condom | Others | Not using | TOTAL |
| LEBUTALA | | | | | |
| Oral Pill | 91 | 1 | 10 | 25 | 127 |
| Condom | 2 | 17 | -- | 8 | 27 |
| Other methods | 2 | -- | 94 | 7 | 103 |
| Not using | 22 | 6 | 56 | 417 | 501 |
| TOTAL | 117 | 24 | 160 | 457 | 758 |
| EKDUARIA | | | | | |
| Oral Pill | 77 | 4 | 11 | 55 | 147 |
| Condom | -- | 11 | 3 | 5 | 19 |
| Other methods | 2 | -- | 130 | 28 | 160 |
| Not using | 7 | 3 | 70 | 450 | 530 |
| TOTAL | 86 | 18 | 214 | 538 | 856 |

Note: Two cases in Lebutala and 20 in Ekduaria were excluded either because they were not visited by fieldworkers or use status was not recorded.

Source : *Fieldworkers' Registration Book and Follow-up Survey.*

Since there is no baseline to compare the relative accuracy of Lebutala's and Ekduaria's fieldworker records before the pricing intervention, one cannot conclude that the better reporting in the intervention union was caused by the intervention. However, there are three ways the intervention may have exerted influence. First, introduction of a pricing strategy may have induced fieldworkers to keep more accurate records in order to remember which clients owed them money. Second, women who actually paid for their contraceptives may have been more likely to use them. If asked to pay, women who have no intention of using contraceptives will likely not accept them. Third, increased supervision and monitoring in the intervention area may have led to better fieldworker record keeping.

## 4.5 Pill Dropouts as a Result of Pricing

Low discontinuation rates can be at least as important in fostering a high contraceptive use rate as high rates of acceptance (Jain, 1989). Policies which help women to continue their current method or switch methods should their current method be unsuitable are crucial if family planning programs are to have high contraceptive prevalence rates.

One serious concern about pricing is that women, even if sufficiently motivated to accept pills, will be unable to routinely pay for them. Even when contraceptives are free, continuation rates may be low. The 1990 Pill Use Study found, for example, that the average pill adopter in Bangladesh only uses the method for little more than one year (Larson and Mitra, 1991). This study also suggested that pill prices might exacerbate low continuation rates. It showed that women who obtained pills from pharmacies had substantially higher discontinuation rates than those who obtained free supplies from fieldworkers. Price may have been one factor contributing to this difference.

The life table methodology is the standard technique for estimating the cumulative probabilities of stopping a method at the end of an interval of use.[3] It uses durations of use for all users and distinguishes between those whose duration of use is known from those whose duration is not known because they were still using at the time of the interview. A life table uses all of the information on the latter cases up to the time of the interview and then disregards the case. Because of the small number of condom users, this analysis is restricted to pill users.

One way to gauge the effect of pricing on contraceptive use is to compare the probability of pill discontinuation for women in the intervention union with those in the control union and also with the national average. Based on the experience of a cohort of women who adopted pills in early 1989,[4] 35 percent discontinued within the first six months and 50 percent discontinued within the

3 *The interested reader can learn more about life tables and their application to studying contraceptive use dynamics by reading Krishnan Namboodiri and C. M. Suchindran, Life Tables Techniques and Their Applications, Academic Press, New York, 1987.*

4 *These were women who had started an interval of pill use, not necessarily their first time using pills.*

first year of use (Larson and Mitra, 1991). The study unions had a better use record. Among new recruits who started using pills during the intervention period, just under 20 percent discontinued their pill use within the first six months and about one-third (34 percent in the intervention union and 32 percent in the control union) within the first year.

The effect of pricing on discontinuation can also be seen by comparing the cumulative probability of pill use between the baseline and follow-up surveys for the intervention and control unions. Women from the intervention union who used pills at the time of the baseline survey had a 27 percent chance of dropping out within six months. Their counterparts from the control union had a 31 percent chance. At the end of the intervention year, 37 percent had discontinued in the intervention union compared with 50 percent in the control union.

In conclusion, based on the contraceptive histories given during the follow-up survey, there is no evidence that the pricing intervention had an adverse effect on pill continuation rates.

## 4.6 Rate of Attracting New Pill and Condom Users during the Intervention Period

In a sense, the question regarding the trends in attracting new clients to adopt pills or condoms has already been answered. The intervention union had an increase in pill use and no change in condom use, whereas the control union had no change in the use of either method. Intervention union users also had an equal or somewhat higher probability of continuing to use pills. Therefore, the rate of recruiting new users must have been greater in the intervention than control union. Nonetheless, it is interesting to see the extent of the difference and also the pattern over time.

Table 4.5 shows the number of women who used neither pills nor condoms , and the percentage who started using one of those methods in the following month. The data are based on the contraceptive calendars administered in the follow-up survey. Each month, the number of recruits is small so that the percentages fluctuate quite a bit. Nevertheless, the rate of attracting new users is very similar in Lebutala and Ekduaria during the study period. The only major difference is in the last month, when Lebutala fieldworkers recruited more than two percent of nonusers and Ekduaria fieldworkers recruited less than one percent. Again, the conclusion is that the pricing intervention did not result in the intervention union having less success than the control union in attracting new pill and condom users. The ability to attract new users may actually have increased during that year, a situation possibly caused by greater fieldworker attentiveness to their duties or better supervision and monitoring on the part of the study and field managers.

TABLE 4.5 : Oral Pill and Condom adopters in the two study unions, by month

| Month | LEBUTALA | | EKDUARIA | |
|---|---|---|---|---|
| | No.of nonpill or condom users in previous month | Percentage adopting oral pill or condom | No.of nonpill or condom users in previous month | Percentage adopting oral pill or condom |
| 1990 | | | | |
| May - June * | 541 | 1.7 | 498 | 1.2 |
| June - July | 541 | 1.7 | 498 | 1.2 |
| July - August | 540 | 1.5 | 497 | 0.6 |
| August - September | 536 | 0.9 | 497 | 1.2 |
| September - October | 538 | 0.6 | 493 | 0.8 |
| October - November | 540 | 0.6 | 493 | 1.4 |
| November -- December | 538 | 1.9 | 487 | 0.8 |
| December -- January(1991) | 529 | 0.9 | 484 | 0.8 |
| 1991 | | | | |
| January - February | 529 | 1.3 | 483 | 1.4 |
| February - March | 526 | 1.3 | 480 | 1.7 |
| March - April | 525 | 1.7 | 477 | 0.8 |
| April - May | 518 | 2.1 | 479 | 0.8 |

* The English months given in pairs correspond to complete Bengali months.

Source : *Follow-up Survey.*

## 4.7 Use of Other Family Planning Methods

Woman may decide to switch to a free contraceptive method if asked to pay for the one they currently use. Based on the contraceptive histories, this practice did not occur to a substantial extent. Out of the 42 women in the intervention union and 37 women in the control union who stopped using pills or condoms during the intervention period, 8 (about 10 percent) adopted another modern method. In the intervention union, two women adopted injectables and two had a tubectomy. In the control union, one started using vaginal foam tablets (a priced method) and three had an IUD inserted.

Two reasons women in the intervention union were not more inclined to adopt other free modern methods were: (1) they were faced with transportation and opportunity costs going to the union or upazila health centers, and (2) they faced psychic costs switching to a new method. These costs may have made alternative clinical methods less attractive, even if the commodity and service costs for these methods were free. Five satellite clinic sessions were held a month in Lebutala after the pricing began, but in that time only 6 new injectable clients and 12 IUD clients were served.

## 4.8 Trends in Distribution and Use in Other Project Sites

Effects of charging for condoms and pills have been monitored in several other localities throughout Bangladesh. Despite differences in setting and implementation, the results have been quite similar.

The MCH-FP Extension Project provides technical and managerial assistance to the government family planning program in two upazilas. To help monitor its interventions, the Project conducts a Sample Registration System which, among other data, records both contraceptive distribution statistics and women's reported contraceptive use.

As previously mentioned, the government introduced a condom charge in July 1990. The number of condoms distributed declined substantially in both the project upazilas. However, similar to what was found in Lebutala, there was no discernible effect on the condom use rate (Nessa, et al., 1991).

All FP NGOs introduced prices for their condoms effective the same time as the government circular on condom pricing. Some FP NGOS, including those coordinated and monitored by the Family Planning Association of Bangladesh, The Pathfinder International and The Asia Foundation, introduced prices for their condoms and pills at about the same time as the government order to charge for condoms. These NGOs also observed that distribution of condoms and pills declined after the introduction of prices, but that the number of users either was not affected or declined slightly and recovered within months. All three NGOs allowed their fieldworkers to give clients supplies on credit or for free. In the various project sites this amounted to anywhere from 20 percent to far more than one-half of all pill and condom clients. NGO fieldworkers were not expected to make up that amount themselves and NGO supervisors stressed that fieldworkers should not lose clients because of the charge. The cost recovery from this price introduction may have been marginal, however, because losses incurred from bad debts were made up from donor-provided funds.

# SECTION 5

# FIELDWORKER COVERAGE BEFORE AND AFTER THE PRICING INTERVENTION

## 5.1 Introduction

Home visits by government female fieldworkers are a crucial element of Bangladesh's family planning program. Research has highlighted the importance of frequent visits in convincing women to adopt and to continue using family planning methods (MCH-FP, ICDDR,B, 1988). National surveys have shown that fieldworker coverage is still low. The 1989 Contraceptive Prevalence Survey found that only one-quarter of eligible women reported a visit from a fieldworker to discuss family planning in the past six months. Moreover, fieldworkers tend to go to women who are the easiest to approach. Among the very poorest women, only 20 percent recalled a visit in the past six months compared to 30 percent of the women in the highest economic category.[5]

## 5.2 Effect of Pricing on Fieldworker Home Visitation

One concern in implementing community-based contraceptive pricing is that fieldworkers will selectively visit only those women who can afford their products. The first round of in-depth interviewing which occurred four months after the intervention noted that:

> an implication of this [pricing] system is that FWAs could have less incentive to spend time with their poorer clients who may have the greatest need. Several poorer women reported that the FWA did not always come to their house but they collected their pill supplies from her when she sat at a neighbor's home. The neighbors are not always users themselves but may be friends with whom the FWA feels comfortable (Chowdhury, et al., 1991).

A few months later additional focus group discussions and semi-structured interviews were held with the fieldworkers and clients in Lebutala and at several NGO family planning projects. At that time, differential treatment of poorer clients as a result of pricing was discussed more thoroughly, and it was reported that:

5 *Economic status is based on the ownership of six consumer items. The poorest lived in households with none or only one item and the best-off had five or six items. See, Mitra, et al., 1990.*

> ... the workers are gradually losing interest in clients whose debts have been accumulating over time. The workers have started motivating such clients to accept methods which are distributed free; however, they would continue to provide such clients with contraceptives on credit for another two to three months after which even if such clients do not accept free methods they would stop selling to such clients on credit. The FWAs in Lebutala Union said that henceforth they would supply contraceptives to the clients on credit for a maximum cumulative debt of Tk. 3.0, after which they would stop selling contraceptives to such clients on credit. That is, access to the priced contraceptives among clients unable and/or unwilling to buy will be adversely affected (Khuda et al., 1991 a).

In the final round of focus group discussions, however, FWAs remarked that they visited clients more frequently after pricing was introduced. They claimed they did so because regular visits were the only way to increase their sales of pills and condoms and also to improve their chances of collecting money owed to them for supplies previously given on credit. The pricing intervention itself, as a well-monitored and important activity, may also have encouraged FWAs to perform better. There was one caveat to this general impression of better service. In separate discussions, FWAs and women who had stopped using pills or condoms during the intervention period agreed that dropouts were visited less regularly. Both groups indicated that a stalemate had developed. After the FWA had discussed clinical methods with her client and the client had reiterated that she did not want to use them, FWAs saw little purpose in additional visits. As one of them noted: "Since they do not have the money to buy condoms and pills, I find it useless to talk to them about such methods. Indeed, I try to motivate them to adopt those methods which are distributed free, and I have been successful so far in motivating a few of my clients to adopt injection and IUD. However, a large majority of such clients are unwilling to accept such methods, and I find myself in quite a helpless condition because I cannot go on distributing pills and condoms either free or on credit which is difficult to realize."

The baseline and follow-up surveys indicate that fieldworkers may have visited their clients more regularly during the intervention period. Judging by women's own recollection of whether the fieldworkers had visited them in the six months before the baseline survey or in the one year prior to the follow-up survey, visitation rates improved. This can be seen in Table 5.1, which excludes women protected from conception by sterilization. The two visitation figures are not strictly comparable; however, only ever-visited rates are being compared and every eligible woman was supposed to have been visited once every three months prior to July 1990 and every two months from August 1990. Therefore, all respondents should have been able to recall two visits in the six months prior to the baseline survey and about six visits in the one year prior to the follow-up survey. The fieldworker was clearly negligent if for either survey a woman could not recall any visits.

TABLE 5.1 : Percentage of nonsterilized married women recalling a visit from a family planning worker six months prior to the Baseline Survey and one year prior to the Follow-up Survey, by various socio-economic indicators and union.

| Background variables | LEBUTALA | | EKDUARIA | |
|---|---|---|---|---|
| | Baseline | Follow-up | Baseline | Follow-up |
| TOTAL | 68 | 85 | 76 | 84 |
| Annual Household Income | | | | |
| < 9,000 Tk. | 61 | 85 | 79 | 84 |
| 9,000-12,999 Tk. | 70 | 92 | 78 | 82 |
| 13,000-17,999 Tk. | 71 | 82 | 70 | 81 |
| 18,000-27,999 Tk. | 72 | 81 | 77 | 82 |
| 28,000 + | 68 | 85 | 77 | 91 |
| Respondents' Schooling | | | | |
| None | 63 | 83 | 77 | 83 |
| Primary School | 70 | 88 | 74 | 82 |
| Secondary School or higher | 75 | 85 | 75 | 91 |
| Consumer items | | | | |
| Zero, one | 68 | 86 | 74 | 83 |
| Two, three, four | 65 | 86 | 79 | 85 |
| Five, six | 82 | 77 | 77 | 89 |

Note: *Includes only women not protected by voluntary surgical sterilization (tubectomy or vasectomy) and those available for both interviews. This This amounted to 694 respondents in the Intervention union and 799 respondents in the Control union.*

Source : *Baseline and Follow-up Surveys.*

In the baseline survey, there was a tendency for the poorest and least educated women in the union to be visited less often in the intervention union. In the follow-up survey, this was no longer true. The opposite was true in the control union. The poorest and least educated women were less likely to be served at the time of the follow-up than at the time of the baseline survey. A probable reason for these patterns is that in the intervention union pressure for the fieldworkers to perform well added to their incentive to visit all households. In addition, the fieldworkers may have needed to improve their chances of motivating acceptors and to collect debts, thereby resulting in better coverage of poor women. In the control area, the fact that a study was going on in the upazila may have helped to improve fieldworker's overall visitation rates; however, without the need to target poor couples to encourage them to adopt and to repay accumulated debt, they paid somewhat less attention to them.

Similarly, one of the largest differences in visitation rates between the two unions was among women who were not sterilized but who also did not use pills or condoms during the study period. Table 5.2 contrasts change in contraceptive use status between the baseline and follow-up surveys with the proportion who reported a visit from the fieldworker in that year. As can be seen, visitation rates are very high in both unions for continuous pill and condom users, dropouts, and acceptors. Also, in both unions, women who are nonusers are visited less often. In Lebutala these women are substantially less likely to be visited than those in the Ekduaria.

TABLE 5.2 : Percentage of nonsterilized respondents reporting a visit by the fieldworker in the previous twelve months by their history of use of oral pill and condom between the Baseline and Follow-up Surveys

| Oral Pill/Condom at Follow-up Survey compared to Baseline Survey | LEBUTALA | EKDUARIA |
|---|---|---|
| Continuous oral pill or condom user | 98.0 (51) | 97.1 (34) |
| Oral pill or condom dropout | 95.8 (24) | 100.0 (25) |
| Oral pill or condom acceptor | 94.8 (58) | 100.0 (44) |
| Nonuser of oral pills and condoms | 78.5 (438) | 88.0 (408) |

Source : *Baseline and Follow-up Surveys.*

Further evidence of the tendency to keep visitation rates as high as possible is shown by the proportion of women protected by a tubectomy or their husband's vasectomy who were visited. According to the registration books, 95 percent of the women protected by sterilization at the time of the baseline survey were visited six times in the last year in the intervention union in contrast to 70 percent in the control union. The respondents' own reports confirm this finding. Eighty percent of the sterilized clients in Lebutala and 57 percent in Ekduaria recalled a visit by a family planning fieldworker in the past year. The mean number of visits reported by sterilized respondents who had been visited was 4.6 and 3.8 respectively. At the time of the baseline survey, 47 percent of the sterilized women in Lebutala and 41 percent in Ekduaria recalled a fieldworker visit to their house.

# SECTION 6
# PAYMENT FOR CONTRACEPTIVES

## 6.1 Introduction

This section examines how clients pay fieldworkers for their condoms and pills, their willingness and ability to pay, their relationship with fieldworkers after pricing was introduced, and their and the field functionaries' opinions about a government pricing strategy. In addition, estimates are made of revenue generation from contraceptive sales, and wastage reduction resulting from the pricing intervention.

## 6.2 Mode of Payment

Although the study design called for fieldworkers to sell their condoms and pills, they were not able to collect cash for a sizeable proportion of the contraceptives they distributed.[6] Table 6.1 gives the proportion of condoms and pills sold on cash and credit in the intervention union by month from July 1990 to May 1991 as recorded by fieldworkers. Charging for condoms became effective in the third week of July 1990; before that the government distributed condoms for free. Table 6.1 shows that slightly more than one-third of all condoms were sold on credit.

The proportion of clients buying condoms on credit remained virtually unchanged from the time charging was introduced, except in March 1991 when the proportion buying on credit was considerably lower and in May 1991 when it was considerably higher. It is important to note that condom sales increased considerably in May, and these sales are largely accounted for by credit. FWAs can thus push sales, especially of condoms, provided they agree to sell on credit.

Table 6.1 shows that slightly less than one-half of all pill sales were sold on credit. During the intervention period, 35 percent of pill users, on average, took supplies on credit; these are most heavily concentrated with women who remained continuous users through the intervention year and those who were recruited during the year but who then later dropped out (data not shown). The proportion buying pills on credit increased from September 1990 to February 1991, while the volume of sales remained largely unchanged. With a decline in volume in March and April, the proportion buying pills on credit also declined, but then increased again in May with a rise in volume. This increase in volume toward the end of the year probably reflects an attempt by fieldworkers to meet their annual targets.

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6 *This also became evident from interviews with fieldworkers of selected NGO sites visited. See Khuda, et al., 1991 (a). See also, Nessa, Maru, and Whittaker, 1991, for evidence of low (7 out of 23 clients observed) level of cash purchase of condoms in Abhoynagar and Sirajganj upazilas in the MCH-FP Extension Project areas.*

TABLE 6.1 : Sales of Condoms and Oral Pills on credit and cash, and cumulative credit and bad debt realized in Lebutala Union by month : July 1990 - May 1991

| Month/ Year | CONDOM (in Taka) | | | | | ORAL PILLS (in Taka) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Credit | Cash | TOTAL | Cumulative Credit | Debt realized as % of credit sales | Credit | Cash | TOTAL | Cumulative Credit | Debt realized as % of credit sales |
| 1990 July | 12.8 (5.75) | 87.2 (39.00) | 100.0 (44.75) | 12.8 (5.75) | 0.0 ( - ) | ---------- | | | | |
| August | 31.8 (21.00) | 68.2 (45.00) | 100.0 (66.00) | 24.2 (26.75) | 0.0 ( - ) | ---------- | | | | |
| September | 36.0 (27.00) | 64.0 (48.00) | 100.0 (75.00) | 22.5 (41.75) | 22.3 (12.00) | 43.6 (64.50) | 56.4 (83.50) | 100.0 (148.0) | 43.6 (64.50) | 0.0 ( - ) |
| October | 44.6 (25.00) | 55.4 (31.00) | 100.0 (56.00) | 22.9 (55.25) | 29.8 (23.50) | 43.8 (74.00) | 56.2 (95.00) | 100.0 (169.0) | 43.7 (138.5) | 0.0 ( - ) |
| November | 35.1 (13.50) | 64.9 (25.00) | 100.0 (38.50) | 19.9 (55.75) | 39.6 (36.50) | 59.0 (95.00) | 41.0 (66.00) | 100.0 (161.0) | 30.9 (147.5) | 36.8 (86.00) |
| December | 31.2 (15.00) | 68.8 (33.10) | 100.0 (48.10) | 16.1 (52.75) | 50.8 (54.50) | 51.0 (73.00) | 49.0 (70.00) | 100.0 (143.0) | 26.7 (165.5) | 46.0 (141.0) |
| 1991 | 31.2 (12.00) | 68.8 (26.50) | 100.0 (38.50) | 16.8 (61.75) | 48.2 (57.50) | 56.8 (83.00) | 43.2 (63.00) | 100.0 (146.0) | 25.9 (198.5) | 49.0 (191.0) |
| February | 30.9 (8.50) | 69.1 (19.00) | 100.0 (27.50) | 17.8 (70.25) | 45.0 (57.50) | 60.7 (91.00) | 39.3 (59.00) | 100.0 (150.0) | 28.1 (257.5) | 46.4 (223.0) |
| March | 17.8 (6.50) | 82.2 (30.00) | 100.0 (36.50) | 17.2 (74.25) | 43.4 (60.00) | 39.3 (53.00) | 60.7 (82.00) | 100.0 (135.0) | 29.5 (310.5) | 41.8 (223.0) |
| April | 36.8 (12.50) | 63.2 (21.50) | 100.0 (34.00) | 16.4 (76.25) | 48.0 (70.50) | 37.9 (47.00) | 62.1 (77.00) | 100.0 (124.0) | 29.3 (345.0) | 40.6 (235.5) |
| May | 59.0 (36.50) | 41.0 (25.40) | 100.0 (61.90) | 20.3 (106.75 | 41.7 (76.50) | 45.2 (85.50) | 54.8 (103.5) | 100.0 (189.0) | 31.5 (430.5) | 35.4 (235.5) |
| TOTAL | 34.8 (183.25 | 65.2 (343.5) | 100.0 (526.75 | 20.3 (106.75 | 41.7 (76.50) | 48.8 (666.0) | 51.2 (699.0) | 100.0 (1365) | 31.5 (430.5) | 35.4 (235.5) |

Notes: *July figures relate to free distribution, since condom sales started during the third week of July.*

*Figures in parentheses give the amount in Taka.*

Source : *Khuda, et al., 1991 (b).*

Table 6.2 gives the proportion of condoms and pills sold on cash and credit by the six FWAs and one FWV in Lebutala Union from July 1990 to May 1991. FWA '1/A' has the highest volume of sales of pills and condoms followed by FWA '2/B'. The one FWV has the lowest volume of sales of all fieldworkers. FWAs with high volume sales generally sell a larger proportion of condoms and pills on credit than those with low volume, but they also tend to realize a greater share of their bad debts (debt realized as percent of credit sales). It appears that fieldworkers who have higher volume sales are willing to take a greater risk on these sales by offering more credit than those with low volume sales. At the same time, they realize a greater proportion of their debt, suggesting more frequent visits to their clients. The tactics used by these fieldworkers to obtain the money owed to them, however, are unknown.

During the in-depth interviews, women were more likely than fieldworkers to report that they took contraceptive supplies on credit. Fieldworkers may have wanted to gloss over the magnitude of debt owed to them, thinking that it was a poor reflection on their performance. During the third round of in-depth interviews, 25 percent of pill users and 50 percent of condom users said that they always paid for their supplies when they received them. In contrast, two-thirds of the follow-up respondents who had used pills or condoms any time during the intervention period made the same contention.

During the third round of in-depth interviews, one-tenth of pill users and over one-quarter of condom users said that they always bought the methods on credit. None of the condom users reported having ever obtained the method free from the fieldworkers. However, 5 percent of the pill users stated that they received the method free from the fieldworkers, and these clients are quite poor. The FWAs in Lebutala Union also reported that while they generally did not distribute free condoms, they did supply them to about 5 percent of their very poor clients. They also reported that since pills are distributed free in other unions another 5 percent of their clients may have received free pills from fieldworkers in neighboring unions. Although none of the condom users reported having bought the method from shops, 5 percent of the pill users said they bought the method from this source. Also, the FWAs in Lebutala Union reported that about 5 percent of their clients bought the more expensive brands from shops.

TABLE 6.2 : Sales of Condoms and Oral Pills on credit and cash, and cumulative credit and and bad debt realized by the fieldworkers in Lebutala Union : July 1990 - May 1991

| Name of FWA/FWV | Unit No. | CONDOM | | | | | | ORAL PILL | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Users (Pc.) | Credit | Cash | TOTAL (in Taka | Cumulative credit | Debt realized as % of credit sales | Users (Pc.) | Credit | Cash | TOTAL (in Taka | Cumulative credit | Debt realized as % of credit sales |
| Arati Rani Roy | 1/A | 2614 | 45.0 (65.00) | 55.0 (79.60) | 100.0 (144.60) | 21.8 (31.50) | 51.5 (33.50) | 966 | 59.2 (190.50) | 40.8 (131.50) | 100.0 (322.00) | 33.4 (107.50) | 43.6 (83.00) |
| Shamima Afrad | 1/B | 693 | 48.4 (18.75) | 51.6 (20.00) | 100.0 (38.75) | 35.5 (13.75) | 26.7 (5.00) | 408 | 34.6 (47.00) | 65.4 (89.00) | 100.0 (136.00) | 23.9 (32.50) | 30.9 (14.50) |
| Razia Akhter | 2/A | 882 | 28.7 (12.50) | 71.3 (31.00) | 100.0 (43.50) | 21.8 (9.50) | 24.0 (3.00) | 516 | 54.1 (93.00) | 45.9 (79.00) | 100.0 (172.00) | 45.3 (78.00) | 16.1 (15.00) |
| Aleya Parveen | 2/B | 1028 | 36.4 (47.50) | 63.6 (82.90) | 100.0 (130.40) | 15.7 (20.50) | 56.8 (27.00) | 933 | 45.8 (145.50) | 54.2 (165.50) | 100.0 (311.00) | 27.2 (87.50) | 39.9 (58.00) |
| Delwara Begum | 3/A | 1698 | 20.4 (20.00) | 79.6 (78.00) | 100.0 (98.00) | 18.4 (18.00) | 20.0 (2.00) | 648 | 62.4 (133.00) | 38.4 (83.00) | 100.0 (216.00) | 38.0 (82.00) | 38.3 (51.00) |
| Chhaya Rani Barman | 3/B | 876 | 44.8 (19.50) | 55.2 (24.00) | 100.0 (43.50) | 31.0 (13.50) | 30.8 (6.00) | 366 | 46.7 (57.00) | 53.3 (65.00) | 100.0 (122.00) | 35.2 (43.00) | 24.6 (14.00) |
| Hosne Ara Akhand (FWV) | FWC | 474 | 0.0 ( - ) | 100.0 (28.00) | 100.0 (28.00) | 0.0 ( - ) | 0.0 ( - ) | 258 | 0.0 ( - ) | 100.0 (86.00) | 100.0 (86.00) | 0.0 ( - ) | 0.0 ( - ) |
| TOTAL | | 8265 | 34.8 (183.25) | 65.2 (343.50) | 100.0 (526.75) | 20.3 (106.75) | 41.7 (76.50) | 4095 | 48.8 (666.00) | 51.2 (699.00) | 100.0 (1365.0) | 31.5 (430.50) | 35.4 (235.50) |

Note: *The figures in parentheses give the amount in Taka.*

Source : *Khuda, et al., 1991 (b).*

## 6.3 Cumulative Credit/Bad Debt

Are fieldworkers able to collect their debts during subsequent visits? Table 6.1 shows that about one-fifth of condoms and about one-third of pills sold on credit had accumulated into bad debts (defined as three months of non-payment). Over two-fifths of cumulative credit related to condom sales and over one-third related to pill sales had been realized. Debt realized as percent of credit sales showed an increasing trend for condoms until December 1990 and for pills until January 1991, and thereafter declined, indicating that debt realization has been suffering since the beginning of 1991.

Clients are more likely than fieldworkers to report that they have repaid their debts. For example, over three-fifths of current pill users and over two-

thirds of the current condom users interviewed during the third round said that they have repaid all their debts to the fieldworkers. Among those with bad debt, the majority -- 70 percent of pill users and half of condom users -- said that they have three months' supplies on credit which have not been repaid.

While two FWAs had realized over half of their bad debts related to condom sales, realization of bad debt remained at considerably lower levels for the others. Three FWAs realized about two-fifths of their bad debts related to pill sales, and the rest considerably lower. Again, it appears that volume of sales is related to realization of bad debt.

Assuming that cumulative credit is equal to bad debt, the average annual bad debt per family planning worker comes to only Tk.100 -- Tk.18 on account of condoms and Tk.82 on account of pills -- or just over Tk.8 per month. This amount represents less than 1 percent of her average monthly wage of about Tk.1500 (Tk.1300-2200). Given this small sum, fieldworkers were willing to provide a substantial proportion of the clients with supplies on credit, knowing that a portion of this credit would never be realized. Fieldworkers accepted this small loss because of their need to meet their monthly targets.

## 6.4 Willingness and Ability to Pay

According to client reports in the baseline survey, 74 percent in the intervention union and 85 percent in the control union expressed a willingness to pay a price of Taka 1 per month's requirement of pills or condoms. This price was twice as high as the 50 paisha price the government eventually decided to charge for condoms. About half the women in the intervention union and about three-quarters in the control union reported that they would be willing to pay a price even higher than Taka 1 per month's requirement of pills or condoms.

One purpose of the follow-up survey was to investigate the respondents' behavior and not their attitudes. Therefore, no question was asked directly to ascertain their willingness to pay. Nonetheless, they were asked whether they were aware of the pricing policy, and those aware of the policy were asked how they believed they and their husbands should respond to it. Also, they were asked what they believed their husbands' opinion to be regarding the pricing policy.

The findings from the follow-up survey showed that about two-fifths of women in the intervention union were aware of the government decision to charge for condoms compared to less than one-fifth in the control union, where charging for condoms was discontinued soon after its introduction. The policy to charge for pills was better known than the policy to charge for condoms in the intervetion union. (Control union residents were not asked about this policy, because there was no pricing for pills in the control union).

The question in the follow-up survey which best captured willingness to pay for condoms was a question asked of women who knew about condoms fees about their and their husbands prospective use of the method after price introductions. Because only a low proportion of these women had actually used condoms, this question was largely hypothetical. Slightly over half of these

women who knew of the charge said that they intended to use condoms but the remainder expressed an inclination to use a free method, buy condoms from shops, or find a free source. This response indicates a weaker endorsement of condom prices than the willingness to pay response found in the baseline survey.

Respondents reported that they believed their husbands would be even less inclined to pay for condoms than they themselves were (44 percent versus 53 percent). Since women may have projected their own reluctance to pay a fee onto their husbands, the lower figure may be a better measure of willingness to pay for fieldworker-delivered condoms.

Data collected during the baseline surveys indicated that roughly 60 percent of women had no cash in the house on the day of the interview and 20-30 percent usually had no cash (data not shown). The three rounds of in-depth interviews confirmed this finding, showing that the majority of the women interviewed had no independent earnings. Many also did not have cash at their disposal, and even those who did only had a small amount (generally Tk.1 to Tk.5), and had no authority to personally spend it. Even among those who could spend the cash without having to have prior approval of their husbands and in-laws, most said that they often had so many other pressing household needs that they attached a low priority on buying contraceptives.[7] A few responses from the in-depth interviews are reproduced below to show that some users of pills and condoms in the intervention union dropped out because they could not afford to pay:

"I am a poor person, and used to practice family planning to control my family expenses. If, however, we have to pay, then what is the point of using it? My husband told me not to use any method that costs money."

"I wanted to continue using, but could not because my husband will not pay."

"How can you expect me to spend money on contraceptives? Don't I need other things to buy for my family which are much more important than buying contraceptives? If I buy contraceptives only I benefit directly, but if I buy, say, salt, everyone at home can have a meal."

## 6.5 Fieldworker-Client Relationship

Did the fieldworker-client relationship change after the fieldworkers asked clients to pay for contraceptives?

Fieldworkers in both the study unions and the NGO field sites visited complained that in the absence of a national media campaign to publicize the

7 *Similar impressions were also obtained from the field visits made to selected NGO sites (Khuda, et al., 1991a). Also, evidence from Abhoynagar and Sirajganj upazilas in the MCH-FP Extension Project shows that a majority of the clients do not have money to buy condoms, and, according to the fieldworkers, majority of poor clients have stopped using condoms because they cannot afford to buy (Nessa, Maru, and Whittaker, 1991).*

government policy toward charging, clients suspected that they pocketed the sale proceeds.[8] Although this suspicion was largely allayed in the intervention union because of IEC efforts, some clients still suspected the fieldworkers because they had not heard anything about the pricing policy on the radio.

According to in-depth interviews with clients, the frequency of fieldworker home visitation improved among current users of pills and condoms. Dropouts, however, complained that not only had fieldworker home visitation become more irregular after price introductions but also during such visits fieldworkers tried to motivate them to adopt free clinical methods, thereby denying them access to condoms and pills.

The fieldworkers reported that they became more restrictive in providing supplies on credit over time. Most of them at the time of the second and third round in-depth interviews said that although initially they extended credit without much concern about repayment, they have since provided a maximum of only three months supply on credit. The fieldworkers acknowledged this policy penalizes poor clients and mentioned that such clients had already started complaining about the fieldworkers. In-depth interviewers also had discussions with women who were unable to pay their debts, and most of them had stopped receiving supplies from fieldworkers.

## 6.6 Reactions to Pricing Policy

During the initial few months of the intervention period, both clients and fieldworkers expressed strong reservations about the government pricing policy. Before the pricing introduction, the clients accepted free supplies, and the fieldworkers did not have to deal with problems associated with the collection of payment. Although resentment still perists, the fieldworkers and some of their clients have begun to understand reasons for the government pricing policy.

At the time of second round of in-depth interviews, most clients felt that paying for contraceptives represented an indirect tax on them. Also, they argued that the policy was inherently discriminatory . As many reported "If pricing has to be done, why shouldn't it be introduced for the other methods as well? The policy should be uniform for all methods and should not be directed against particular method users."

Some change in attitude was evident by the time of the third round in-depth interviews. One-quarter of the women interviewed said that the pricing policy was justified: one-tenth because it reduced wastage, and one-sixth because costs could be recovered from the richer section of the community. However, three-quarters of the respondents still felt that the policy was not justified, because it discriminated against users of specific methods and against the poor. Although the number of women who expressed reservations againt the government pricing policy declined somewhat over time, it still remained quite high.

8 *Also, a similar evidence is discernbile from the MCH-FP Extension Project areas. See, Nessa, Maru, and Whittaker, 1991.*

A change in the fieldworkers' attitude was also discernible by the time of third round in-depth interviews. Although the FWAs had to absorb bad debts and face client suspicion, they expressed the belief that over time clients would increasingly accept a policy of paying for their own condoms and pills.

The Upazila Family Planning Officer/Monohardi and the Deputy Director/Family Planning, Narsingdi District also felt that more time was needed to make the pricing intervention successful. According to them, lack of a national media campaign on the issue has seriously affected fieldworker credibility. People still suspected that the fieldworkers pocketed the sales proceeds, and in the absence of any national media campaign inter-personal communication and group meetings were not completely effective in removing client misgivings. Thus, they strongly argued in favor of a strong media campaign to help make the pricing intervention successful.

## 6.7 Use of Sale Proceeds

Although a MOHFW circular of August 27, 1990 authorized the UFPO/Monohardi to spend revenue generated from the sale proceeds of condoms and pills in the intervention union on a specified number of items, this revenue has so far not been spent and it now lies in a bank account. This authorization of revenue was based on prior discussions with the DD-FP/Narsingdi, UFPO/Monohardi, and other officials. Even after an authorization was given by the Ministry to the field, no initiative was taken at the lower levels to improve program performance by purchasing items they believed were essential to their activities. In the rest of Monohardi Upazila and the remainder of the country no government circular authorizing use of condom sales proceeds has been issued and the funds remain unspent.

## 6.8 Revenue Generation from Contraceptive Sales

Since one reason for contraceptive pricing was to cover costs, the purpose of this section is to assess the volume of revenues generated in the intervention union from pill and condom sales, and extrapolate this revenue to Bangladesh's 4,401 unions.

Table 6.1 shows that from the third week of July 1990 to May 1991 revenue generated from condom sales was Tk.526.75 (Tk.51.39 per month for 10.25 months) or Tk.75.25 per fieldworker. From September 1990 to May 1991 revenue generated from pill sales was Tk.1,365.00 (Tk.151.67 per month for 9 months) or Tk.195.00 per fieldworker.

Assuming that condom sales per month in the intervention union represents expected average monthly sales figures for all the 4,401 unions in the country, the annual revenue generated from condom sales would be Tk.2,714,008.68. (This expectation may be unrealistic, given that the intervention union experienced intensive efforts unlikely to be repeated to other unions). Likewise, the annual revenue generated from pill sales extrapolated nationwide would be Tk.8,009,996.04. Thus, the total annual revenue generated from condom and pill sales based on the experience of the intervention union would be Tk.10,724,004.72. However, assuming that about one-fifth of condoms and

pills sales turn into bad debt, one-fifth of the total revenue would be borne by the fieldworkers.

Assuming that there are about 20,000 family planning workers deployed in the 4,401 unions of the country, and further assuming that their average monthly salary is Tk.1500, the total annual expenditure for fieldworkers is Tk.360,000,000. Annual revenue generated from condom (and pill pricing if introduced nationwide) would thus only equal 2.98 percent of the total annual salaries paid to the fieldworkers. Revenue generated from contraceptive sales by government fieldworkers therefore represents only a negligible proportion of total program costs.

## 6.9 Estimates of Wastage Reductions

Another reason for introducing pricing was to reduce contraceptive wastage by clients. The review of distribution statistics and survey results in Section 4 supports the hypothesis that pricing may reduce some wastage, since in the intervention union the number of condoms distributed declined and use remained constant and the number of pill cycles stabilized while use increased. It is useful to estimate the magnitude of savings, even though these estimates are very approximate

A simple technique is used to estimate the amount of wastage reduction. The annual number of supplies distributed to couples is divided by the average number of users during that period. The denominator should be women's reported actual use and refer, if possible, to the mid-point in the year. For this purpose, as close to a year's worth of distribution expressed in terms of months is used. The denominator is based on the baseline survey use rates for the pre-intervention period and the mid-point in the contraceptive calendar from the follow-up survey for the post-intervention period.

Table 6.3 gives the principal estimates and assumptions used in this exercise. The number of eligible women was taken from Table 2.2, and was assumed to remain constant throughout the intervention period. The pre-intervention period was represented by the total number of condoms and pills distributed in both unions for the year July 1989 to June 1990. The post-intervention period varies for condoms and pills.

TABLE 6.3 : Estimates of wastage reduction caused by the pricing intervention by study union

| | LEBUTALA | EKDUARIA |
|---|---|---|
| Total Number of Eligible Couples | 3,101 | 3,485 |
| CONDOMS | | |
| Number distributed | | |
| July 1989-June 1990 (12 months) | 18,900 | 6,840 |
| Aug. 1990-June 1991 (11 months) | 9,883 | 6,162 |
| Use rate - baseline | 3.1% | 2.0% |
| Use rate - mid-point from follow-up survey | 2.5% | 2.3% |
| Monthly supply per user | | |
| Pre-intervention | 17 | 8 |
| Post-intervention | 12 | 7 |
| ORAL PILLS | | |
| Number distributed | | |
| July 1989-June 1990 (12 months) | 4,929 | 3,552 |
| Sep. 1990-May 1991 ( 9 months) | 4,569 | 5,040 |
| Use rate - baseline | 10.5% | 9.8% |
| Use rate - mid-point from follow-up survey | 13.0% | 10.0% |
| Monthly supply per user | | |
| Pre-intervention | 1.3 | 0.9 |
| Post-intervention | 1.3 | 1.6 |

There was a reduction in the monthly supply of condoms to the average user in the intervention union following the pricing intervention. However, no decline was observed in the control union where the monthly requirement was lower than in the intervention union.

No change in the number of pill cycles is discernible in the intervention union. However, the fact that the average number increased in the control union may have been influenced by more frequent fieldworker visits. Fieldworkers in the intervention union may have taken more care than their counterparts in the control union to ensure that women did not have surplus cycles.

The next question is how much savings these reductions would bring to the program. Pills will be ignored, since there is no evidence of any sustained reduction in distribution. However, for condoms, it is assumed that the average user received 60 less condoms per year (5 x 12 months) because of pricing and the change in the government distribution policy. Based on the 1989 Contraceptive Prevalence Survey, 1.2 percent of married women used condoms supplied by the government or NGOs. Using population projections based on the 1981 census, this would amount to 266,000 users. If each of them used 60 less condoms a year and condoms cost US$0.025 a piece at the international price, the program may have realized a savings through wastage reduction of US$399,000 or Tk.14,563,500 had pricing and the government distribution policy been in place since 1989. Even though this amount is quite small, it exceeds the estimates of the revenue generated through cost recovery alone.

# SECTION 7
# LESSONS LEARNED AND CONCLUSIONS

## 7.1 Lessons

The findings reported in this document come from more than a year of investigating the impact of a pricing intervention by government fieldworkers in one of Bangladesh's 4,401 unions. The intervention may have been one simple change to the ongoing family planning program, but it represented a major shift from client and program reliance on free products to one of greater self-reliance. This new direction is desirable both from the standpoint of program cost-recovery and client responsibility for their family planning needs. The key issue is not philosophical, but tactical. There is a general consensus that this shift is desirable given that there is no substantial loss of new acceptors or continuing users because of resistance to pricing, no substantial loss of poor clients who are unable to afford prices, and real cost savings from instituting pricing interventions.

**The first and most important lesson from the pricing study is that there are severe constraints to fieldworkers' effectively implementing a pricing intervention.** Most Bangladeshi women do not have access to disposible income, and they often need authorization from other household members to spend it. In addition, fieldworker home visits are unannounced, so that even if women had access to money, they probably would not have it at the proper time. This lack of ready cash means that fieldworkers must extend credit to women unable to pay on hand. This imposes administrative costs, and more seriously, financial costs on fieldworkers who are not able to realize bad debt. Fieldworkers will tolerate this situation over the short term because of their need to meet program targets and also because their financial loss is minimal. It is unclear, however, whether this tolerance would extend over the long term.

Even though fieldworkers appeared to show greater understanding of the rationale for a government pricing policy over time, this occurred in the context of greater IEC inputs to field personnel than would likely be the case in a national program. The intervention union also appeared more prosperous than the national average, and if the pricing intervention raised questions of non-payment in this union, it is likely that it would raise similar questions in other unions.

**The second lesson from the pricing study is that price introductions may work against the interests of the poor.** The need for fieldworkers to collect on their credit appeared to raise their number of field visits. This increase could be beneficial if the purpose of the visit were to bolster client knowledge and motivation. If, however, the purpose were primarily to collect money, which is likely to be the case under these circumstances, negative client reactions could rebound against the program.

Poor clients who failed to repay their debts also thought that fieldworkers visited them less than or tried to motivate them to use "unwanted" clinical methods. Although the service statistics do not indicate fewer visits, client perceptions are important and could lead to widespread sentiments that pricing discriminates against the poor and nonclinical method users. Most clients recognized this discrimination, and even though this perception waned over time, it was still strongly expressed at the end of the intervention.

**The third lesson from the pricing study is that cost savings are likely to be minimal from instituting this scheme.** Extrapolating the money collected in the intervention union to all unions nationwide showed that fieldworkers only collected a small fraction of the amount of money budgeted for their salaries. If this money were offset by the managerial and administrative costs of instituting a pricing strategy nationwide, savings would be few, if any.

More cost recovery is realized through wastage reduction than direct revenue generation. Condom wastage has been widespread in Bangladesh, but presumably it will be lessened by the 50 paisa charge recently insituted by the government. Condom use, however, is minimal, and wastage reductions are unlikely to have a great impact on cost savings. The amount and causes of pill wastage are unclear, and should be subject of a small study. It is implausible, however, that pill wastage in and of itself would justify pill pricing by government fieldworkers. One beneficial outcome of pricing is that pill continuation rates are higher, but this may be the result of increased fieldworker visitation linked to the need to maintain targets, realize bad debts, and supervision and monitoring by the project managers.

Cost recovery programs can be beneficial not only in terms in money saved but also in terms of the way revenues are allocated to improve program quality. At the outset of the intervention, these revenues should have been spent to buy equipment for fieldworkers and clinics. Despite this, the money was never used by the relevant officials. If this were the case in a study with extensive oversight by project managers, it would hold equally true for a nationwide program without such extensive oversight.

**The fourth lesson from the pricing study is that the level of use need not decline as the result of price introductions.** Pill use increased, and condom use did not decline after the intervention. Contraceptive use can increase if clients perceive higher product or service quality, but there is no evidence of this positive consumer reaction in this case. The most probable explanations for the increased use are enhanced IEC (primarily group meetings and face-to-face communication) and more frequent and intense fieldworker visitation. Both these effects spring from the study and may not be implementable or affordable on a nationwide basis.

The mere act of being studied, even if passively, may also have increased fieldworkers' efforts to motivate and supply clients as well as their supervisors' determination that they do so. Other fieldworkers in a more relaxed work environment may attach greater importance in not losing a portion of their own salaries through bad debts than in maintaining a large number of continuing and new users.

**The fifth lesson from the pricing study is that the distribution of pills and condoms may decline if prices are introduced.** There was substantial condom distribution reduction and no increase in pill distribution after prices were introduced. By observing the timing, both appear linked to pricing. During the course of the study, however, the government instituted a new distribution policy which also would have led to declines, so that it is difficult to disentangle the pricing effect from the distribution policy effect. Comparing intervention and control areas is also difficult, because the control area had substantially lower condom and somewhat lower pill distribution than the intervention union. This difference may have been caused to the control union's greater access to clinical methods in the upazila health center.

Substantial difference in method mix between areas raises an additional question of equity. If Area A has higher pill and condom use than Area B and if prices are only imposed on these methods, its contraceptive users will be relatively penalized. This problem was highlighted in this study where the intervention union was as prosperous as the control union but its use of non-clinical methods was higher. The introduction of pill and condom prices would thus have discriminated against condom and pill users in the intervention union.

**The sixth lesson from the pricing study is that hypothetical questions regarding willingness to pay for supplies should not be taken literally.** Although subtantial numbers of married women said that they were willing to pay for pills and condoms at the outset of the study, their willingnes was dampened after they were faced with the actuality of paying.

## 7.2 Conclusions and Recommendations

This study has found that nominal fees can be charged for contraceptive supplies distributed by the fieldworkers without sacrificing the level of contraceptive use. However, this can happen only with considerable cost. Overcoming resistance on the part of clients and fieldworkers requires large, time-consuming publicity campaigns. Women who are unwilling or unable to pay will either go without services or be subsidized by the fieldworkers. In effect, the more successfully implemented the pricing program, the greater the tax on the fieldworkers who must absorb a substantial proportion of this cost, and it is not clear whether the fieldworkers will take on this burden if they are not well-supervised.

Policy makers will have to decide if these costs are worth the benefits. Revenue gained from the nominal fees is minimal and probably a net loss, if managerial and adminitrative costs are considered. The revenue is normally left untouched in bank accounts. There were genuine cost savings from reducing the amount of supplies distributed to clients who do not use them for contraceptive purposes. However, it may be that wastage can be reduced through policies other than pricing. Improved communication between client and fieldworker would go a long way toward ensuring that a correct amount of supplies went to the right clients.

Despite the poor prospects of FWAs implementing a successful cost recovery program, several alternatives can be pursued which have greater likelihood of success.

1. URC/Bangladesh developed a model for the Social Marketing Company (SMC) to sell contraceptives, ORSaline, and safe delivery kits by utilizing Community Sales Workers (CSWs) who receive a small honorarium plus commission on sales. An operations research study is being conducted by URC/Bangladesh to assess the effectiveness of the model. Should the model prove cost-effective, it could, then, be replicated by others.

2. A woman-to-woman (FWA to client) distribution of condoms may not be a cost-effective supply approach. Since most condom distribution is already through the commecial sector and since administrative costs are attached to revenue receipt, the government may want to eliminate this method from its repertoire of community- supplied contraceptives.

3. Government fieldworkers can both sell and give contraceptives away for free. There would probably be serious managerial and administrative costs attached to this strategy which would mitigate the cost recovery effects, but its virtue would be weaning clients who can afford to pay away from free products.

4. Top priority accorded to the population sector should be reflected in increased budgettary allocations for the sector.

All these alternatives require exploratory research, but they offer ways to direct clients to use priced products and to recover some program costs. Given the need to maintain and to increase the contraceptive prevalence rate and the need also to service ever increasing numbers of women entering the reproductive age group, it is important to maintain a large and free public-sector program at least in the foreseeable future. This particularly holds true, given the likelihood that Bangladesh's economic position is not likely to appreciably improve in the foreseeable future.

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# Appendix 1

# CONTRACEPTIVE PRICING PROJECT

## BASELINE SURVEY

## Questionnaire

URC
BANGLADESH

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CONTRACEPTIVE PRICING PROJECT
BASE LINE SURVEY

## SAMPLE IDENTIFICATION

Batch [ ][ ] Converted No. [ ][ ][ ][ ] Sample No. [ ][ ][ ]

Union [ ][ ] Ward [ ] Unit [ ]

Name of Respondnt: _____

Name of husband: _____

Address Vill. _____ Union _____

## Interview Information

| Attempt No. | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Date | | | | |
| Result Code* | | | | |
| Interviewer Code | | | | |

*Result Codes

| | | | |
|---|---|---|---|
| Completed | 1 | Refused | 4 |
| Not Available | 2 | Dwelling vacant | 5 |
| Deferred | 3 | Other _____ (Specify) | 6 |

## Supervision and Data Processing Information

Scrutinized [ ] Reinterviewed or spot checked [ ] Edited [ ] Coded [ ]

By [ ][ ] By [ ][ ] By [ ][ ] By [ ][ ]

Date _____ Date _____ Date _____ Date _____

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## Section I

## BACKGROUND CHARACTERISTICS

| | RESPONSE | SKIP |
|---|---|---|
| 101. How old are you?(PROBE) | Age [ ][ ] | |
| 102. Did you ever attend school? | Yes 0<br>No 1 | <br>--> 105 |
| 103. Was it a Primary school, Madrasa, secondary school or higher that you attended last ? | Primary school 2<br>High school 3<br>College/University 4<br>Madrasa 5<br>Other _____ (Specify) 6 | |
| 104. What was the highest class you passed? | Class [ ][ ] | |
| 105. What is your religion? | Islam 1<br>Hinduism 2<br>Christianity 3<br>Buddhism 4<br>Other _____ (Specify) 5 | |
| 106. Aside from doing normal household work, have you ever done any other work (for cash or kind) such as agricultural work, making things (for sale), selling things in the market, or any thing else? | Yes 1<br>No 2 | |



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107. In the rural areas, there are various types of activities in which women engage themselves in order to earn money. I want to be sure, whether you were engaged in any of such activities during the last year? Who helped you in selling/trading the product? And what was the income earned from such activities during the last year?

INTERVIEWER: IF RESPONDENT HAS SAID "NO" TO Q 106 AND GIVES RESPONSE TO Q 107, CORRECT THE RESPONSE IN Q 106

INTERVIEWER: PLEASE RECORD ANSWER IN TABLE 1

TABLE 1: ECONOMIC ACTIVITIES AND INCOME DURING THE LAST YEAR.

| Work/Activities | 108 Were you involved in _____ ? (activity) | 109 Who helped you in selling/ trading the majority of the product ? | 110 What was the income earned during last year from _____ ? (activity) (Taka) |
|---|---|---|---|
| Service | Yes 1 No 2 | | |
| Trading | Yes 1 No 2 | Self 1 Spouse 2 Other 3 | |
| Raising cattle | Yes 1 No 2 | Self 1 Spouse 2 Other 3 | |
| Raising poultry | Yes 1 No 2 | Self 1 Spouse 2 Other 3 | |
| Kitchen gardenig | Yes 1 No 2 | Self 1 Spouse 2 Other 3 | |
| Paddy husking | Yes 1 No 2 | Self 1 Spouse 2 Other 3 | |
| Handicrafts | Yes 1 No 2 | Self 1 Spouse 2 Other 3 | |
| Making fishing net | Yes 1 No 2 | Self 1 Spouse 2 Other 3 | |
| Earth work | Yes 1 No 2 | | |
| Other _____ (Specify) | Yes 1 No 2 | Self 1 Spouse 2 Other 3 | |
| Total | | | |

| | RESPONSE | SKIP |
|---|---|---|
| 111. Please tell me the annual income of your family during the last year. (IN TAKA)<br><br>INTERVIEWER: IF NECESSARY, PLEASE TAKE HELP FROM HUSBAND OR ANY COMPETENT FAMILY MEMBER | In cash [ ][ ][ ][ ][ ]<br>In kind [ ][ ][ ][ ][ ]<br>Total [ ][ ][ ][ ][ ] | |
| 112. How much cash do you have in hand today? (IF NONE, ENTER 000) | [ ][ ][ ][ ][ ] | |
| 113. How much cash do you usually have at hand ? (IF NONE, ENTER 000) | [ ][ ][ ][ ][ ] | |
| 114. INTERVIEWER: PLEASE CHECK Q 110 AND TICK APPROPRIATE BOX BELOW:<br><br>[ ] EARNED CASH/ KIND<br>[ ] DID NOT EARN ANYTHING (SKIP TO 118) | | |
| 115. You have said that you earn some income by yourself. Now, would you please tell me who spends that money? | Self alone 1<br>Spouse alone 2<br>Self and spouse together 3<br>Other _____ 4<br>(Specify) | |
| 116. Do you usually consult your husband/in-laws to spend some/ any of the money you earn prior to spending ? | Always consult 1<br>Occasionally consult 2<br>Never consult 3 | |
| 117. What are the major areas you spend your earnings on ? | Buy food items 1<br>Buy clothes 2<br>Buy medicine 3<br>Education 4<br>Invest in business 5<br>Other _____ 6<br>(Specify) | |

| | RESPONSE | SKIP |
|---|---|---|
| 118. What is the age of your husband ? (Complete year) | Age [ ][ ] | |
| 119. Did your husband ever attend school ? | Yes 0<br>No 1 | → 122 |
| 120. Was it a Primary school, Madrasa, secondary school or higher that you attended last ? | Primary school 2<br>High school 3<br>College/University 4<br>Madrasa 5<br>Don't know 6<br>Other _____ (Specify) 5 | |
| 121. What was the highest class he passed? | Class [ ][ ] | |
| 122. What is your husband's primary occupation?<br>Occupation: _____ | [ ][ ] | |
| 123. Does he do anything else? | Yes 1<br>No 2<br>Don't know 3 | → 125 |
| 124. What is your husband's secondary occupation?<br>Occupation: _____ | [ ][ ] | |
| 125. Does your household own any cultivable land ? | Yes 1<br>No 2 | → 127 |
| 126. How much ?<br>Local unit: _____ | [ ][ ][ ][ ]<br>Decimals | |



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127. INTERVIEWER: Record under the given categories the construction materials of the dwelling structure in which the respondent lives.

| Categories | Concrete | Tin | Katcha | Other |
|---|---|---|---|---|
| Roof | 1 | 2 | 3 | 4 |
| Wall | 1 | 2 | 3 | 4 |
| Floor | 1 | XXXXX | 3 | 4 |

| | RESPONSE | SKIP |
|---|---|---|
| 128. Does your household (or any member of the household) have the folowing items?<br>INTERVIEWER: PLEASE CHECK THE ITEMS, AND THEN CIRCLE | Cot 1<br>Chair/Bench 2<br>Almirah 3<br>Watch/clock 4<br>Cycles/boat/cart 5<br>Radio 6<br>TV 7 | |
| 129. Does your household have electricity ? | Yes 1<br>No 2 | |



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Section II

## CHILD BEARING AND FERTILITY PREFERENCE

| | RESPONSE | SKIP |
|---|---|---|
| 201. Now, I would like to ask you some questions about child bearing. Have you ever given birth? | Yes 1<br>No 2 | --> 210 |
| 202. I would like to ask you about all of the children you have given birth to that are still living. | | |
| 203. How many of your sons are living with you? | Sons living together [ ] | |
| 204. How many of your daughters are living with you? | Daughters living together [ ] | |
| 205. How many of your sons are living away from you ? | Sons living away [ ] | |
| 206. How many of your daughters are living away from you ? | Daughters living away [ ] | |
| 207. Total living sons and daughters | [ ] Sons [ ] Daughter [ ][ ] Total | |
| 208. That means, you have ____ living sons and ____ living daughters, making a total of ____ living children, is that correct ? (INTERVIEWER: If no, correct answer in Q 203-207). | Yes 1<br>No 2 | |
| 209. How old is your youngest child ? | Months [ ][ ] | |



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| | RESPONSE | SKIP |
|---|---|---|
| 210. Are you currently pregnant ? I mean, are you carrying a baby? | Currently pregnant 1<br>Not currently pregnant 2<br>Don't know 3 | |
| 211. Do you want to have any (more) children ?<br>[INTERVIEWER: If code '1' is circled in Q 210, ask: Do you want any more children beyond the one you are already carrying ?] | Yes 1<br>No 2 | --> 301 |
| 212. How long would you like to wait from now before the birth of a (another) child ? | [ ][ ] months | |



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## Section III

## CONTRACEPTION

301. Now I would like to talk about a different topic. There are various ways or methods that a couple can use to delay or avoid a pregnancy. Which of these ways or methods do you know of or have you heard about? CIRCLE CODE 1 IN 302 FOR EACH METHOD MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN THE COLUMN, READING THE NAME OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 2 IN 302 IF METHOD IS RECOGNIZED, AND CODE 3 IF NOT RECOGNIZED. THEN, IF THE RESPONDENT HAS MENTIONED (code 1 or 2) FOR PILL AND/OR CONDOM, ASK 303. AND FINALLY, FOR EACH METHOD WITH CODE 1 OR 2 CIRCLED IN 302, ASK 304 BEFORE PROCEEDING TO THE NEXT METHOD.

| Methods | 302<br>Have you ever heard of _____?<br>(METHOD) | 303<br>Do you know any place or person from where pill and condom can be obtained? If yes, what are those ? | 304<br>Have you (has husband) ever used (METHOD)? |
|---|---|---|---|
| 01. Pill | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | FP worker 1 Clinic/Hospital 4<br>Pharmacy 2 Depot-holder 5<br>Shop 3 Don't know 6 | Yes 1<br>No 2 |
| 02. Condom | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | FP worker 1 Clinic/Hospital 4<br>Pharmacy 2 Depot-holder 5<br>Shop 3 Don't know 6 | Yes 1<br>No 2 |
| 03. Diaphragm/ Foam/ Jelly | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |
| 04. Injection | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |
| 05. IUD | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |
| 06. Female Sterilization | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |
| 07. Male Sterilization | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |
| 08. M.R. | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |



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| | | | |
|---|---|---|---|
| 09. Safe period | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |
| 10. With-drawal | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |
| 11. Abstin-ence | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |
| 12. Other _____ (Specify) | Yes/SPONT 1<br>Yes/PROBED 2<br>No 3 | ==========<br>==========<br>========== | Yes 1<br>No 2 |

305. INTERVIEWER: CHECK 210 AND TICK THE APPROPRIATE BOX.

NOT CURRENTLY PREGNANT OR DON'T KNOW ☐

CURRENTLY PREGNANT ☐ (SKIP TO 309)

| | RESPONSE | SKIP |
|---|---|---|
| 306. Are you (or is your husband) currently using some family planning method or doing something to avoid a pregnancy? | Yes 1<br>No 2 | <br>-> 309 |
| 307. What is that method? | Pill 01<br>Condom 02<br>Vaginal methods 03<br>Injection 04<br>IUD 05<br>Female sterilization 06<br>Male sterilization 07<br>Safe period 09<br>Withdrawal 10<br>Abstinence 11<br>Other _____ (Specify) 12 | |
| 308. For how long have you been using _____ (Current method) continuously? | Months ☐☐ | |



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309. INTERVIEWER: CKECK Q 304 AND TICK APPROPRIATE BOX BELOW:

CURRENT OR PAST USER OF PILL OR CONDOM [ ]

NEVER USER OF PILL OR CONDOM [ ] (SKIP TO 328)

INTERVIEWER: IF USED BOTH PILL AND CONDOM ASK 310-313; IF USED ONLY PILL ASK 310-311 AND SKIP TO 314; IF USED ONLY CONDOM SKIP TO 312.

| | RESPONSE | | SKIP |
|---|---|---|---|
| 310. Have you experienced any problem from using the pill ? | Yes<br>No<br>Don't remember | 1<br>2<br>3 | -> 312 |
| 311. What are the problems that you have experienced from using the pill? | Dizziness/headache<br>Weakness/sickness<br>Spotting/irregular menstruation<br>Burning sensation in the body<br>Gain weight<br>Shortage of/ irregular supply<br>Other _____ (Specify) | 1<br>2<br>3<br>4<br>5<br>6<br>7 | |
| 312. Have you experienced any problem from using the condom ? | Yes<br>No<br>Don't remember | 1<br>2<br>3 | -> 314 |
| 313. What are the problems that you have experienced from using the condom ? | Discomfort during coitus<br>Breaks during coitus<br>Itching/burning sensation<br>Shortage of/irregular supply<br>Other _____ (Specify) | 1<br>2<br>3<br>4<br>5 | |

314. INTERVIEWER: CKECK Q 307 AND TICK APPROPRIATE BOX BELOW:

CURRENT USER OF PILL OR CONDOM [ ]

NON-CURRENT USER OF OF PILL OR CONDOM [ ] (SKIP TO 328)

| | | | |
|---|---|---|---|
| 315. Have you any _____ in your house now ? (method) | Yes<br>No | 1<br>2 | -> 318 |
| 316. Can you show them to me?<br>If shown, Brand: _____ | Shown<br>Not shown | 1<br>2 | -> 318 |



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| | RESPONSE | SKIP |
|---|---|---|
| 317. INTERVIEWER: SHOW SAMPLES AND THEN ASK THIS QUESTION:<br><br>Is it one of these ?<br><br>INTERVIEWER: WRITE DOWN THE BRAND NAME BELOW.<br><br>Brand _____ | [ ][ ] | |
| 318. Who usually gets (used to get) the method that you are (or your husband is) currently using? | Self 1<br>Husband 2<br>Other _____ (specify) 3 | |
| 319. From where do (did) you (your husband) usually obtain the supply? | FP worker 1<br>Pharmacy 2<br>Shop 3<br>Clinic/Hospital 4<br>Depot-holder 5<br>Other _____ (Specify) 6<br>Don't know 7 | --> 321 |
| 320. Do you (does your husband) collect the supply from the worker's house or does this worker come to your house to give you the supply ? | Supply is given at home 1<br>Supply is collected from the worker/other sources 2 | |
| 321. Have you ever got supplies from any another source ? | Yes 1<br>No 2 | --> 323 |
| 322. What were the sources of such supplies ?<br><br>Other sources: _____ | [ ][ ] | |



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| | RESPONSE | SKIP |
|---|---|---|
| 323. Do you usually buy pill/condom or get it free of cost? | Buy 1<br>Free 2<br>Other 3 | --> 326 |
| 324. Have you ever paid for any pill or condom (cash, kind, or both)? | Yes 1<br>No 2 | --> 326 |
| 325. Have you ever given anything to the FWs in return for the free supplies of pills and condoms? | Yes 1<br>No 2 | -->328 |
| 326. How much do you pay (cash, kind, or both) for one cycle of Oral Pill/one dozen of Condom?<br><br>One cycle Oral Pill<br><br>One dozen Condom | [ ][ ] Taka [ ][ ] Paisa<br><br>[ ][ ] Taka [ ][ ] Paisa | |
| 327. Whom did you pay for the pill/condom ? | FP worker 1<br>Pharmacy 2<br>Shop 3<br>Clinic/Hospital 4<br>Depot-holder 5<br>Other _____ (Specify) 6<br>Don't know 7 | |
| 328. During the last six months, has any one visited you in your home to talk to you about family planning or to give you any family planning method? | Yes 1<br>No 2 | --> 330 |
| 329. When was the last time the worker visited you in your home? | [ ][ ] Month's ago | |



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330. INTERVIEWER: PLEASE CHECK 306 AND TICK APPROPRIATE BOX BELOW:

NOT CURRENTLY USING ANY CONTRACEPTION [ ]

CURRENTLY USING ANY TEMPORARY METHOD [ ] (SKIP TO 333)

CURRENLY USING STERILIZATION [ ] (SKIP TO 411)

| | RESPONSE | | SKIP |
|---|---|---|---|
| 331. Do you intend to use any family planning method in the future ? | Yes | 1 | |
| | No | 2 | -> 401 |
| | Not decided | 3 | -> 401 |
| 332. What method do you intend to use in the future ? | Pill | 01 | -> 401 |
| | Condom | 02 | -> 401 |
| | Vaginal methods | 03 | -> 401 |
| | Injection | 04 | -> 401 |
| | IUD | 05 | -> 401 |
| | Female sterilization | 06 | -> 401 |
| | Male sterilization | 07 | -> 401 |
| | Other _____ (Specify) | 08 | -> 401 |
| 333. Do you intend to switch to some other method in the future ? | Yes | 1 | |
| | No | 2 | -> 401 |
| | Not decided | 3 | -> 401 |
| 334. To what method do you intend to switch in the future ? | Pill | 01 | |
| | Condom | 02 | |
| | Vaginal methods | 03 | |
| | Injection | 04 | |
| | IUD | 05 | |
| | Female sterilization | 06 | |
| | Male sterilization | 07 | |
| | Other _____ (Specify) | 08 | |



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Section IV

## WILLINGNESS TO PAY FOR CONTRACEPTIVES

401. Probably you know that Family Planning methods are quite expensive, and yet, the government has been providing these methods free of costs. In view of the huge costs involved, it would be difficult for the government to continue to provide Family Planning methods free of charge. Therefore, as a partial cost recovery measure, the government has recently decided that pills and condoms would no longer be supplied free. Instead, the government will charge modest price for pills and condoms @ Tk. 1 per cycle of pill and Tk. 1 per dozen of condoms.

| | RESPONSE | SKIP |
|---|---|---|
| 402. Would you be willing to pay the GOB recommended price ? | Yes 1<br>No 2<br>Don't know 3 | -> 404 |
| 403. Would you be willing to pay more ? | Yes 1<br>No 2<br>Don't know 3 | -> 407 |
| 404. Would you be willing to pay a smaller amount ? | Yes 1<br>No 2<br>Don't know 3 | -> 406 |
| 405. How much would you be able to pay for one cycle of pill and one dozen of Condom ?<br>One cycle Oral Pill<br>One dozen of Condom | [ ][ ] Paisa<br>[ ][ ] Paisa | -> 407 |
| 406. Why do you think that you could not pay any price ? | Couldn't afford 1<br>Other _____ (Specify) 2 | -> 408 |



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# APPENDIX 2

# COMPREHENSIVE RICHER PROJECT

## FOLLOW-UP SURVEY

## Questionnaire

BRC

BANGLADESH

CONTRACEPTIVE PRICING PROJECT
FOLLOW-UP SURVEY

## SAMPLE INDENTIFICATION

Batch [ ][ ] Converted No. [ ][ ][ ][ ] Sample No. [ ][ ][ ]

Union [ ][ ] Ward [ ] Unit [ ]

Name of Respondent: _____

Name of Husband: _____

Address Vill: _____ Union _____

## INTERVIEW INFORMATION

| Attempt No. | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Date | | | | |
| Result Code * | | | | |
| Interrviewer Code | | | | |

### * RESULT CODES

| | | | |
|---|---|---|---|
| Completed | 1 | Refused | 4 |
| Not Available | 2 | Dwelling vacant | 5 |
| Deferred | 3 | Other _____ (Specify) | 6 |

## Supervision and Data Processing Information

Scruitinized [ ] Reinterviewed or spot checked [ ] Edited [ ] Coded [ ]

By [ ][ ] By [ ][ ] By [ ][ ] By [ ][ ]

Date _____ Date _____ Date _____ Date _____

SECTION I

## BACKGROUND CHARACTERISTICS

| | RESPONSE | SKIP |
|---|---|---|
| 101. Are you currently married ? | Yes 1<br>No 2 | Terminate interview |
| 102. When we spoke to you last year you told us that you had (not done any activities to earn money)/(had been involved in _____, _____, _____, _____, _____, _____ to earn money. Now I want to ask you what kinds of work have you done this past year to earn money. Have you done : | | |

TABLE 1

| Work/Activity | Involved during past year ? |
|---|---|
| Service | Yes 1 No 2 |
| Trading | Yes 1 No 2 |
| Raising cattle | Yes 1 No 2 |
| Raising poultry | Yes 1 No 2 |
| Kitchen gardening | Yes 1 No 2 |
| Paddy husking | Yes 1 No 2 |
| Handicrafts | Yes 1 No 2 |
| Making fish net | Yes 1 No 2 |
| Earth work | Yes 1 No 2 |
| _____ (Specify) | Yes 1 No 2 |

| | | |
|---|---|---|
| 103. INTERVIEWER: If the respondent did no work for cash in the last year SKIP TO | | → 106 |
| 104. During the last year would you say that you did more work for money than you have in the preceding 2/3 years, about the same amount of work or less work ? | More 1<br>About the same 2<br>Less 3 | |

| | RESPONSE | SKIP |
|---|---|---|
| 105. During the last year would you say that you earned more money than you usually earned in a year during the preceding 2/3 years, about the same or less money ? | More 1<br>About the same 2<br>Less 3 | |
| 106. Last year you told us that your husband's principal occupation was _____ (and that he was also secondarily involved in _____). Did he do this work during last year ? | Yes 1<br>No 2 → | 108 |
| 107. Did he do any other work to earn money ? | Yes 1<br>No 2 → | 111 |
| 108. What was his principal occupation last year ? | _____<br>_____<br>_____ | |
| 109. Did he do any other kind of work ? | Yes 1<br>No 2 | |
| 110. What was his second main occupation ? | _____<br>_____<br>_____ | |
| 111. Does your household own any cultivable land ? | Yes 1<br>No 2 → | 113 |
| 112. How much ?<br>Local unit : _____ | [ ][ ][ ][ ]<br>Decimals | |
| 113. What was the total family income last year ?<br>INTERVIEWER: Ask other family members for help, if necessary. | In cash [ ][ ][ ][ ][ ]<br>In kind [ ][ ][ ][ ][ ]<br>Total [ ][ ][ ][ ][ ] | |
| 114. Compared to the preceding 2/3 years, did your family earn more money than usual the last year, about the same or less money ? | More 1<br>About the same 2<br>Less 3 | |

| | RESPONSE | SKIP |
|---|---|---|
| 115. Everything considered, how much the family earned and the things you had to spend money on, was the last year a good year, about the same, or a hard year compared to the preceding 2/3 years ? | Good 1<br>Same 2<br>Hard 3 | |
| 116. Did you have any cash in your own hand last week ? | Yes 1<br>No 2 | → 119 |
| 117. Did you spend any money last week ? | Yes 1<br>No 2 | → 119 |
| 118. Did you get prior permission to spend money from anyone ? | Yes 1<br>No 2 | |
| 119. Today do you have two or three Taka in your hand ? | Yes 1<br>No 2 | |

## SECTION 2

## FERTILITY QUESTIONS

| | RESPONSE | SKIP |
|---|---|---|
| 201. Pregnancy status at baseline interview | Yes 1<br>No 2 → 206<br>Not sure 3 → 206 | |
| 202. When we spoke to you last year you were pregnant. What was the outcome of that pregnancy ? | Baby boy born alive 1<br>Baby girl born alive 2<br>Pregnancy ended without birth 3 → 204<br>Was not pregnant 4 → 206 | |
| 203. When was your baby born ? | Month _____<br>Year _____ → 211 | |
| 204. When did the pregnancy end ? | Month _____<br>Year _____ | |
| 205. For how many months were you pregnant ? | Month [ ][ ] → 211 | |
| 206. Have you ever been pregnant since we spoke to you last ? | Yes 1<br>No 2 → 211 | |
| 207. What was the outcome of that pregnancy ? | Baby boy born alive 1<br>Baby girl born alive 2<br>Pregnancy ended without birth 3 → 209<br>Currently pregnant 4 → 213 | |
| 208. When was your baby born ? | Month [ ][ ] Year [ ][ ] → 211 | |
| 209. When did the pregnancy end ? | Month _____<br>Year _____ | |
| 210. For how many months were you pregnant ? | Month [ ][ ] | |

| | RESPONSE | SKIP |
|---|---|---|
| 211. INTERVIEWER: Please check Q.203-205 and 208-210 and fill in the months pregnant on the calendar in Table 2. | | |
| 212. Are you pregnant now ? | Yes 1<br>No 2<br>Not sure 3 | → 215 |
| 213. For how many months have you been pregnant ? | [ ][ ] | |
| 214. INTERVIEWER: Record current pregnancy on contraceptive calendar in Table 2 | | |
| 215. INTERVIEWER: Fill in blanks from Q.202 and 207, then ask:<br>When we talked to you last year, you had ___ sons and ___ daughters. And you have had (no)/___son/___daughter during the last year. So, you have now ___ sons and ___ daughters. Is that correct ? | Yes 1<br>No 2 | → 220 |
| 216. Why isn't it correct ? | Child died 1<br>Other 2 | → 220 |
| 217. How many of your children died ? | Sons died [ ]<br>Daughters died [ ] | |
| 218. INTERVIEWER: Record total number of sons and daughters now living | Son [ ]<br>Daughter [ ] | |

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| | RESPONSE | SKIP |
|---|---|---|
| 219. INTERVIEWER: If the answer to Q.216 is other than child died, probe and correct answers to Q.203-213. | | |
| 220. (In addition to the baby you are carrying now) Would you like to have a (another) child ? | Yes 1<br>No 2 | → 223 |
| 221. How many ? | [ ][ ]<br>Number | |
| 222. Do you definitely want to have (another) child or are you not sure ? | Definitely want 1<br>Not sure 2<br>_____ 3<br>(Specify) | → 301 |
| 223. Do you definitely want to have no (more) children or are you not sure ? | Definitely no more 1<br>Not sure 2<br>_____ 3<br>(Specify) | |

## SECTION 3

## CONTRACEPTION

| | RESPONSE | SKIP |
|---|---|---|
| 301. Now I would like to talk to you about a different topic. There are various ways or methods that a couple can use to delay or avoid a pregnancy. | | |
| 302. Have you ever heard of oral pills ? | Yes 1<br>No 2 | → 305 |
| 303. Do you know any place or person from where oral pills can be obtained ? | Yes 1<br>No 2 | → 305 |
| 304. What are those places or persons from where oral pills can be obtained ?<br>(Multiple responses permitted) | FP Worker 1<br>Shop/Pharmacy 2<br>Clinic/Hospital 3<br>Depot-holder 4<br>Others_____ (Specify) 5 | |
| 305. Have you ever heard of condoms ? | Yes 1<br>No 2 | → 308 |
| 306. Do you know any place or person from where condoms can be obtained ? | Yes 1<br>No 2 | → 308 |
| 307. What are those places or persons from where condoms can be obtained ?<br>(Multiple responses permitted) | FP Worker 1<br>Shop/Pharmacy 2<br>Clinic/Hospital 3<br>Depot-holder 4<br>Others_____ (Specify) 5 | |

| | RESPONSE | SKIP |
|---|---|---|
| 308. When we talked to you last year in Jaishtho you told us that at that time you/your husband were (not using a family planning method)/using _____. Is that true ? (method) | Yes 1<br>No 2 | ---> 312 |
| 309. Were you or your husband using a method to avoid pregnancy at that time ? | Yes 1<br>No 2 | ---> 311 |
| 310. What was that method ? | Oral Pill 01<br>Condom 02<br>Foam/Jelly 03<br>Injection 04<br>IUD 05<br>Female sterilization 06<br>Male sterilization 07<br>MR 08<br>Safe period 09<br>Withdrawal 10<br>Abstinence 11<br>Other_____ 12<br>(specify) | |
| 311. Why do you think the answer we have recorded from last year was wrong ?<br>INTERVIEWER: Record verbatim response | _____<br>_____<br>_____<br>_____ | |
| 312. Are you and your husband doing something now to avoid pregnancy ? | Yes 1<br>No 2 | ---> Table 2 |
| 313. What method are you using ? | Oral Pill 01<br>Condom 02<br>Foam/Jelly 03<br>Injection 04<br>IUD 05<br>Female sterilization 06<br>Male sterilization 07<br>MR 08<br>Safe period 09<br>Withdrawal 10<br>Abstinence 11<br>Other _____ 12<br>(specify) | |

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TABLE 2 : Calendar on Contraceptive Related Information for the past 12 months

| 314 Year/ months (from current month) | 315: Pregnancy INTER-VIEWER: Refer back to Q.203 & 213 and fill in the re-quired inform-ation Write: 1 for Pregnant 2 for not pregnant | 316:Method Use INTERVIEWER: Fill in the code for contraceptive use for the month of base-line survey and current month. Probe for duration of continuous use, taking into account periods of pregnancy (1) | (ONLY FOR PILLS AND CONDOMS) 317: For each month in which pills or condoms are used, ask: Did you or your husband get new supplies during this month ? 1 - Yes 2 - No | 318 : If Q.317 is yes, ask what was the source of supply (2) | 319 : Was there a charge ? 1. Yes 2. No | 320 : If 319 is yes, ask: How much was it charged for ? (per cycle/ dozen) | 321 : Did you pay this money or ask for credit ? Paid - 1 Asked for Credit-2 | 322 : Dropout If dropped out, ask : Why did you drop out ? (3) | If answer to Q.322 is 10 or 11, don't ask Q.323. but write full explanation at bottom<br>323 Apart from the reasons you stated, did the price of the method affect your decision to stop ? Yes 1 No 2<br>If yes, record verbatim explanation |
|---|---|---|---|---|---|---|---|---|---|
| (1397) | | | | | | | | | |
| Jaishtho | | | | | | | | | |
| Ashar | | | | | | | | | |
| Sraban | | | | | | | | | |
| Bhadra | | | | | | | | | |
| Ashwin | | | | | | | | | |

Table 2 continued on next page

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TABLE 2 : Calendar on Contraceptive Related Information for the past 12 months (continued)

| 314 Year/ months (from current month) | 315: Pregnancy INTER-VIEWER: Refer back to Q.203 & 213 and fill in the required information Write: 1 for Pregnant 2 for not pregnant | 316:Method Use INTERVIEWER: Fill in the code for contraceptive use for the month of base-line survey and current month. Probe for duration of continuous use, taking into account periods of pregnancy (1) | 317: For each month in which pills or condoms are used, ask: Did you or your husband get new supplies during this month ? 1 - Yes 2 - No | 318 : If Q.317 is yes, ask what was the source of supply (2) | 319 : Was there a charge ? 1. Yes 2. No | 320 : If 319 is yes, ask: How much was it charged for ? (per cycle/ dozen) | 321 : Did you pay this money or ask for credit ? Paid - 1 Asked for Credit-2 | 322 : Dropout If dropped out, ask : Why did you drop out ? (3) | If answer to Q.322 is 10 or 11, don't ask Q.323. but write full explanation at bottom<br>323 Apart from the reasons you stated, did the price of the method affect your decision to stop ? Yes [1] No [2]<br>If yes, record verbatim explanation |
|---|---|---|---|---|---|---|---|---|---|
| Kartik | | | | | | | | | |
| Agra-hayan | | | | | | | | | |
| Poush | | | | | | | | | |
| Magh | | | | | | | | | |
| Falgun | | | | | | | | | |
| Chaitra (1398) | | | | | | | | | |
| Baishakh | | | | | | | | | |

(1) Method Codes: Pill-01; Condom-02; Diaphragm/foam/jelly-03; Injection-04; IUD-05; Female Sterilization-05; Male Sterilization-07; MR-08; Safe Period-09; Withdrawal-10; Abstinence-11; Other_____ -12; None-13.
(specify)

(2) Source of supply: Fieldworker-1; Shop/Pharmacy-2; Qualified Doctor-3; Traditional Doctor-4; Clinic/Hospital-5; Mobile Camp-6; Depot-holder-7; Other_____ -8; Don't know-9.
(specify)

(3) Reasons for dropout: Side-effects (including menstrual problems)-1; Respondent's health consideration-2; Respondent does not like using-3; Husband's objection to using method-4; Husband/wife too old-5; Supply problem-6; Wants another child-7; Became pregnant while using the method-8; Temporarily separated from husband-9; Cannot afford method-10; Husband objected to paying for method-11; Other (INTERVIEWER: write complete explanation)-12.

Verbatim explanation of price as a factor for dropping method (Q.322, 323): _____

## SECTION 4

### AWARENESS ABOUT PRICING INTERVENTION AND CLIENTS' RESPONSE TO CHARGING

| | RESPONSE | SKIP |
|---|---|---|
| 401. The GOB has started charging for condoms distributed by the FWs nationwide. Are you aware of this ? | Yes 1<br>No 2 | → 501 |
| 402. What is your opinion about what you and your husband should do as a result of this policy ?<br>(Single Answer) | Pay fieldworker for distributed method 1<br>Switch to free method 2<br>Buy from shop 3<br>Ask for credit 4<br>Look for free supply 5<br>Stop using family planning 6<br>Never intended to use condoms 7<br>Pricing policy does not affect our area 8 | |
| 403. What is his opinion about what you and he should do as a result of this policy ?<br>(Single Answer) | Pay fieldworker distributed method 1<br>Switch to free method 2<br>Buy from shop 3<br>Ask for credit 4<br>Look for free supply 5<br>Stop using family planning 6<br>Never intended to use condoms 7<br>Pricing Policy does not affect our area 8<br>Don't know husband's opinion 9<br>Husband does not know about policy 10 | |
| 404. INTERVIEWER: Ask Questions 404-413 only to respondents in the experimental union.<br>When did you first hear about this ? | [ ][ ] months ago | |
| 405. Who told you first about the GOB's decision regarding the pricing of condoms nationwide ? | Family Planning Worker 1<br>Other family members 2<br>Friends/Neighbors 3<br>Baseline Survey 4<br>Other _____ (specify) 5 | |
| 406. What is the price per dozen of condom ? | Tk. _____ | |

| | RESPONSE | SKIP |
|---|---|---|
| 407. Has this price been changed ? | Yes 1<br>No 2<br>Don't know 3 | → 410 |
| 408. Who told you about this change ? | Family Planning Worker 1<br>Other family member 2<br>Friends/neighbors 3<br>Others _____ (specify) 4 | |
| 409. What was the previous price ? | Tk. _____ | |
| 410. Do you know that the GOB has started charging for oral pills in Lebutala Union ? | Yes 1<br>No 2 | → 501 |
| 411. When did you first hear about this ? | [ ][ ] months ago | |
| 412. Who told you first about the GOB's decision regarding the pricing of oral pills in Lebutala Union ? | Family Planning Worker 1<br>Other family member 2<br>Friends/neighbors 3<br>Baseline Survey 4<br>Others _____ (specify) 5 | |
| 413. What is the price per cycle of oral pills ? | _____ Taka _____ Paisa | |

## SECTION 5
## FIELDWORKER CONTACT

| | RESPONSE | SKIP |
|---|---|---|
| 501. Did a family planning worker visit you during the last year ? | Yes 1<br>No 2 | → 522 |
| 502. How many times did a worker visit you during the last year ? | [ ][ ] times | |
| 503. How many months ago did the worker last visit you ? | [ ][ ] months ago | |
| 504. INTERVIEWER: Did the respondent use pills during last year ? (Check Table 2) | Yes 1<br>No 2 | → 506 |
| 505. During the last year, did the fieldworker have a discussion with you about the pill ? | Yes 1<br>No 2 | |
| 506. INTERVIEWER: Did the respondent use condoms in the last year ? | Yes 1<br>No 2 | → 508 |
| 507. During the last year, did the fieldworker have a discussion with you about condom ? | Yes 1<br>No 2 | |
| 508. During the last year, did the fieldworker discuss methods other than pill or condom with you ? | Yes 1<br>No 2 | → 510 |
| 509. What methods ?<br><br>TERMINATE INTERVIEW IN CONTROL UNION | Oral Pill 01<br>Condom 02<br>Foam/Jelly 03<br>Injection 04<br>IUD 05<br>Female sterilization 06<br>Male sterilization 07<br>MR 08<br>Safe period 09<br>Withdrawal 10<br>Abstinence 11<br>Others _____ 12<br>(specify) | |
| INTERVIEWER: ONLY FOR RESPONDENTS IN THE EXPERIMENTAL UNION | | |
| 510. INTERVIEWER: Did respondent get any pills or condoms from the fieldworker on credit ? (Check Table 2) | Yes 1<br>No 2 | → 515 |

| | RESPONSE | SKIP |
|---|---|---|
| 511. Why did you have to ask for credit ? | Verbatim: _____ _____ _____ | |
| 512. How many cycles/condoms have you taken on credit ? | _____ cycles<br>_____ dozens | |
| 513. Have you paid back none, some, or all of the amount to the fieldworker ? | None 1<br>Some 2<br>All 3 | → 518 |
| 514. INTERVIEWER: Did the respondent pay for any pills or condoms received from the fieldworker ? (Check Table 2) | Yes 1<br>No 2 | → 518 |
| 515. Did you get permission from your husband before you gave the fieldworker money for supplies ? | Yes 1<br>No 2 | |
| 516. Did you have any problems paying for pills or condoms ? | Yes 1<br>No 2 | → 518 |
| 517. What problems ? | Verbatim: _____ _____ _____ | |
| 518. Did the fieldworker ever refuse to give you pills/condoms because you could not pay or because you wanted it on credit ? | Yes 1<br>No 2 | → 520 |
| 519. What did you do ? | Adopted method distributed free 1<br>Bought from shop 2<br>Found free source of pills and condoms 3<br>Found/borrowed money to pay fieldworker 4<br>Used no method 5 | |

| | RESPONSE | SKIP |
|---|---|---|
| 520. Did you ever offer to pay the fieldworker for pills or condoms in kind rather than in cash ? | Yes 1<br>No 2 | <br>→ 522 |
| 521. What happened ? | Fieldworker accepted in kind payment 1<br>Fieldworker refused in kind payment and: Respondent paid cash 2<br>Respondent got supplies on credit 3<br>Respondent did not get supplies 4<br>Other _____ (Specify) 5 | |

522. TERMINATE THE INTERVIEW.

When you terminate the interview and before you leave the respondent, check back over the schedule and make sure there is an answer to all applicable questions, skip instructions are correctly followed and that responses are entered legibly and in the correct form. THANK THE RESPONDENT FOR HER TIME AND COOPERATION.

Time Ended: _____