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Establishing a Systematic Pricing Mechanism for MCH-FP Services of NGOs in Urban Bangladesh:

A Preliminary Assessment

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Foreword

I am pleased to release these reports on urban Maternal and Child Health and Family Planning issues which are based on the operations research activities of the MCH-FP Extension Project (Urban) of the Centre. Over the years, the Centre has acquired a unique expertise on urban development matters that ranges from operations research on reproductive health, child survival and environmental issues to providing technical assistance for capacity building to service delivery organizations working in urban areas.

This work has produced important findings on the health conditions and needs of city dwellers, particularly the poor and those living in slums. The research has also identified service delivery areas in which improvements need to be made to enhance effectiveness. Together, these research findings have been translated into interventions currently being applied in government and non-government settings.

In order to carry out this innovative work, the Centre has established a partnership effort known as the Urban MCH-FP Initiative, with different ministries and agencies of the Government of Bangladesh and national non-government organizations, notably Concerned Women for Family Planning, a national NGO with wide experience in the delivery of MCH-FP services. The partnership receives financial and technical support from the United States Agency for International Development (USAID).

The overall goal of the partnership is to contribute to the reduction of mortality and fertility in urban areas. In practice, this joint work has already resulted in the development and design of interventions to improve access, coordination and sustainability of quality basic health services to urban dwellers with emphasis on the needs of the poor and those living in slum areas.

The Centre looks forward to continuing this collaboration and to assist in the wider dissemination and application of sustainable service delivery strategies in collaboration with providers in government, the NGOs and the private sector.

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Summary

The increasing pressure to sustain MCH-FP programmes has led most service delivery organisations to explore alternative financing. Programme managers and policy makers attempted to introduce prices or increase existing price levels of services during the last decade. However, there was very little systematic efforts for price determination, and price setting mechanisms were not guided by proper pricing policies. The limited ability of poor clients to pay for services was often not taken into account; cross subsidization was not possible; and cost recovery was not optimal. The expected results of revenue generation were often undermined by practical implementation problems. Such forms of pricing would not be conducive toward enhancing institutional capacity for cost recovery and financial sustainability.

In this context, the MCH-FP Extension Project (Urban) of ICDDR,B initiated an operations research to establish a systematic pricing mechanism for NGOs providing MCH-FP services in urban areas. The study was conducted in collaboration with a leading national NGO, Concerned Women for Family Planning (CWFP).

The overall objective of the intervention was to increase cost recovery through systematic price setting mechanism. It was expected that price setting should be effective in order to minimize subsidization and increase cost recovery without reducing the utilization of services and affecting equity. The intervention attempted to develop guidelines for the pricing mechanism through the following three different steps:

a. *determining the cost of producing the services*

b. *assessing the willingness of clients to pay for the services*

c. *surveying the prices of other providers in the market for the same goods and services*

The costs of providing the family planning services to the new acceptors both at the field and the clinics were found to be high because in such cases, field workers spent more time for visits and motivation. Assessment of clients' willingness to pay for services revealed that the clients were, in most cases, willing to pay more than what they were then paying for MCH-FP services provided by the NGOs. This indicated that there was scope for increasing the service charges. Market assessments to examine the price of other providers, particularly other NGOs, were also done. The prices at the pharmacies for pills and condoms and antenatal care were also taken into consideration. MCH-FP services among other NGOs were found to be provided free of charge by some and at nominal charges similar to those of CWFP. The prices of low-cost pills and condoms of Social Marketing Company (SMC) sold by the pharmacies were found to be comparable with those of CWFP and other NGOs. Antenatal care at the pharmacies was more expensive compared to NGOs and the CWFP units considered in the intervention.

A new set of prices was determined for the MCH-FP service considering the assessment of costs, willingness of the clients to pay and market assessment. In most cases, marginal increases were made. These new sets of prices were introduced in January 1997.

Introduction of receipt for acknowledging the payment made by the clients helped service providers to improve the confidence of clients on them. The clients were able to know what they are paying for, and this made it easy for providers to convince them to pay the increased amount. The time period was not enough to examine the impact of the price

increase on the revenue generation. However, cost recovery ratios, for four months before and after the price changes through systematic pricing mechanism had increased during the period.

The experience and perception of the programme managers and senior management of CWFP about the systematic approach in setting prices were evaluated. The discussion revealed that a systematic price setting mechanism facilitated the programme managers to examine the different aspects of the supply of and demand for the services. The programme managers felt that examining the cost of producing the services would help them take strategic decisions in setting prices on the basis of priority and cost recovery goals. They could examine the clients' willingness to pay and more specifically the consumers' surplus existing in the market. They could also assess the prices of other providers of the services in the market, which were taken into consideration in setting new prices.

1. Introduction

With the growth of the nation's population, resource requirement for financing health and family planning services is enormous. In order to achieve the national goal of attaining replacement fertility rate of 2.2 by the year 2005, family planning services in Bangladesh need to be extended from 27 million to 40 million families by 2005. The number of contraceptive users would have to be increased from 12 to 28 million, and CPR has to be raised to 70 percent. In order to reduce the infant mortality rate to 50 per 1000 by 2005, the immunization services need to be extended to cover approximately 6.3 million infants from the present level of 4.2 million infants (less than 1 year of age) per year. All these would require the extension of programme coverage, which would increase the cost of providing services. The estimated annual cost of family planning programme alone to achieve the above mentioned goals would require an increase from Tk. 480 crore in 1995 to Tk. 880 crore (US $ 220 million) in 2005 (Robert F Cunnane, 1995).

2. Background

Family planning programmes in Bangladesh are heavily dependent on donors' fund. During 1991/92 and 1994/95, over 60% of the total fund in the population sector was obtained from external resources [Ministry of Health and Family Welfare, 1995]. Due to changing economic and political realities in many major donor countries, external fund is gradually being reduced. On the other hand, the country's internal resource allocation in the health and family planning sector is only about 6.8% of the national revenue budget [Ministry of Health and Family Welfare, 1995 (2)]. It is often not possible to increase financial allocation internally by

increasing the tax ratio[1], because the country has a small tax base. Besides, the priority of allocation of resource from tax revenue is often more on visible development projects rather than on the health and family planning sector.

Due to persistent economic problems in financing the public health sector, and for the reforms under structural adjustments, Bangladesh, like many other developing countries, has considered the introduction of alternative financing and cost recovery measures for health and family planning programmes. Non-governmental organisations are under pressure to foster an environment conducive to financial sustainability and cost recovery. The limitations of alternative forms of financing and the need to support health and family planning sector have led many government and NGOs toward implementing user charges. The main justification is: the consumers are already paying some prices for the services, and at the same time, facing a number of other costs.[2] It was found in a survey that about 80% of the current users of contraceptives in selected urban areas of Dhaka have paid for their adopted methods [Begum *et al.* 1994]. However, there are users of pills who are receiving the supplies free of charge at their doorstep in the rural areas of the country.

2.1 Problem Statement

There has been a practice among the NGOs, and to some extent, in the government, of charging some nominal price/service charges for contraceptives in Bangladesh since July 1990. The government providers

[1] only 12% of GDP consists of tax revenue

[2] Other costs include opportunity cost of waiting time, travel time, direct travel costs, etc.

charged for condoms only, while NGOs had fees for pills and condoms. These prices, which were nominal in all cases, were initially set to stop wastage and introduce a sense of value for family planning commodities among clients. Later, to improve financial sustainability, NGOs have, *inter alia*, used MCH-FP service pricing partially for cost recovery. In many instances, they either changed their prices that already exist or introduced the price for the services that were provided free of charge.

These prices were often set arbitrarily, and were not guided by a proper pricing policy or structure. In such cases, cost recovery may not be optimal, poor clients' inability to pay were not always taken into account, and cross subsidization had rarely been adopted. The expected results of revenue generation are often undermined by practical implementation problems. The revenue generated through unsystematic pricing or fees set arbitrarily are often not properly managed or utilized. Such unsystematic pricing mechanism may not be effective for a move toward financial sustainability in the long run.

A stable source of financing for a sustainable MCH-FP programme of NGOs would require a pricing mechanism guided by a policy and process. The issues that should be taken into account are: the cost of producing services, the willingness and ability of clients to pay for the services, the desired level of cost recovery, acceptability of the charges or prices, the administrative cost, and management of the revenues gained.

2.2 The Intervention

The MCH-FP Extension Project (Urban) of ICDDR,B initiated an operations research to introduce a systematic pricing mechanism for NGOs providing MCH-FP services in the urban areas. Concerned Women

for Family Planning, one of the partners in the Urban Operations Research Initiative, collaborated in this effort. The CWFP is one of the largest national NGOs working in the urban areas of Bangladesh with 18 units spread over the country.

2.3 Objectives

The overall objective is to increase cost recovery through systematic price setting mechanism.

The specific objectives are:

(i) to develop a guideline for price setting mechanism

(ii) to test the implementation and effects of the new pricing mechanism and revenue generation on cost recovery

(iii) to assist in institutionalization of a systematic pricing mechanism

The utilization and management of revenue, which is an essential part of price setting, is beyond the scope of the intervention. The only issue of revenue collection system considered was the introduction of a receipt system for collection of fees. The cost recovery ratios including the level of service utilization were also monitored.

2.4 Conceptual Framework of the Intervention

Leaving MCH-FP services to the market for the price to be determined is neither possible nor desirable for mainly two reasons. These are:

(i) externalities prevailing in the production and consumption, where marginal cost pricing makes the production and distribution inefficient, and

(ii) such services are to be considered as *merit goods*[3] and are supplied for social benefits, where marginal cost pricing neglects the equity consideration.

In economic theory, the prices are determined in the market, where we think of a market as being divided neatly between buyers and sellers and the correct price as one at which sellers have the incentive to produce exactly the amount the customers want to buy (the market-clearing price). This is a cost-based principle because the sellers have an incentive to bring products to the market only when the price they can charge covers at least the cost of producing the goods. This cost-based approach may have little apparent application to the NGOs or the government MCH-FP service providers, which is always subsidized, but it is actually quite useful. Even if the policy for pricing public or social goods gives less importance to the issues of pure market mechanism and marginal cost pricing, it is important to consider the cost of producing the service so as to see what differences it makes to the level of cost recovery with different levels of prices that can be charged. Additionally, customers' willingness to pay, and consumers' alternative choice in the market also need to be considered (Griffin, 1987).

In an attempt to develop guidelines for setting prices or increasing service charges/prices, the intervention included the following steps:

a. *determining the cost of producing the services*
b. *clients' willingness to pay for the services*
c. *prices set by other providers in the market for the same goods and services*

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[3] Goods and services for which a society decides on the preferences of individuals and are not left to the market to determine the level of consumption

2.4.1 *Costing the services*

One of the basic tools for economists and indeed for planners is costing exercise and cost analysis of goods and services. In the process of the costing exercise, there are a number of steps that need to be followed, the first being determination of the stakeholders and the different types of costs incurred from their perspectives.

Cost from whose perspectives?

In determining the costs of programmes, an important aspect of the costing exercise is to identify all the costs involved and on whom they fall. For example, antenatal care services may incur costs for each of the following parties:

- health services, for example, in the form of drugs or personnel
- individual, in the form of charges, transport, costs of time away from home or work;
- individual's employer or family, in covering for her absence.

What should be costed?

The basic approach to what may be called bottom-up costing requires identification of all the resources required in the implementation of the activity; and of whether the costs are capital or recurrent.

Identification of these costs often amounts to listing the *ingredients*[4] of the programme, both variable cost[5] and fixed overhead cost[6].

Translate the resources into money

After all these inputs are identified and listed, these need to be valued in terms of money, using, where necessary, *shadow prices*[7] for determining the cost of all these inputs.

Allocation of cost

For an ultimate aim of determining the cost per unit of services, it is necessary to allocate the cost incurred for all different inputs, personnel (directly and indirectly involved in providing the service) drugs, medical supplies, other supplies, other cost (rent, utilities, etc.).

2.4.2 *Willingness to pay for services*

Willingness to pay (WTP) is being increasingly used in assessing the demand for services at different levels of prices because prices based only on cost take no account of the demand, or people's willingness to pay. The technique of WTP is based on the principle that the maximum amount of

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[4] Following *ingredients* approach of costing which was also used in the Bamako Initiative

[5] The cost which varies with the level of output

[6] The cost that is fixed in the short run and had to be initially incurred to produce a given capacity of output , even zero level of production; such cost is positive

[7] A price which is imputed as the marginal value of a good or opportunity cost of a resource and may differ from market price

money an individual is willing to pay for a commodity is an indicator of the utility or satisfaction of the consumer of that commodity (Ryan *et al* 1996). When deciding on maximum amount that would be paid for the services, an individual consumer will take into account of the characteristics or attributes that are important to him or her. WTP approach to assess the demand was felt to be appropriate when considering the value of the MCH-FP services a clients will assign to these. A client would incorporate the values of all the outcomes from utilization of the MCH-FP services.

2.4.3 *Assessment of the market*

Besides demand factors, it is also important to examine supply side issues for setting prices, i.e who the other providers are, and what prices they are charging for similar services.

3. Methodology and Planning of the Intervention

Three units of the CWFP were selected for the intervention. These units are: the Wari unit in Dhaka, the Chittagong Branch, and the Rajshahi Branch, located in the three major cities of Bangladesh. The MCH-FP services of these CWFP units mainly include: door-step delivery of pills and condoms, supply of pills and condoms at the clinic, provision of injectables and IUD at the clinic, provision of antenatal and postnatal care, maternal TT, child immunization, and general health care for mother and child. The Chittagong unit also provides follow-up doses of injectables through home visits.

The intervention aimed at:

a. developing a strategy for a pricing mechanism

b. determining effective and appropriate service charges
c. examining the impact of price changes on cost recovery and service utilisation.

The prospects of institutionalisation of the pricing mechanism were inquired among programme managers and central management authority of CWFP. The discussion focused on the opinions of NGO managers on how systematic pricing schemes can be established within the organisation.

3.1 Developing a Strategy for Pricing Mechanism

3.1.1 Assessment of cost of providing the services

The purpose of the costing exercise was to determine the unit cost of producing MCH-FP services. To start with the costing exercise, all the services that are provided by the units at different outlets, field or clinics, were identified and listed. The services provided were classified into two groups: Family Planning, and Maternal and Child Health Services.

The family planning services included:

- recruiting new acceptors of pills and condoms in the field and at the clinic
- resupply of pills and condoms to a current user in the field and at the clinic
- roviding services to new acceptors of injectables, services for follow-up doses and side-effect management to an injectable user, referrals for injectables in the field
- IUD service at the clinic to the new acceptor, follow-up service and side-effect management of the IUD users, removal of IUD of the current users

The maternal and child health services included:

- providing antenatal and post-natal care
- treatment of sick mother and sick child
- Maternal TT
- Child Immunization
- Distribution of vitamin A capsules

The total volume of all the above services provided from the two different outlets - field and clinics - were noted.

In this intervention, the costs from providers' perspective were examined, and the cost borne by the clients was not considered.

The resources used for producing the services were first identified. These resources or the inputs required were then classified into capital and recurrent costs. Only the recurrent costs were taken into account to estimate the degree of recovering the operational costs of the programme.

The commodities or inputs directly used for services were listed separately. The inputs used for the services were classified as: personnel, family planning commodities, EPI supplies, drugs, non-drug medical supply, and non-medical supplies. Data collection instruments were used for collecting all the necessary information from the selected branches of CWFP. The information on service volume of all the different types of services, and inputs used in the exercise was obtained for 1995.

For personnel cost, the salaries and benefits paid to all the employees at the branches were considered. The market prices of drugs

and supplies (medical and non-medical supplies) were used in determining the cost of drugs and supplies.

The family planning commodities and EPI supplies were also costed[8], even though these are received by CWFP free of charge from the Government. This is done not only to determine the opportunity cost of the resource used for such commodities which could have been spent otherwise but more because to show that such cost would have to be incurred by NGOs if the donors' contribution is withdrawn from such programmes.

Service-wise proportions of time for all the services were worked out. All cost items were apportioned among the various services according to proportions/ratios determined on the basis of time allocated to different services in order to determine the cost per unit of services.

3.1.2 Assessment of willingness to pay

It was observed, the prices of commodities and service charges of the different units of CWFP in the three different cities of the country were nominal. It was assumed that charges paid by users of the CWFP services do not reflect the maximum amount they were willing to pay, which might be greater.

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[8] These were costed on the basis of the procurement prices of the Family Planning Logistics Management (FPLM), a corporate agency for logistics management of USAID family planning programmes in Bangladesh

The questions[9] on willingness to pay were designed to remind the client of valuations and choices that they have made and to value the services with respect to the prices. This can be attributed as contingent valuation (CV) to assess not only the amount the clients are willing to pay but also to assess whether the amount the clients are paying reflects the maximum amount. Since direct interviews were carried out for the willingness to pay, bidding technique (Russel *et al*, 1995) was used but the bid amount did not vary among clients as is often in the case of open-ended contingent valuation questions.

Different bids of price increase over the existing levels were tested. Individuals were asked if they would be willing to pay a first level of increase over the existing prices. If the answer was found to be affirmative i.e. 'yes', the clients were asked whether they would pay the next higher levels of prices. In this study, three bids of higher prices were tested[10]. The clients were asked directly whether they would pay specified amounts for the given services, with the possible answer: `yes' or `no'. The willingness to pay was estimated directly from the data provided (Quayyum *et al.* 1997).

Two questionnaires - one for family planning service and another for the maternal health service - were administered to examine the willingness to pay for the MCH-FP services in a selected sample of user.

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[9] The main four are, as explained in Ryan *et al.* (1997), open-ended; bidding and payment card; and closed-ended

[10] Normally in bidding exercise, the bids are increased until they reach amounts that the respondents are not willing to pay

Sample Selection for the survey on willingness to pay for MCH-FP services

Questions on the willingness to pay were asked to those clients who were using the CWFP facilities for the selected MCH-FP services.

The family planning services that were included for the assessment of willingness to pay were door-step supply of pills and condom, injectable service at the clinic. The maternal and child health services that were included to assess the willingness and ability to pay were: antenatal care, maternal and child immunization, treatment of sick mother and sick child.

For the survey on willingness to pay, the number of clients selected in each category of services (all the selected MCH and FP services) was 30 or more. The basis of selecting such a number is that if 21 (73%) out of 30 agree to a particular bid, this means that the majority, (more than 50%) of the sample are in favour of such increase, and this can be said with 95% confidence level (Lemeshow and Lwanga 1990).

To draw the sample of clients receiving the door-step delivery of pills and condoms, 60% of the total field workers were selected randomly in each intervention units. From the field workers' couple registration book, 60 clients of oral pills and condoms were selected to ensure that at least 30 clients could be interviewed.

To draw the sample of clients receiving the selected services at the clinics, (injectable contraceptives, ANC, maternal and child immunization), all the clients who attended and used the services at each intervention unit (facility) in the last one month were listed. Sixty clients in each category were selected randomly from the list, and at least 30 to

40 clients were interviewed to assess the willingness to pay. In cases where such type of clients in the last one month was less than sixty, the list was extended to include the clients visited in the last three months, or even last four months, so that the required number can be interviewed.

3.1.3 *Assessment of the market*

The Government, CWFP units and other NGOs had their respective catchment areas for door-step delivery of pills and condoms. However, as far as clinical services were concerned, other NGO clinics and government clinics often located in the same catchment areas, were found to be supplying pills and condoms and providing other MCH services.

For the assessment of prices of other providers in the market, NGOs other than CWFP working in the area were considered. From the list of NGO facilities located in the areas, three NGOs were selected. Other providers in the government sector and private sector were not included for such assessments. Providers in the public sector provided services free of charge, and the private sector providers' prices were much higher than the prices charged by the NGOs. However, prices of pills and condom and for antenatal care at the pharmacies in the catchment areas were examined.

The programme managers were requested to select the NGOs which they considered to be their competitors. The prices they charged for supply of pills, condoms, and for selected maternal and child health at the clinic, were examined.

3.2 Determining Effective and Appropriate Prices

The results of the assessment of cost, willingness to pay and market assessment were used in setting the new prices for the MCH-FP services. The unit mangers and senior management of CWFP had a meeting to discuss the issue to decide upon the new prices.

3.3 Evaluation Method

The evaluation considered the following two aspects:

(i) opinions, views and experiences of the programme mangers and senior management of CWFP on the pricing mechanism, and

(ii) assessment of cost recovery and service use in the intervention units.

3.3.1 *Opinions, views and experiences of the programme managers and senior management of CWFP on systematic pricing mechanism*

In order to examine the possibility of the application of the steps of the systematic pricing mechanism, discussions were arranged at the intervention units. The respondents consisted of the programme manager of the unit, paramedic, health worker, representative of the field supervisors, and representative of field workers of the unit. Another interview was also carried out at the central office with the group of senior management officials.

The discussions were made based on guidelines, which covered questions relating to the objective and the experiences with the user charges or price they had been following before the pricing intervention, their idea about the steps to be followed or issues to be considered to implement a pricing policy, and their views on institutionalising the

current pricing mechanism. Their views and opinions on the changes made on prices and the pricing system were also sought.

3.3.2 *Assessment of the cost recovery and service utilisation*

The period was too short to evaluate the impact of price change on the cost recovery ratio[11]. However, the revenue generation[12] before and after introduction of the new sets of prices was examined. The cost was considered not for each type of services, but of all the services and was determined on the basis of the total monthly expenditure for four months before introducing the new prices (September-December 1996) and four months after that (January-April 1997).

4. Findings

This section presents the findings on assessments of cost, willingness to pay and market price levels, setting the new prices, the opinions of programme managers of the CWFP, impact of new prices on cost recovery and utilisation of services.

4. 1 Cost of Producing the Services

The results of the costing exercise are shown in Table 1. It was found that the costs of providing services to new acceptors of pills and condoms were high at all the units included in the study. In some cases, the differences in the cost of some services, for example for ANC, among

[11] Cost Recovery Ratio is the Total Revenue/Total Cost. Total revenue is the total earnings of the unit from all the MCH-FP services provided at the field and clinic.

[12] The donations received during the period was excluded.

the units are very high. One important factor that has contributed to such differences was the allocation of personnel time for different services. Service volume also affected the unit cost, low volume of service in most of the cases led to high unit cost.

Table 1. Unit cost (in Taka[13]) of services in the intervention units

Type of Services	Intervention Unit		
	Dhaka	Chittagong	Rajshahi
Pill: new acceptor at clinic	89.7	109.7	40.7
Pill: new acceptor in field	87.9	174.0	63.7
Pill: resupply at clinic	40.6	47.2	40.6
Pill: resupply in field	27.1	47.6	33.9
Condom: new acceptor at clinic	100.4	76.9	55.6
Condom: new acceptor in field	80.8	140.8	68.1
Condom: resupply at clinic	75.8	61.2	39.0
Condom: resupply in field	42.1	61.8	32.3
Injection: new acceptor	142.3	135.6	93.8
Injection: follow-up	135.4	102.3	92.7
ANC	101.9	119.8	232.3
Treatment of sick mother	63.8	55.0	208.1
Treatment of sick child	56.9	55.0	221.9
Maternal TT	38.0	33.6	25.0
Child immunization	39.9	45.1	12.5

[13] 1 US$ = Taka 44.66 at the 1996 exchange rate

4.2 Willingness to Pay for MCH-FP Services

The results of the willingness to pay for the MCH-FP services are presented in two sections: for family planning services and MCH services.

Willingness to pay for family planning services

Most of the clients using pills and condoms were found to be willing to pay the increased bid of service charges. The first step of increase from Taka 2 to Taka 3 for one cycle of pills and for one dozen of condom was acceptable by most of the clients. Clients in Rajshahi and Dhaka were more willing to pay this increased price. When the second level of increase in the price from Tk 3 to Tk 4 was examined, it was found that the clients using pills or using condoms in Chittagong were less willing to accept it. It can be said that increase in service charges for pills and condoms from Tk 2 to Tk 3 at selected CWFP facilities is acceptable by more than 80% of the clients.

Table 2. Willingness to pay for family planning services

Type of services and areas	First bid	Second bid	Third bid
Pill			
Dhaka, n = 30	86.7%	83.3%	70.0%
Chittagong, n = 30	83.3%	66.6%	63.3%
Rajshahi, n = 31	87.0%	87.0%	83.9%
Condom			
Dhaka, n = 31	93.3%	83.3%	73.3%
Chittagong, n = 30	83.3%	66.6%	50.0%
Rajshahi, n = 40	82.5%	75.0%	70.0%
Injectables			
Dhaka, n = 31	93.5%	90.3%	90.3%
Chittagong, n = 33	69.6%	60.6%	51.5%
Rajshahi, n = 38	76.3%	71.0%	68.4%

Note : The first, second, and the third bids for pills and condoms were Tk 3, 4 and 5 respectively. For injectables these were Tk 6,7 and 8 respectively.

Willingness to pay the increased bid of Tk 6 from the existing service charge of Tk 5 for injectables was found to be quite high in Dhaka, and to some extent, in Rajshahi showing that it is possible to charge Tk 6 instead of Tk 5. The clients in Chittagong were not much willing to accept the increase in the service charge.

Willingness to pay for maternal and child health care

In case of maternal and child health services, most respondents were ready to accept an increase in service charge. Antenatal care clients

of CWFP units in three different selected urban sites, valued ANC very high and were willing to accept increased service charges. About 80-90% of the clients in all the three intervention areas were found to be willing to pay Tk 35. It may be mentioned here that the types of services that were provided as ANC by the units of CWFP are much cheaper than other private providers'. It needs to be mentioned here that the willingness to pay of only the user of ANC services were examined.

Table 3. Willingness to pay for maternal and child health services

Type of services	First bid	Second bid	Third bid
ANC			
Dhaka, n = 30	96.7%	93.3%	90.0%
Chittagong, n = 32	90.0%	83.3%	80.0%
Rajshahi, n = 32	90.6%	84.4%	78.1%
Maternal TT			
Dhaka, n = 30	93.3%	90.0%	86.7%
Chittagong, n = 31	93.5%	70.9%	67.7%
Rajshahi, n = 30	100%	86.7%	80%
Child Imm/EPI			
Dhaka, n = 30	93.3%	90.0%.	86.7%
Chaittagong,n = 34	97.0%	91.2%	91.2%
Rajshahi, n = 30	100%	93.3%	93.3%

Note: The first, second, and the third bid for ANC was Tk 25, 30 and 35, respectively; for maternal TT immunization the bids were Tk 5, 8 and 10; and for child immunization, Tk 5, 7 and 10

For maternal TT, similar results were found. The service is highly valued by the clients in Rajshahi. All the clients interviewed were willing to accept the first bid. The services are provided free of charge; no

additional payments are required for maternal TT, once the clients paid the registration fee and are registered. A service charge of Tk 5 was acceptable to 93-100% of the clients interviewed (Table 3).

Similarly, child immunization was provided free of charge for the vaccine. However, not only CWFP, but almost all other NGOs, collect something from the clients on the day of immunization in the form of either donations, or service charges not directly reported to be a payment for cost of immunization. CWFP collects much of the donation from the clients on the immunization day. It was felt that the clients would not hesitate to pay a nominal amount of fees for child immunization. Hence the willingness to pay some nominal charges was tested. More than 90% of the clients expressed the willingness to pay a nominal charge of Tk 5 for child immunization. All the clients interviewed in Rajshahi were found to be willing to accept a service charge of Tk 5 which they were actually paying. It seems that they value the services for maternal and child health more and the willingness to accept the increase or introduction of service charges was high. In Chittagong, willingness to accept the increase in service charges for family planning services was not as high as in other two cities.

4.3 Market Assessment

The prices of other providers for the selected MCH-FP services in the market were not much different from CWFP prices. Some NGOs were even providing free services. A variation in the fees for ANC care was observed (Table 4). The charge for antenatal care at the pharmacies included the doctor's fee only. The prices of low-priced SMC pills and condoms at the pharmacies were examined. The classification of the new acceptors at the field and clinic was not applicable in cases of pharmacies, and hence no data are shown in the respective columns (Table 4).

Table 4. Prices (in Taka) of other providers of the services in the market

Services	Dhaka		Chittagong		Rajshahi	
	NGOs other than CWFP	Pharmacy	NGOs other than CWFP	Pharmacy	NGOs other than CWFP	Pharmacies
FP, Pills						
New acceptor, field	Free-5.00	-	Free-2.00	-	1.00-3.00	-
New acceptor, clinic	Free-7.00	-	Free-7.00	-	6.00-8.00	-
Resupply/supply	Free-5.00	2.00-8.00	Free-2.00	2.00-8.00	1.00-3.00	2.00-8.00
FP, Condom						
New acceptor, field	Free-5.00	-	Free-2.00	-	1.00-3.00	-
New acceptor, clinic	Free-7.00	-	Free-2.00	-	6.00-8.00	-
Resupply/supply	Free-5.00	5.00-12.00	Free-2.00	3.00-12.00	1.00-3.00	3.00-12.00
FP-Injectables						
New acceptor	5.00	-	5.00-10.00	-	2.00-3.00	-
Follow-up	2.00	-	5.00-10.00	-	2.00-3.00	-
MCH						
ANC	15.00-50.00	50.00	10.00-30.00	30.00-80	10.00-50.00	30.00-60.00
Maternal TT	Free-5.00	-	Free-5.00	-	Free-5.00	-
Child immunization	Free-5.00	-	Free-5.00	-	Free-5.00	-

4.4 Setting of the New Prices

The unit cost of services determined was used for calculating the cost recovery ratio for each type of services at initial price levels. The prices of other providers (as shown in Table 4) in the intervention areas for the selected services were taken into consideration. The cost recovery ratios before the price change, the willingness to pay for a chosen bid were taken into consideration for setting the new prices. The expected cost recovery ratios for the selected services with the new set of prices were also estimated. It was assumed that the utilisation level would remain unchanged. Tables 5, 6, and 7 provide such information.

For setting the prices of pills and condoms, the willingness to pay the first bid, Tk 3 was chosen for all the three branches. The question of willingness to pay was designed for the door- step delivery only, and hence the information on willingness to pay at the clinics, both for the new acceptors of pills and condoms was not available. For injectables, the first bid of increase was Tk 6, and the question was asked to inquire whether the clients were registered with CWFP, and then were asked to pay Tk 6 and so on for the follow-up doses. They were already paying Tk 5 in Dhaka and Chittagong and Tk 7 in Rajshahi.

For door-step delivery of pills and condoms, the fees (for one cycle of pills and for one dozen of condoms) were increased to Tk 3 in Dhaka and Chittagong. The prices at the clinic for new acceptors of pills and condoms were higher because the registration fee of Tk 5 were added to these. The unit in Dhaka, which was charging low prices for pill and condom supply at the door-step, decided to increase the service charge, but later on, the programme manager decided not to go ahead with the new set of price for contraceptives in the field. For antenatal care, the unit

in Dhaka, set the price at Tk 40, which was more than the third bid. The clients' willingness to pay the third bid (Tk 35) was high, and most providers in the area were charging high prices as well. The Rajshahi unit, did not change the service charges for all the selected MCH-FP services. This unit had, in fact, changed in May 1996. The prices shown in the column as new prices were already introduced before the price setting exercise was conducted for the intervention units. Prices for new acceptors of injectables and for antenatal care only were changed. The willingness to pay for the first bid in case of antenatal care was considered. They were already taking some service charges for child and maternal immunization whereas the other two units were not directly charging for this but were generating some revenue through donations from the clients on immunization days. The programme manager in Chittagong decided to increase the prices even though the willingness to pay the increased prices for most of the services was found to be low.

Table 5. Initial prices, cost recovery ratios, willingness to pay, the new prices and corresponding cost recovery ratios in Dhaka

Type of service	Initial price (Tk)	Cost recovery ratio(%)	Willingness to pay the chosen bid, (Tk)	Other providers' price range, (Tk)	New price (Tk)	Expected cost recovery ratio (%)
FP, Pills						
New acceptor, Field	2	4.5	3	Free-5.00	3	6.8
New acceptor, Clinic	7	10	-	Free-7.00	8	12.3
Resupply, Field	2	14.8	3	Free-5.00	3	22.1
Resupply, Clinic	2	9.8	-	Free-5.00	3	14.8
FP, Condom						
New acceptor, Field	1	2.5	3	Free-5.00	3	7.4
New acceptor, Clinic	6	6.9	-	Free-5.00	8	10.9
Resupply, Field	1	4.7	3	Free-5.00	3	14.2
Resupply, Clinic	1	2.6	-	Free-5.00	3	7.9
FP- Injectables						
New Acceptor	15	10.5	-	Free-5.00	20	14
Follow-up	5	3.6	10	Free-2.00	10	7.4
MCH						
ANC	25	24.5	35	15.00-50.00	40	39.2
Maternal TT	Free	0	5	Free-5.00	5	13.2
Child Immunization	Free	0	5	Free-5.00	5	12.5

Table 6. Initial prices, cost recovery ratios, willingness to pay, the new prices and corresponding cost recovery ratios in Chittagong

Type of service	Initial price (Tk)	Cost recovery ratio(%)	Willingness to pay the chosen bid, (Tk)	Other providers' price range, (Tk)	New price (Tk)	Expected cost recovery ratio (%)
FP, Pills						
New acceptor, Field	2	2.3	3	Free-2.00	3	12.5
New acceptor, Clinic	7	8.2	-	Free-7.00	8	10.1
Resupply, Field	2	8.4	3	Free-2.00	3	12.6
Resupply, Clinic	2	8.5	-	Free-2.00	3	12.7
FP, Condom						
New acceptor, Field	2	2.8	3	Free-2.00	3	4.3
New acceptor, Clinic	7	11.7	-	Free-7.00	8	14.3
Resupply, Field	2	6.5	3	Free-2.00	3	9.7
Resupply, Clinic	2	6.5	-	Free-2.00	3	9.8
FP- Injectables						
New Acceptor	5	3.7	-	5.00-10.00	10	7.4
Follow-up	5	4.9	6	5.00-10.00	5	4.9
MCH						
ANC	20	16.7	25	10.00-30.00	25	20.9
Maternal TT	Free	0	5	Free-5.00	5	14.9
Child Immunization	Free	0	5	Free-5.00	5	11.1

Table 7. Initial prices, cost recovery ratios, willingness to pay, the new prices and corresponding cost recovery ratios in Rajshahi

Type of service	Initial price (Tk)	Cost recovery ratio (%)	Willingness to pay the chosen bid, (Tk)	Other providers' price range, (Tk)	New price (Tk)	Expected cost recovery ratio (%)
FP, Pills						
New acceptor, Field	3	9.4	3	1.00-3.00	3	9.4
New acceptor, Clinic	8	27	-	6.00-8.00	8	27
Resupply, Field	3	17.7	3	1.00-3.00	3	17.7
Resupply, Clinic	3	14.8	-	1.00-3.00	3	14.8
FP, Condom						
New acceptor, Field	3	8.8	3	1.00-3.00	3	8.8
New acceptor, Clinic	8	19.8	-	6.00-8.00	8	19.8
Resupply, Field	3	18.6	3	1.00-3.00	3	18.6
Resupply, Clinic	3	15.4	-	1.00-3.00	3	15.4
FP- Injectables						
New Acceptor	12	12.8	-	2.00-3.00	22	23.4
Follow-up	7	7.5	10	2.00-3.00	7	7.6
MCH						
ANC	21	9	25	10.00-50.00	25	10.8
Maternal TT	5	20	5	Free-5.00	5	20
Child Immunization	5	40	5	Free-5.00	5	40

The new prices in all the units were effective from January 1997. The service providers at the clinic and the field started to inform the clients about the new set of prices in December 1996. All the clinics were required to display the list of service charges so that the clients can see them when they visit the clinic. The providers also motivated the clients by telling them that the prices they are charging are still lower than the private sector. For pill and condom supply, the client were told that the increase in the service charges from Tk 2 to Tk 3 is not much compared to services for providing door-step delivery and counseling.

A receipt system was introduced. The clients were provided with receipts on payment for the service(s) received, which showed the amount of money paid for specific purposes. Acknowledging the payment made by clients has helped the service provider enhance clients' confidence on them. The clients now know what they are paying for, which enhanced the acceptability of the increased prices. After introducing receipts, the service providers, i.e. the field workers, paramedics and health workers, were able to convince the clients easily that the money they were collecting in exchange of the services was officially set by the organisation and were being deposited in the organisation's account.

4.5 Opinions, Views and Experience on Pricing MCH-FP Services at CWFP Study Units

This section reports on the findings of the two group discussion sessions held for examining the perception, views and experiences on charging for services, setting new prices, and systematic pricing mechanism.

I. *Perception about charging for services*

It was reported that the main objective of introducing charges initially was to create value in the client's mind for the services that they were so long getting free of charge. The service that were provided free of charge were misused. The field workers mentioned that some women were just accepting the family planning commodities and not using them. They used to keep the contraceptives supplied at their homes out of courtesy to the field worker. Introducing nominal prices reduced wastage. The central management reported that initially the revenue generated from service charges were used providing medicine to the poor clients, either free or at subsidized prices.

The objective of financial sustainablity and partial cost recovery was considered at later stages and changes in service charges were mainly guided by the objective of recovering part of the cost. As far as partial cost recovery is concerned, it was reported that the branches were paying a proportion (10-15%) of their rent of building and utilities from the revenue they are generating from the service charges. The medicine, which the central office are providing to these units as per their indent, were also bought with the revenue generated by the units or branches.

ii. *Setting of prices*

The price changes that were made on several occasions, were often gradual and on experimental basis so as to see the clients' reaction to the changes first. Some programme managers also mentioned that other providers' prices were also taken into consideration. The intervention units believed that they have advantage over other providers with respect to service quality and hence can still charge or increase the service charge. Prices or service charges set at the units had always been on agreement

from the central office. On some occasions, the programme managers at the unit level changed their prices on their own and sought the permission of the central office. The central office often accepted such suggestions. The central management appreciated some extent of decentralization in taking these decisions. Some degrees of flexibility were found which could be seen from differences in service charges among units. This happened mainly due to the fact that some branches did not implement the revision or changes in the past and could continue to charge the old fees/service charges.

iii. ***Systematic pricing mechanism***

Programme managers were asked what they would take into consideration to determine service charges, when they would have to introduce prices for the services initially provided free or when they would introduce prices for services in new catchment areas.

They indicated that first they would assess the area and the socioeconomic status of the population to determine the ability to pay for the services. The next step they felt was to assess the demand for the services of which the price changes would be considered through direct inquiry from the catchment population. They mentioned that they would also examine the extent of utilization of the clinic.

They also mentioned that it is important to find out whether there are any other providers that deliver similar services, particularly from the public sector. It was also felt the price changes should also be accompanied with improvement in service quality, if prices have to be competitive. Thus, it is important to find out the extent to which consumers respond to the current level of prices.

CWFP's managers indicated that they would try to improve their quality in comparison with other providers to motivate people to use their service. They mentioned that some of the clients may use government facilities to obtain pills and condoms if prices are increased.

Some programme managers mentioned that current prices may not be enough to cover the cost, because such level of prices may not be acceptable or feasible among the clientele.

The central management brought in other policy issues which they thought should be considered at policy levels. These included the conditions set by donor agencies, particularly in reference to charging for services and cost recovery. Another important factor is that they also believe, types of services they provide are social services that render social benefit to the community. This should be the prime consideration, and a balance between social obligations and cost recovery would be necessary.

The groups were reminded that in the pricing intervention, different steps were taken. They were asked to comment on the usefulness of all the assessments.

They mentioned that such steps were essential and useful. They felt that clients' acceptance of an increase in prices in the bidding exercise reflected an inclination to pay the stated amount, and they could refer to that in promoting the new set of increased prices. They believe that following such steps is systematic and setting prices in such a way takes into account both providers' and clients' interests. The managers indicated all the assessments to be necessary. They placed importance in assessing the demand and willingness to pay, as it generates direct information on clients' perspectives. The central management also felt that the cost of

producing services is the most important aspect to take into consideration. Additionally, the social gains from services, the attitudes of the clients toward paying, the need to create market facilities, and undertake quality improvements are also necessary in price setting.

The respondents were asked whether they will be able to do on their own all the steps that were taken for the pricing intervention, including the costing exercise.

They believe, it would not be difficult in terms of personnel to conduct a small survey for determining clients' willingness to pay. They have a practice of conducting a household survey in their catchment area every two years, and such questions on willingness to pay might be added in their survey. In cases where the household-level service delivery would be discontinued and such survey would not also be conducted, a special survey on willingness to pay could be conducted. Survey on prices and quality of services of other providers can also be conducted by them.

They indicated that some technical assistance is still necessary to undertake the costing exercise. The cost implication of such exercises needs to be considered in order to institutionalize such activities within the organisation. The programme managers felt that they understand the different steps taken to establish prices. It would be essential to build the capabilities of NGO staff initially and some support in undertaking all the steps may still be necessary for some time. Conducting the survey on the willingness to pay may not be so difficult with a bit of training in conducting the interviews.

The group was asked to comment on the frequencies of conducting such exercise for changing the prices.

There were differing views, some branch managers recommended that prices and use rates be reviewed every year but the changes should be made every two years. The staff at Dhaka unit felt that these prices should be reviewed and changed every year. The central office had the opinion that prices should be reviewed half yearly and should not be revised within two years, because they believed that frequent changes would not be good, and they might lose clients.

Suggestion for improving the pricing mechanism

The groups' suggestion on the improvement of the pricing scheme mainly relates to the improving information required for setting the price. Another important issue is that there should be consistency between the government agencies and the NGOs on pricing. These two different types of providers have different pricing strategy some provide free services, and some have user fees for the same services in the same areas. The managers indicated that the commitment of the staff and professional expertise is important in improving and establishing the pricing mechanism. Another important aspect they felt is that improvement of quality is important to implement a pricing mechanism effectively. In fact, one unit made changes in service quality by employing a physician who attended the clients at the clinic once a week, which increased the utilization of the clinic for curative care and ANC.

The groups were asked about the experiences with the new changes under the pricing intervention.

The group noted that the increase was not so substantial compared to what they had been charging before the intervention. In Chittagong, they found some difficulties initially to get the increased amount of service

from all of their clients. However, they convinced their clients gradually that the charges are not that high as far as other providers are concerned. The providers in Wari unit of Dhaka reported that they did not find any difficulties in implementing the new set of prices for their services at the clinic. The clients accepted the changes and continued to pay the stated amounts.

The branch personnel highly appreciatd the introduction of the receipt system. Although it takes a minimal amount of their time, it was very useful and helped make the clients understand what they are paying for. The staff in the three intervention units recommended that the receipt system be applied to other units of CWFP as well. The group informed that the increase in service charges would be easier if certain improvements in service quality could be made.

4.6 Cost Recovery

This was examined for only two of the three intervention units - Dhaka and Chittagong - for the periods, four months before and four months after the changes in price.

Table 8. Cost recovery ratio (%) four months before and after the price changes

Intervention unit	Cost recovery ratio (%) before the changes in price (Sept.-Dec. 1996)	Cost recovery ratio (%) after the changes in prices (Jan.-Apr. 1997)
Dhaka	5.9	6.2
Chittagong	7.2	7.5

The cost recovery ratios during the intervention period with the new set of prices improved in both the units after the increase in prices as shown in Table 8.

4.7 Utilization of Services

The period was not long enough to report on utilization rates, but this indicator has not declined in these units. The utilization of services in Dhaka and Chittagong four months before and four months after the new prices were introduced was reviewed. The average number of family planning clients did not drop during this period. There was actually an increase in injectable clients. There was a decline in the average number of clients for pills and condoms, ANC, maternal TT, and child immunization. However, the NGO managers indicated that this is a usual trend[14], and that January-April figures are normally lower than those for September-December. This may be due to the fact that pregnancy and delivery outcomes in Bangladesh is seasonal. Most delivery outcomes occur in October-January, and visits for antenatal care are mostly made during the last trimester of pregnancy. As a result, volume of TT immunization and child immunization services increase during these months.

[14]The Urban Panel Survey, a surveillance of the MCH-FP Extension(Urban) also shows this to be true

Table 9. Average number of clients served four months before and after the price changes

Services	Dhaka		Chittagong	
	Sept.-Dec. '96	Jan.-Apr.'97	Sept.-Dec.'96	Jan.-Apr.'97
Pill	393	441	1282	1098
Condom	473	425	372	293
Injectables	97	94	233	244
ANC	38	27	57	47
Maternal TT	73	43	92	44
Child Imm.	181	165	245	135

5. Discussion

This study discussed the steps required for systematic price setting for MCH-FP services among NGO service providers.

The systematic pricing mechanism examined the cost of producing the services, and determined the cost recovery ratio for each type of service. The unit costs of providing services to the new acceptors of family planning at the clinic and antenatal care were found to be high. One reason is that these services are low in volume. There should be efforts to increase the volume of such type of services as the cost recovery ratio was favourable. Full cost recovery in case of MCH-FP services provided by the NGOs was not an aim, but with the growing necessicity of attaining financial sustainability, a partial cost recovery is required and providers should reduce the cost of different inputs required in providing the services.

There exists a substantial extent of willingness of the clients to pay for the MCH-FP services provided by the CWFP, particularly in Dhaka and Rajshahi. Marginal increases in the prices for door-step supply of pills and condoms were acceptable to the clients. Such services are high-volume ones, and price increases contribute substantially to cost recovery. The consumers obviously valued such services, and took into account the price for alternative sources and also the travel and time cost associated with purchasing these elsewhere.

Assessing the market of providers and their prices is often done, but may not be done systematically because the information flow about such issues may be sporadic and not very reliable. Information on the prices of other providers was obtained by identifying competing providers and surveying their prices. It would be important to substantiate the prices stated by the providers with price information from clients. In such cases, exit interviews can be conducted. It is also important to assess the price of the providers taking into consideration the quality of their services provided by other providers.

Khuda *et al.* (1991), Ciszewski and Harvey (1995), Lewis (1986), suggest that a marginal increase in the prices of contraceptives is possible without affecting the demand. The study of Khuda *et al.* in one union of Bangladesh showed that increase in the price of pills and condom did not affect the contraceptive prevalence rate. Ciszewski and Harvey's study showed that prices of the low-cost socially marketed contraceptives are not very elastic. The study also suggest that the programme managers should take the relative magnitude as well as the absolute size of the increase into account whenever considering the price increase. Lewis, in a review paper, showed the evidence from the studies in Sri Lanka, Jamaica, Colombia, and Thailand that contraceptive demand is relatively inelastic.

There has been a very few studies that addressed the question of what consumers are willing and able to pay for contraceptives, either directly or indirectly. Levin *et al.* (1996), in their study, surveyed the willingness to pay for contraceptives in selected rural areas of Chittagong, Bangladesh, where people were getting supply of contraceptives free of charges. They found that the clients were willing to pay for contraceptives. The question on willingness to pay was directly addressed but no distinction was made between pills and condoms. Streatfield *et al.* (1997), in their study conducted in selected rural areas in Chittagong and Rajshahi divisions of Bangladesh, have shown that the clients are willing to pay an increased amount of prices. However, in their investigations, the willingness to pay was not measured by contingent valuation technique.

The new prices set for new acceptors were such that prices for services at the door-steps were low, as desired by the programme managers. It should be the other way around in order to encourage the use of fixed sites or clinics. Clients were willing to accept a marginal increase in the prices for injectable services provided at the clinic facilities of CWFP in Dhaka and Rajshahi, but not so much in Chittagong. The decision making in a fully decentralized manner has both advantages and disadvantages. A centralized decision rule may sometimes be necessary to overrule the decentralized decision for implementing effective cost recovery measures.

The increase in the prices for antenatal care was highly acceptable to the clients who had used the services at the three branches of the CWFP. Introduction of service charges for maternal TT and child immunization can be explored as the clients are willing to pay a nominal service charge for such type of service. The service volume for child immunization is a substantial proportion of the total services provided, and

the possibility of earning some revenue by introducing a nominal service charge will help cost recovery. Weaver *et al.* (1996) have used willingness to pay measured by contingent valuation for quality improvement for child survival health care and have found that the majority of the population is willing to pay the estimated costs of quality improvements and more than half of the population is willing to pay substantially more than the costs. Similarly, maternal TT services are also highly valued by the clients. A question may arise that such services of primary health care should be available free of charge. The proportion of pregnant women seeking antenatal care is quite low. So increasing prices may create a barrier for access to care. To retain the level of use, a marginal improvement of the quality of services would help in this regard. Motivation through information, communication, and education should also be undertaken to increase the level of service use.

The establishment of the systematic pricing mechanism would not require any sophisticated expertise for most of the NGOs. Most units felt that after going through the process, they can adopt such systems that will enhance their knowledge about the issues that are important in pricing and also increasing the revenue that would help achieve financial sustainability through cost recovery. However, some technical assistance will be necessary at the initial stages, and it may be useful if this sort of expertise can be developed within the organisation. In this regard, it is necessary to examine the capacity of the NGOs in establishing the different steps of systematic pricing mechanism. Cost analyses would require technical assistance to develop a routine system of costing within the finance section of the central office and the unit office could provide the necessary information. With some training, the programme managers at the unit level would be able to undertake the survey on the willingness to pay of the clients for the services. The survey for the assessment of the prices of

other providers in the market could be managed along with the survey on willingness to pay by the programme unit.

The unit-level managers may be allowed to have choices to decide upon the price for the services and can deviate from any standardized level of prices that may be set on the basis of a systematic price setting mechanism. Some level of flexibility should be available on the part of the unit-level programme managers. Programme managers may take aggressive or conservative decisions for cost recovery and would either increase the prices of services or keep them constant. In such cases, assessment of market and willingness to pay would provide a guideline for taking the correct steps. The desired level of cost recovery may vary at the unit level.

It should be noted that the cost recovery through increase in prices may not be substantial, so subsidies may need to be continued. For financial sustainability, other means, like increasing efficiency, cost saving strategy, revenue generation through other economic activity should also be considered by the NGOs.

6. Limitations of the Study

The assessment of the prices of other providers in the market did not include their quality of services. In this sense, the information does not fully indicate the scale of competitiveness in the market.

The sample size for different types of clients for the survey on willingness to pay was small, and the results of the willingness to pay should be treated with caution. However, the application of the tool for

bidding in adopting such systematic approaches in price setting for service provided by NGOs seemed to be appropriate.

The other limitations of the study include the time period within which the intervention was implemented; the duration was too short to comprehensively evaluate the impact on cost recovery and use of the facilities for the MCH-FP services; the study also did not examine the effect of price changes on change in method, source of supply of method. The impact of such changes would have different implication for the programme and may change the unit cost estimates.

Revenue management was not examined in detail. The main reason was that there were no changes in the current system of managing revenues. It would be important to experiment with different forms of investing revenues and evaluating the outcomes on cost recovery and financial sustainability.

7. Conclusion and Policy Implications

All the different steps mentioned in the intervention for a systematic pricing mechanism may help in setting price effectively. The information on cost per unit of services would help decide the allocation of resources between services and the outcomes on cost recovery. Systematic steps in setting prices would help programme managers to examine clients' willingness to pay, and more specifically, the consumers' surplus existing in the market. This would assist the programme managers to examine the scope of adjusting the price of services for increased cost recovery without any fall in service use. Examining the willingness of clients to pay for services would help protect them by setting prices according to their

preferences. The issue of balance between equity and efficiency should not be ignored. The price setting mechanism should also cater to organizational goals and objectives.

A receipt system should accompany the system of charging for services. This enhances the acceptability of the clients to the change or introduction of prices. It also helps the providers increase the confidence of their clients on them.

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