The Impact of Incentives on Ante Natal Care and Delivery in Bauchi State. A Case Study of Conditional Cash Transfer

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Abstract: **As part of the project embedded in the subsidy Reinvestment and Empowerment Program (SURE-P), the Maternal and Child Health component initiated an incentive programme to bring would be mothers for ante and post natal care to the facilities especially child delivery by skilled birth attendant. This cash transfer was set up to ensure effective management of financial resources acquired from the removal of subsidy from 2012, thereby reducing maternal and child mortality rate in line with Millennium Development Goals number four and five. Four Primary Health Care Facilities were chosen for the pilot programme in Bauchi. This paper conducted a research in all the four facilities so as to be able to identify whether the incentive yielded the desired result. Therefore the overall objective of the research is to undertake a study to see the impact the incentives has on ante natal care and delivery in all the four facilities in Bauchi State. The research made use of both primary and secondary data. The data collected were analyzed by the use of descriptive statistics, with the aid of tables and graphs to show the significance of the incentives. The study found that a significant number of women were motivated by the incentives to avail themselves with the ante natal care and delivery by skilled Health worker available at the health facility, we however found delivery at the facility did not increase at the same rate with the ante natal care visits because of the presences of Traditional Birth Attendants in those villages, none Challant attitude of the Health workers towards pregnant women and administrative bottle neck that resulted in late payment and lack of essential items needed for safe delivery. The research concluded by recommending that an effective payment mechanism be put in place, possibly increase the incentive amount, the Traditional Birth Attendants should be incorporated to be part of the skilled birth delivery attendant and prompt supply of all tools needed for safe delivery at the facility.**

I. INTRODUCTION.

As part of the project embedded in the Subsidy Reinvestment and Empowerment Program (SURE-P) of the Federal Government of Nigeria, the Maternal and Child Health component initiated an incentive programme to bring would be mothers for ante and post natal care to the facilities especially child delivery by skilled birth attendant. This cash transfer was set up to ensure effective management of financial resources acquired from the removal of subsidy in 2012 thereby reducing maternal and child mortality rate in line with Millennium Development Goals numbers four and five.

The demand component of the SURE-P MCH intervention will serve to increase the utilization of health services in the health facilities through use of incentives provided after fulfillment of set conditions. These incentives are in form of monetary value and referred to as Conditional Cash Transfer (CCT). The target beneficiaries are pregnant women and the resident Community Health Resource Persons who identify pregnant women and refer them to the PHC for enrolment. People in developing countries are exposed to a range of risks that could reduce ability to lead productive lives and make them vulnerable. These risks usually affect large groups (e.g. economic recession, wars, famine, natural disasters) or individuals (such as illness of family members and loss of household income). In these situations, social protection mechanisms are needed to reduce vulnerability that people could be exposed to. The mechanisms are geared towards poverty reduction and human development.

The programme is to run for three years from 2012-2015 by concentrating on rural and under developed communities. The Conditional Cash Transfer of N5000 to mothers who meet the pre-condition which are , ante-natal care for at least four visits to the hospital, delivery by skilled birth attendant and immediate post-natal care visit is expected to encourage pregnant women in Nigeria to access Health Care facilities thereby reducing maternal and child mortality.

Based on the aforementioned, this research study is sought to track and see how incentives such as Conditional Cash Transfers have been used to attract non hospital attendance become compliant, in so doing also look at how far such incentives have been able to achieve the desired objective of reducing mortality in both maternal and new born.

1.2 The Objective of the study.

The overall objective of the study is to undertake an independent study to see the impact incentives had on ante and post natal care in a selected facility in Bauchi State; In addition we will also analyze the incentives which include the monetary inducement, health workers, free medical care, drugs and hospital equipment. Then conclude with useful recommendations.

1.3 The Scope of the study.

As part of the pilot study in Bauchi State four facilities were chosen three that is Soro, Sade and Papa in Darazo Local Government and Jalam in Dambam Local Government under Surep MCH programme. For the purpose of this research we took all the four facilities to represent our research population. The study covered a period from August 2012 to April 2015. The Surep MCH Conditional cash transfer was launched in December 2012, therefore the period covers five months prior and twenty eight months after the launching of the programme.

II. LITERATURE REVIEW

2.1 Meaning of Incentives.

An incentive is something that causes and encourages a given response: inducement, motive, encouragement, urge, come-on, spur, lure, bait, motivation, impulse, stimulus, impetus, stimulant, goad, incitement, enticement (Complete and Unabridged 2nd Edition. 2002 © HarperCollins Publishers 1995, 2002). While Conditional Cash Transfers are social programmes that condition regular cash payment to poor households on use of certain services such as Health services and School attendance (SurepMCH, 2012).

According to a Technical briefs for Policy-Makers by World Health Organisation described Conditional cash transfer (CCT) programs as a welfare program that gives money to the poor people in return for fulfilling a specific behavioral condition. These conditions include for example children's school attendance, up-to-date facility vaccinations or regular visits to a primary care by pregnant women. CCT's are a new type of social programme with the primary objective of alleviating poverty. The government (or a charity) only transfers the money to persons who meet certain criteria. These criteria may include enrolling children into public schools, getting regular check-ups at the doctor's office, receiving vaccination, or the like. CCTs are unique in seeking to help the current generation out of poverty, through breaking the cycle of poverty for the next through the development of human capital.

CCT programmes involve a cash payment to poor families or individuals in exchange for their fulfilling certain behavioral conditions (De Janvry and Sadoulet, 2006). Also referred to as conditionalities, these conditions may include such things as consistent school attendance, pre-natal health check-ups or physicals and vaccinations for children (Fiszbein, 2009). CCTs function by increasing 'human capital' investment—encouraging parents to send their children to school rather than work and promoting preventative health care measures (Marshall, 2015). At the same time, they reduce poverty levels by increasing a family's income to provide money for food and other necessities.

Large-scale government conditional cash transfer (CCT) programmes have become a mainstay in poverty reduction strategies and child health interventions throughout Latin America and are increasingly being implemented in sub-Saharan Africa and the Middle East (World Bank Report, 2011 and Baird et al 2013). The Latin Americas (Mexico, Brazil, Nicaragua, and Honduras) are the pioneers of CCTs in the 1990s with the largest and iconic CCT programme being *Bolsa Familia* programme in Brazil reaching ~11 million families (Fiszbein, 2010). As a form of social protection, CCTs transfer cash to poor households on condition that such transfers are invested in the human capital development (health, nutrition and education) of children (World Bank Report, 2011). In sub-Saharan Africa (SSA), CCTs are increasingly used as a social protection strategy to address poverty and improve the health and well-being of orphan and vulnerable children (OVC) living in poor households (UNICEF 2009). Development partners particularly the World Bank, Department for International Development (DFID) and UNICEF continue to pay attention to CCT programmes in SSA (DFID, 2011). This is underpinned by the fact that social protection schemes of this nature play a significant role in the fight against child health inequalities and vicious cycle of poverty which has engulfed developing countries as well as meeting the MDG 4 which focuses on reducing child mortality (Garcia and Moore, 2012). Yet, the question of by what pathways CCTs work to improve child health remains largely unanswered since majority of impact evaluation studies have focused on quantifying the health outcomes of the programme (Lagarde et al 2007).

The World Bank in 2005 reported that several developing economies have recently introduced conditional cash transfer programs, which provide money to poor families contingent on certain behavior, usually investments in human capital, such as sending children to school or bringing them to health centers. The approach is both an alternative to more traditional social assistance programs and a demand-side complement to the supply of health and education services. Unlike most development initiatives, conditional cash transfer programs have been subject to rigorous evaluations of their effectiveness using experimental or quasi-experimental methods. Evaluation results for programs launched in Colombia, Honduras, Jamaica, Mexico, Nicaragua, and Turkey reveal successes in addressing many of the failures in delivering social assistance, such as weak poverty targeting, disincentive effects, and limited welfare impacts. There is clear evidence of success from the first generation of programs in Colombia, Mexico, and Nicaragua in increasing enrollment rates, improving preventive health care, and raising household consumption. Many questions remain unanswered, however, including the potential of conditional cash transfer programs to function well under different conditions, to address a broader range of challenges among poor and vulnerable populations, and to prevent the intergenerational transmission of poverty. Dr Fernald, School of Public Health, University of California, wrote that many governments have implemented conditional cash transfer (CCT) programmes with the goal of improving options for poor families through interventions in health, nutrition, and

education. Families enrolled in CCT programmes receive cash in exchange for complying with certain conditions: preventive health requirements and nutrition supplementation, education, and monitoring designed to improve health outcomes and promote positive behavior change. With the aim of differentiating the effects of cash transfer from those of other programme components. His conclusions suggest that the cash transfer component of Oportunidades is associated with better outcomes in child health, growth, and development. In 2005, with the goal of reducing the numbers of maternal and neo-natal deaths, the Government of India launched Janani Suraksha Yojana (JSY), a conditional cash transfer scheme, to incentivize women to give birth in a health facility. Dr Gakidou, of the Institute for Health Metrics and Evaluation, University of Washington, independently assessed the effect of JSY and came out with an assessment that are encouraging, but they also emphasize the need for improved targeting of the poorest women and attention to quality of obstetric care in health facilities. Continued independent monitoring and evaluations are important to measure the effect of JSY as financial and political commitment to the programme intensifies intervention coverage and health outcomes.

2.2 Theoretical conception.

2.2.1 Definitions of Incentive Theory.

- "According to this view, people are pulled toward behaviors that offer positive incentives and pushed away from behaviors associated with negative incentives. In other words, differences in behavior from one person to another or from one situation to another can be traced to the incentives available and the value a person places on those incentives at the time." (Bernstein, 2011)

2.2.2 Important Observations about Incentive Theory.

- Incentives can be used to get people to engage in certain behaviors, but they can also be used to get people to *stop* performing certain actions.
- Incentives only become powerful if the individual places importance on the reward.
- Rewards have to be obtainable in order to be motivating. For example, a student will not be motivated to earn a top grade on an exam if the assignment is so difficult that it is not realistically achievable.

III. RESEARCH METHODOLOGY:

Survey research design was adopted for the study. The target population is all the four primary healthcare centers adopted for conditional cash transfer programme in Bauchi State, these are primary healthcare facilities of Soro, Sade, Papa and Jalam with an estimated 12,032 patients attending antenatal services. Quota sample was drawn with the proportion comprises of the entire ward representatives, ten from each ward making a total of 40, total health workers in all the four facilities which is 70 and we select 20 beneficiaries from each facility making a total of 80. The total number of respondent is then 190. Data was sought using both primary and secondary source; with an interview schedule and structured and closed ended questionnaire designed and validated for reliability (Cronbarch' Alpha = 0.81) as well as observation method. Data collected was analyzed using descriptive (mean and standard deviations) and inferential statistics (correlation and regression). The analysis was based at 5% level of significance. The hypotheses tested are: Incentives given do not have a significant impact on ante-natal care visit to the hospital; Incentives given do not have a significant impact on delivery by skilled birth attendant and Incentives given do not have a significant impact on post-natal care visit to the hospital. Included are all the Health Workers at the various Clinics sampled. To further support the study, tables and graphs of a sample of the ANC report from one of the facilities, Sade precisely from August 2012 to April 2015 thirty-three months was displayed and analyzed therefrom.

IV. DATA PRESENTATION AND ANALYSIS:

This study is undertaken as a study to observe and measure the impact incentives in form of cash reward, free health care and drugs have in attracting pregnant women in attending ante and post-natal care. The responses collected were tabulated and presented as follows:

Table 1 Number and Qualification of Health Workers at the Facilities.

s/n	Specialty of Health Workers	Permanent Staff	Surep MCH supported Staff
1	Nurses	2	0
2	Midwives	2	12
3	Community Health Extension Workers (CHEW)	6	10
4	Environmental Health Workers	4	0
5	Laboratory Technicians	4	0
6	Junior Community Health Extension Workers (J-CHEW)	6	0
7	Health Information Officers	4	0
8	Village Health Workers	0	20
	Total	28	42

Source: Field Survey

From table 1we can see that the existing Medical Workers are inadequate, especially in the delivery unit. The presence of Surep Assisted worker aided greatly the activities at the maternity. The midwives and CHEWS are responsible for ante natal care, delivery and post-natal care while the VHW took care of the mobilization. It can be seen that the additional Surep MCH supported staff provided the needed manpower to adequately cater for safe delivery. In the absence of the Surep staff the entire clinic has only few CHEW's and J-CHEW's to take care of ante natal and delivery.

Table 2: Data indicating number of expecting mothers attending the ante natal care and Additional information is:

1. The programme was officially launched in December2012.
2. First payment was done in April 2013 and subsequently every quarter.
3. The last payment was done in January 2015.

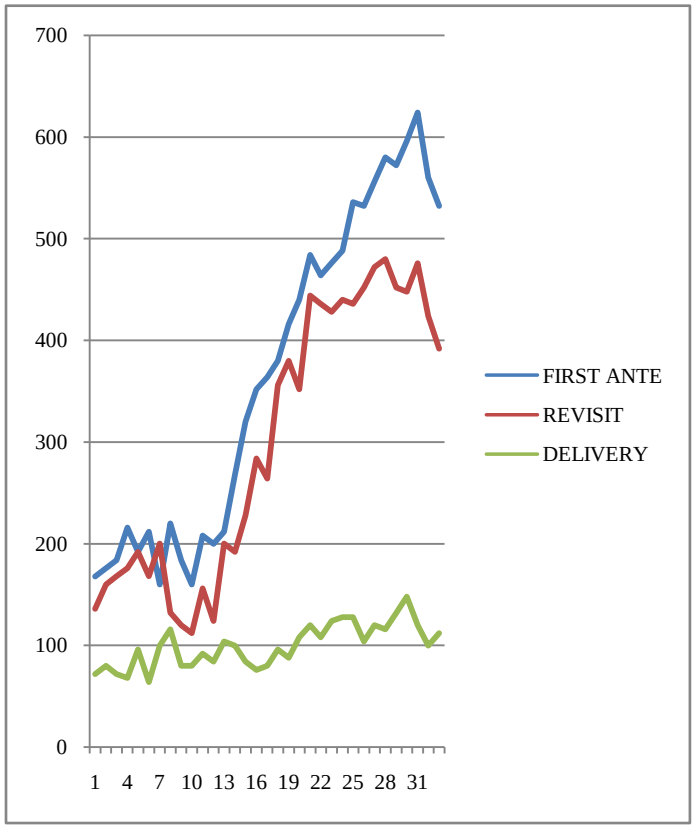
The first column shows the various months the research considered while the second column represent the total number of ante natal visits to the clinics, revisits is in the third column and delivery falls under the fourth column. From the beginning i.e. August 2012upto the period of the initial launch of the programme the average ante natal visit is 187, revisit 166 and delivery is 78 that took place in the clinics. With the launch of the programme in the first and second quarter of 2013 i.e. January to June the ante natal visit initially the average moved to 190, revisit witnessed a decrease to148 and delivery slightly increased to 89. By the third and fourth quarter that's from July to December 2013 the average ante natal care visit jumped from 190 to 286, revisit equally moved from 166 to 215 and delivery nearly maintained the same tempo at an average of 88. In 2014 the average ante natal care drastically moved up from 286 to494, revisit also drastically moved up from 215 to427 and delivery slightly moved from 88 to 112. While in 2015 from January to April ante natal care visit further moved up from the average 494 to 578, revisit too slightly moved from 427 to 435 and delivery shifted from 112 to 120. This can be better depicted in the form of line graph, as in the picture below:

Table 2: Data indicating number of expecting mothers attending the ante natal care and delivery at the various SUREP Supported clinics

Period	FIRST ANTE NATAL	REVISIT	DELIVERY
AUGUST 2012	168	136	72
SEPTEMBER 2012	176	160	80
OCTOBER 2012	184	168	72
NOVEMBER 2012	216	176	68
DECEMBER 2012	192	192	96
JANUARY 2013	212	168	64
FEBRUARY 2013	160	200	100
MARCH 2013	220	132	116
APRIL 2013	184	120	80
MAY 2013	160	112	80
JUNE 2013	208	156	92
JULY 2013	200	124	84
AUGUST 2013	212	200	104
SEPTEMBER 2013	268	192	100
OCTOBER 2013	320	228	84
NOVEMBER 2013	352	284	76
DECEMBER 2013	364	264	80
JANUARY 2014	380	356	96
FEBRUARY 2014	416	380	88
MARCH 2014	440	352	108
APRIL 2014	484	444	120
MAY 2014	464	436	108
JUNE 2014	476	428	124
JULY 2014	488	440	128
AUGUST	536	436	128
SEPTEMBER 2014	532	452	104
OCTOBER 2014	556	472	120
NOVEMBER 2014	580	480	116
DECEMBER 2014	572	452	132
JANUARY 2015	596	448	148
FEBRUARY 2015	624	476	120
MARCH 2015	560	424	100
APRIL 2015	532	392	112

Sourced: From the Four PHC Clinics at Soro, Sade, Papa and Jalam.

Fig: 1. Showing a graphical presentation of Ante natal care, revisit and delivery at the clinic of the four designated Sure-p MCH supported CCT facilities.



Sourced: From Table 2.

The graph above on the horizontal axis represents the number of the variables ante natal care visit in pink, revisit in red and delivery in green that took place in the four mentioned clinics. The vertical axis represents the months with the first one being August 2012 and the last April 2015 representing a

period of 33 months. It can be seen that both first ante natal and revisit care are tremendously impacted by the incentives as can be seen by the movement from less than 200 upto a point where it reached 600 and 400 visits. While on the other hand delivery could slightly pass 100 only.

To further understand the working of the incentives, we will further subject it to added analysis by the ward representatives represented by the Community Ward Committee, Health workers in each of the facility and the beneficiaries of the programme.

Decision Rule

A five point likert-scale was adopted for the measurement of the opinion or aggregate views of the selected research respondents for this study. For five-point Likert scale, the average is:

$$\frac{5+4+3+2+1}{5} = \frac{15}{5} = 3.00$$

This indicated that the mean of 3.00 as cut-off point, that any computed value (mean) that is 3.00 and above is considered significant and accepted, and any other value (mean) below the cut-off point (3.00) is considered insignificant and therefore rejected.

Table 3. Rating the impact of incentives on antenatal care by the Respondent on the scale of 5-1

Respondent	**N**	**Mean**	**Std. Deviation**	**Decision**
C Community Ward Head	190	4.5392	.17261	Significant
Health Workers	190	3.2792	.56881	Significant
Beneficiaries	190	3.8192	.26113	Significant

With 5 = Very High impact, 4 = High impact, 3 = Low impact, 2 = Impact and 1 = No impact.

Source: Author's Computation using SPSS, 2021

Result from the table 3 above indicates that the respondents rated the impact of incentives given have significantly improved antenatal visits to the hospitals as perceived by the respondents. This is because all their average responses are within the cut-off point that is accepted and considered significant. For instance, respondents selected at the community ward said it had impacted (mean = 4.5392 > 3.00) which is accepted and significant. Healthcare workers also perceived that it has significantly impacted on antenatal (mean = 3.2792 < 3.00) which is significant and so also the beneficiaries (mean = 3.8192 > 3.00).

The standard deviations for all the respondents are within the ranges that their diversifications are not significant enough to affect the result above, because all the values are far away from the mean, indicating normality of the data set (responses)

Table 4

Respondent	N	Mean	Std. Deviation	Decision
Community Ward Head	190	3.8345	.18267	Significant
Health Workers	190	2.1462	1.0711	Insignificant
Beneficiaries	190	2.4927	.9309	Insignificant

From the table 4 above, result indicated that the respondents rated the impact of incentives given have an impact on delivery at the hospitals as perceived by the respondents. Some of their average responses are within the cut-off point that is accepted and considered significant while others were out of cut-off point which are rejected and considered insignificant. Respondents selected at the community ward said it had impacted women were coming to the hospital for delivery (mean = 3.8345 > 3.00) which is accepted and significant. However, healthcare workers perceived that it has not significantly impacted on delivery (mean = 2.1462 < 3.00) which is insignificant and so also the beneficiaries (mean = 2.4927 < 3.00). This is unassociated with the fact that most of village women prefer to give birth with the help of traditional birth attendant and to some extent attitudes of some health-workers.

The standard deviations for all the respondents are within the ranges that their diversifications were not significant enough to affect the result above, because all the values are far away from the mean, indicating normality of the data set (responses)

Table 5. Identifying the problem associated with non delivery at the clinic by would be mothers.

s/n	Identified Problems	Frequency	Percentages
1	Small Amount of the incentives (N5,000)	62	33%
2	Presence of Traditional Birth Attendant	173	91%
3	Non-Challant Attitude of Health Workers	103	54%
4	Administrative Bottleneck	44	23%
5	Absence of free delivery kits	69	36%

To further confirm the non-compliance to deliver at the clinic under a skilled birth attendant, we subjected our respondents to identify the likely problems that discourage delivery at the clinic. We were able to identify that 91% unanimously agreed that the presence of Traditional Birth Attendant TBA at the villages to help the would be mothers to deliver at home discourage them from coming to the clinic, followed by 54% that complained of the non challant attitude of health workers in treating pregnant women also contributed to delivery at home under the custody of Traditional Birth Attendant.

Hypotheses Testing

The analysis was based on the recovered questionnaires, even though respondents were spot-checked on each questionnaire filled before leaving to avoid a missing observation. Any questionnaire received was subjected to skim-checking instantly and follow-up (if any), thereby closing any chance of

having missing data which may reduce the precision of the calculated statistics because the assumptions behind any statistical procedures are based on complete cases, and missing values can complicate the theory made therefrom.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.902	.813	.641	.2173603

Source: Author's Computation using SPSS

Anova

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	29.618	8	3.702	9.717	.000
	Residual	1.142	3	.381		
	Total	30.760	11			

Source: Author's Computation using SPSS

The coefficient of multiple correlation shows that there is strong and positive relationship between the incentives given and the explanatory variables (ante-natal care visits, delivery and post-natal care visit), with (R = 0.902). R – Squared, the coefficient of multiple determinations is 0.813. This showed that 81.3% of the total variation is explained by the changes in the independent variables, indicating that incentives given explained ante-natal care visits, delivery and post-natal care visit by 81.3%.

A multiple regression analysis was carried out to assess the impact of these variables. Study shows that when incentives given is sustained, ante-natal care visits, delivery at the hospital and post-natal care visits will got enhanced significantly (P value = 0.000 < 0.05). This showed that incentives given is a significant indicator as it reliably impacted ante-natal care visits, delivery at the hospital and post-natal care visit by 81.3%

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	-2.011	14.123		-.142	.896
	Ante-natal	.367	.033	.555	.622	.000
	Delivery by Skilled Birth Att.	.275	.010	.982	.672	.318
	Post-natal	.225	.250	.824	.900	.099

Source: Author's Computation using SPSS

Result from the regression analysis was carried out to ascertain the combine effect of these variables. The predictor, incentives given on antenatal care visits yielded a significant beta weight of β_1 = 0.367 with its corresponding t-value which is statistically significant (P = 0.000 < 0.05) which form the basis of rejecting the hull hypothesis and concluded that incentives given has a significant impact on the ante-natal care visits to the hospital.

Delivery by skilled birth attendant on the other hand has the value, β_2 = 0.275 with P- value that is insignificant (P = 0.318 > 0.05) indicating that the null hypothesis is not rejected and concluding that incentives given has no significant impact on delivery by skilled birth attendant in the hospital. In other word most women were not reporting to the hospital for delivery which is not unassociated to traditional birth attendant as result found in table 2 above; while,

Post-natal care visits to the hospital has a beta weight of β_3 = 0.225 with its corresponding P-value of 0.000. This showed that the calculated P-value is greater than the level of significant (P = 0.099 > 0.05) which is statistically insignificant and hence, we do not reject the null hypothesis on the basis that incentives given has no significant impact on the post-natal care visits to the hospital. By implication, it means most women do not attend post-natal services.

V. SUMMARY OF FINDINGS.

The analysis of data conducted in the previous section has revealed the following:

- That 76% agreed that the incentives has a very high impact on ante natal care visits, further confirming our believe that incentives has a way of encouraging people. On the other hand only 6% can say the same of delivery at the clinic indicating that the incentives has less impact on delivery at the clinic.
- We were able to identify the problem that stopped would be mothers that attended ante natal care but refused to come to the clinic for delivery even in the presence of the incentives. The problems identified are presence of traditional birth attendance at the villages, non-Chalant attitude of our health workers towards women delivering at the clinic, the small size of the incentives, administrative bottle neck and absence of free delivery kit.
- Our test of hypotheses further confirmed our findings, that incentives succeeded in bringing pregnant women for ante natal care unfortunately the success could not be achieved at delivery level.

VI. CONCLUSION

In the light of the above findings the study would conclude that unless adequate attention is given to attitudinal training of health workers to be responsive to their patient and traditional birth attendance are properly trained and incorporated in the working of the clinics the desired objective of encouraging would be mothers to deliver at the clinic would not be achieved thereby reducing maternal death..

VII. RECOMMENDATION

It is recommended that:

- Government should retrain existing health workers and introduces attitudinal behavior to the curriculum of new health workers so as to enable them to treat the patients compassionately.
- A programme should be developed to train and incorporate traditional birth attendant into the health programmes, in order to achieve two things one their experience and putting them under control as such will abide by standard practices.
- The incentives should be increased to increase the level of compliance and possibly remove all bottlenecks that act as hindrance to the beneficiaries accessing the incentives.
- In addition to that the health workers can improve on their attitude to encourage delivery at the clinic and traditional birth attendance can be incorporated by training to work at the clinics.

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