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AN INSIGHT INTO THE KEY PERFORMANCE INDICATOR OF CONDITIONAL CASH TRANSFER PROGRAM FOR MATERNAL AND CHILD HEALTH IN KHYBER PAKHTUNKHWA PAKISTAN

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ABSTRACT

There are many ways to improve mother and infant health using demand-side financing (DSF) which also includes conditional cash transfers (CCT) besides many others. In general, these initiatives aim to increase health service usage by reducing consumer costs, increasing household income, and encouraging healthy behaviors. This research examines experiences and difficulties faced in the implementation of the CCT program as well as well as its utilization for improving the maternal and neonatal health. Thus, this study explores a range of key performance indicators (KPI) of the CCT program that we developed to evaluate it in the selected five districts of the Khyber Pakhtunkhwa (KP). Our results indicate that the CCT program in KP improves access to quality maternal healthcare for women. According to KPI descriptive data, a well-implemented DSF program can increase access and use, reduce disparities, and improve program efficiency and service quality. This study highlights a set of crucial aspects of the program to consider when creating and executing financial incentive programs such as CCT to improve maternal and child health. Further, this study finds gaps in its implementation and utilizations and informing which could be useful for policy makers in bringing improvements in such programs.

***Key Words**: Conditional Cash Transfer (CCT), Key performance indicators (KPI), demand side financing (DSF),*

maternal and child health (MCH).

INTRODUCTION

Globally there has been an increasing effort to promote Maternal and Child Health (MCH), yet maternal mortality is still relatively high particularly in South Asian countries. Most of these preventable deaths (94%) occurred in low-resource settings (WHO, 2019). Although, global maternal mortality has reduced but it remains a significant public health issue in a number of developing countries like Pakistan (Mumtaz et al. 2012; Sumaiya, 2008; Farooq & Kayani 2014). Pakistan has one of the highest maternal mortality ratios in South Asia (WHO, 2019) with 140 deaths per 100,000 live births in 2017 (2.1%) which declined from 143 in 2016. Pakistan still faces challenges in reducing maternal and child mortality. Timely utilization of MCH care services can ensures safe motherhood through promotive, preventive, curative and rehabilitative health care system. The utilization of MCH care services in Pakistan is far low as compared to other developing countries. The situation is even worse in the province of Khyber Pakhtunkhwa (KP). The maternal mortality rate (MMR) in KP stood at 167 per 10,0000 cases in government health facilities, where 383 women died out of a total of 22,8936 deliveries in 2018 (DHIS, 2018).

Many economic, social, behavioural, and health system factors contribute to MCH underutilization and inequity. High costs (direct and indirect costs of healthcare) and health professionals' attitudes (Moyer, 2013) can make health facilities unavailable or unpleasant (Pell, 2013). Despite various health care reforms in recent years (e.g Sehat Sahulat cards, Sehat Insaf cards in KP), Pakistan's health situation still needs improvement. Providing affordable and high-quality health care is a critical responsibility of the state, since WHO recommends that the state should spend at least 5% of GDP on health. However, the government budget for 2021-22 allocated Rs 28.3 billion for health, or just 0.4 percent of the entire expenditure (GOP, 2022). This makes $45 per capita total health expenditure which is quite low compared to other developing countries. As a result, such minimal government assistance leads to significant out-of-pocket costs, i.e almost about 60%. Thus, poor people cannot afford health care, and rural health facilities' physical remoteness further limits access to services and skilled health workers (Alabi, 2018, Bangdiwala et al., 2010; Abimbola et al., 2005).

Financial incentives, such as conditional cash transfers (CCTs), are increasingly used to incentivize desirable behaviours or actions, such as delivering and using mother and child health services (Sato & Fintan, 2020; Liu et al., 2019;; Owusu, 2016; Hunter & Murray, 2017). These financial incentives work by rewarding people for doing things that promote their long-term health (Marteau, et al., 2009). Furthermore, incentives impact both demand (availability to relevant services at the appropriate time) and supply (providing appropriate services of good quality to anyone in need) (Paina & Morgan, 2014).

Demand-side financing schemes aim to eliminate financial obstacles to access for vulnerable groups by providing them with the purchasing power to use a particular service (Ensor, 2004a). A typical CCT delivers a financial reward directly to beneficiaries who meet a set of conditions (Borghi, 2006; Ensor, 2004b). To achieve the Sustainable Development Goals (SDGs), the province's maternal health service delivery must be enhanced through new ways. The CCT program, which began in 2014 in KP, is one of the initiatives aimed at increasing maternal health service utilization. Similar CCT initiatives in South Asia have demonstrated varied degrees of efficacy such as in Nepal, India, and Bangladesh. All the programs have increased maternal health care utilization (Powell, 2009a; Ahmed & Khan, 2011), but challenges have been identified in Bangladesh (Ahmed & Khan, 2011; Schmidt et al., 2010) and Nepal (Powell, 2009b). These

include issues with timely reimbursement of cash incentives to beneficiaries and providers, as well as barriers to participation for the poorest women.

Khyber Pakhtunkhwa announced Rs. 2700 stipend for pregnant women in the March 2014 with a view to improve the healthcare utilization of the expecting women. It was initially introduced in 10 relatively poorer districts. The main objective of the chief minister's special initiative for mother and child health (CM initiative) is to give incentives to the expecting mothers to encourage them to attend trained birth attendants or seek to hospital care during pregnancy and thus improve mother and child health. Initially, the project began in July 2014 with a budget of Rs 300 million. A stipend of Rs 2700 per pregnancy is granted on the basis of four antenatal visits (at a cost of Rs 300 each visit), one postnatal visit (at a cost of Rs 500), and a birth incentive of Rs 1000. An additional Rs 500 will be paid to the mother if she visits within 42 days after delivery. Additionally, they would receive an additional Rs 300/- to cover their transportation costs as well as free medicines at health centres. Chitral, Nowshehra, Haripur, Bannu, Malakand, Swabi, Shangla, Upper Dir, Lakki Marwat, and Karak were the initial districts to participate in the effort. It was anticipated that it will help around 103,323 mothers across all ten districts. However, later in 2015, the initiative was expanded to include the entire province. The number of beneficiaries increased to 47008 in KP in 2018 from 281 in 2013. Annual disbursements have increased from Rs. 755300 to Rs. 25864400. Women who have been evaluated by a government-licensed Lady Health Visitor (LHV), Lady Health Worker (LHW), Community midwife (CMW), or skilled birth attendant (SBA) at the nearby health facility were also made eligible to receive the CCT.

Qualitative research and process documentation are essential for governments, evaluators, practitioners, donors, and the global health community (Mshelia et al.,2013; Sosa et al., 2011). Previous evaluations on CCTs have been either purely descriptive in nature (Gupta et al., 2011), process-oriented in selected states (UNFPA, 2009), or focused on secondary data (Lim, et al., 2009). There is a dearth of research on directly interviewing the beneficiaries to seek their satisfaction from the program or challenges faced.

In Pakistan, a study by Agha (2011) on CCT found that beneficiaries were 8 percentage points less likely to give birth than non-beneficiaries, had fewer children, and were older at marriage. Early results from an ongoing review of five voucher schemes in Bangladesh, Cambodia, Kenya, Uganda, and Tanzania and Pakistan suggest significant results on service consumption and equity (Bellows, et al., 2013; Alexender, & Hearld, 2012).

This study particularly evaluate the CM initiative program by outlining how the program is implemented and whether participants were satisfied with services provided through the program, whether the amount they receive was appropriate or not, the timeliness of receipt of the cash incentive, difficulties in receiving the cash, mode of payment they received, how and where did they spend the cash, and the main reason to participate in the program. Particularly, this research examines the extent to which the cash transfer program is being utilized, and the major reasons for participation/non-participation by interviewing the expecting women in five randomly selected districts of KP.

LITERATURE REVIEW

The conditional cash transfer programs became popular in late 90's in Mexico, Brazil and Banglades respectively namely Oportunidades (Progresa), Bolsa Família and Food for Education respectively. Later from Latin America these welfare programmes began to spread to the rest of the world. Like the Familias en Acción program (FA) launch in Colombia, the Programa de Asignación Familiar (PRAF) in Honduras, the Program of Advancement through Health and

Education (PATH) in Jamaica, and the Red de Protección Social (RPS) in Nicaragua. These programmes targeted reduction poverty in longer term and in short run it tried to change the behaviour of people towards health, education and nutrition. They are designed to improve their health and nutrition, including antenatal care (ANC), and postnatal care (PNC), immunization, institutional deliveries, regular check-ups, nutrition monitoring and supplementation, and participation in educational programs regarding health, hygiene, and nutrition. The success of these programmes led the way for other countries as well to follow. By 2005, a large literature evaluated the programmes and analysed its outcome (Fernald, 2008) and thus similar initiates were taken (Fiszbein et al. 2009; Grindle and Thomas 1991; Britto 2005). Bosla Familia which by 2011 enrolled 11.1 million people, almost 25% of the country's population (Lindert et al. 2007, 2008). Substantial literature examined the CCT programs throughout the world and supported the evidence that many social and health indicators have been improved as result of these CCT programs. Nevertheless, some of these programmes failed to attain its desired goals. Tahir et al (2022) studied the effect of remittances on maternal health care outcomes for Pakistan. Using Pakistan Social and Living Standards Measurement (PSLM) survey, 2018-19, the study reports a significant and positive effect of international remittances on the healthcare outcomes of childbearing mothers. Thus, financial support or social development programs by the government or non-governmental organization are pivotal in enhancing the healthcare outcomes and ultimately the living standards of childbearing mothers.

MATERIAL AND METHODS

Study area and participants

A cross sectional data were collected through a well-structured questionnaire from the program beneficiaries from the healthcare facilities where the conditional cash transfer was offered. Out of the 25 districts of KPK, district Malakand, Kohat, Swabi, Peshawar and Nowshera were randomly chosen (figure 1). In each district, the number of beneficiaries are known and defined as all those females who enrolled in the program and benefited from the cash incentives. In these districts we randomly selected 408 households[1], and these program beneficiaries were contacted through community midwives (CMW) in a randomly selected union council (UC).

[1] The study used Krejcie and Morgan (1970) method of determining the sample size by the formula $S = \frac{\mathcal{X}^2 NP(1-P)}{d^2(N-1)+\mathcal{X}^2 P(1-P)}$

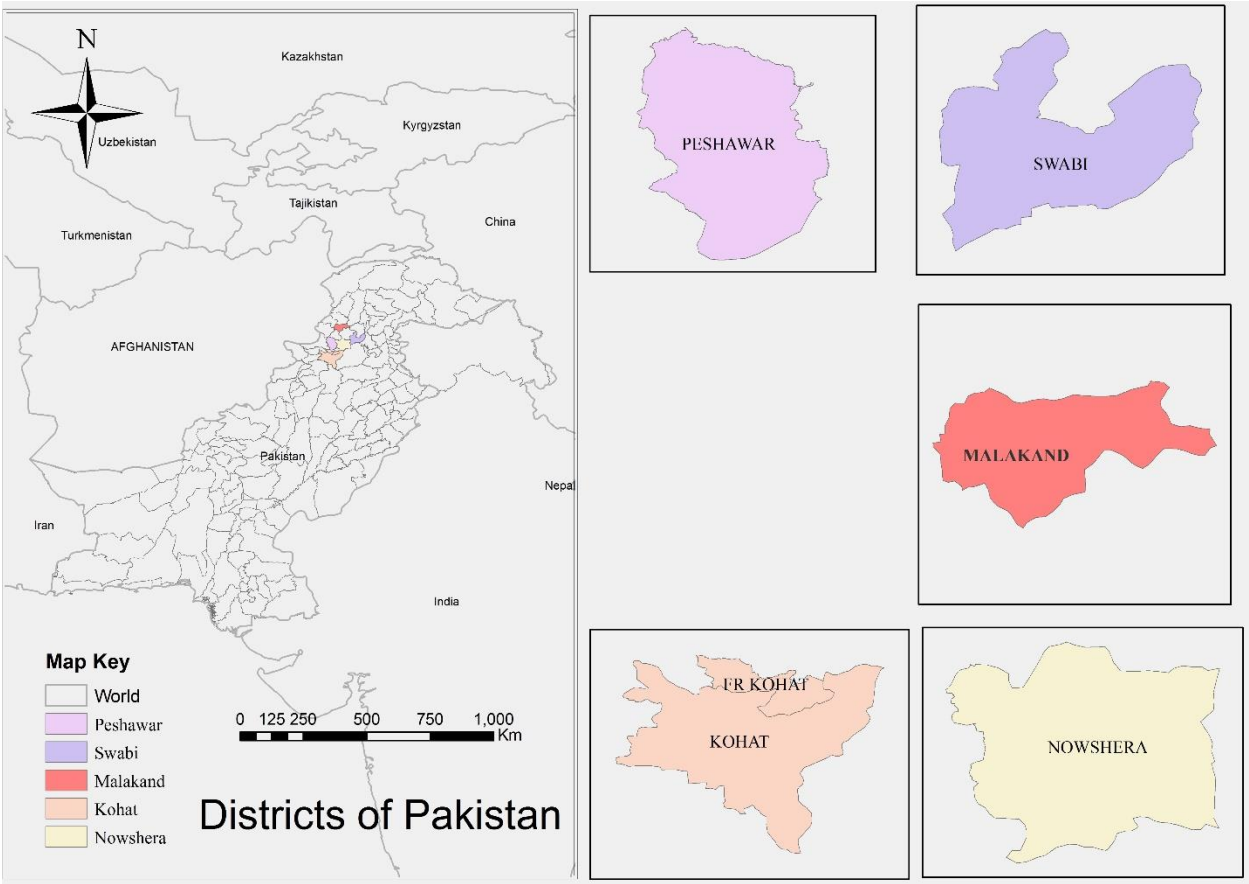

Figure 1: Map of Pakistan showing study area (authors self-generated)

1.1 Data analysis:

This study interviewed married women aged 15-49 years where it is found that the average age of woman was 31.5 years with a standard deviation of 6.36. The respondent's age is a significant factor influencing the decision of women to participate in CCT. As the respondent's age at her first birth is greater, she is mature enough to make health decisions on her own. The average age at first birth is 21.87, with a standard deviation of 3.35. On average, sampled women completed six years of schooling, compared to eight years for their husbands. Almost 93 percent of respondents indicated that they live in a joint family structure, while just 7 percent indicated that they live in a nuclear family system. However almost 79 percent of the respondents indicated access to skilled health provider, therefore 83 percent of deliveries of these respondents took place in public hospital. Not surprisingly, these females had an average of two ANC visits and nearly no PNC visits. One of the primary reasons could be the access to the health facilities, as the survey indicated that around 39 percent of the respondent have access to health facilities and these respondents lived an average of 14 kilometres from the nearest health centre.

Table 1: Characteristics of the CCT program participants

Variables	Units	Mean	SD
Age	Years	31.5	6.36
Age at first birth	Years	21.87	3.35
Women total years of schooling completed	Years	6.38	4.3
Husband years of schooling	Years	8.1	2.87
Total Household size	Numbers	21	8.73
Live pregnancies	Numbers	5	2.07
Total number of pregnancies	Numbers	6	2.47
Health services provider (Skilled/ Unskilled)	Numbers	0.797	0.403
Residence: Rural/ Urban	Binary	0 .91	0.28
Access to ICT info	Binary	0.573	0.495
Place of delivery (institution/Home)	Binary	0.831	0.375
Type of Delivery (Normal/ C section)	Binary	0.88	0.325
Number of ANC visits	Numbers	2.5	1.25
Post Natal care Visits (PNC)	Binary	0.45	0.498
Access to health facility	Binary	0.39	0.488
Birth Interval (<1/>=2 years)	Binary	0.78	0.411

Source: Author's own calculation based on primary data

Key Performance indicators (KPIs) for Evaluation of Conditional Cash Transfer Program

In this section, we shall evaluate the CCT program based on the major objectives of the program and that how respondents viewed the program based on their experiences. All the questions were closed ended with likert scale. It is important to mention here that all the questions regarding program evaluation have been asked from those who participated in the program. Firstly, respondents were asked whether the program was helpful to motivate them to use institutional facilities for deliveries. About 66 percent of the respondents strongly disagreed that it did not motivate them for institutional deliveries as indicated in table 2. One of the primary reasons cited by respondents was the difficulty in obtaining cash incentives. Most respondents indicated that they waited two to three months to obtain the incentives. However, respondent perceptions of program motivation for institutional deliveries are statistically significant across districts.

Table 2. Evaluation of CCT: program helpful to motivate for institutional delivery

District Wise		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total	$\mathcal{X}^2$
Swabi	**N**	67	7	10	10	14	105	64.35 (0.00)
	%	60.95	6.67	9.52	9.52	13.33	100.00	
Peshawar	**N**	62	7	12	0	0	81	
	%	76.54	8.64	14.81	0	0.00	100	
Malakand	**N**	80	12	26	5	1	124	
	%	64.52	9.68	20.97	4.03	0.81	100	
Kohat	**N**	25	3	6	0	0	34	
	%	73.53	8.82	17.65	0	0	100	
Nowshera	**N**	39	5	18	0	0	62	
	%	62.90	8.06	29.03	0	0	100	
Total	**N**	270	34	72	15	15	408	
	%	66.50	8.37	17.73	3.69	3.69	100	

Source: Author's own calculation based on primary data

Since the program's inception, any expectant woman interacting with their nearest accessible LHW, CMW, LHV, or CMW were instantly enrolled in the program, regardless of economic condition. Around 22 percent of program participants felt that the targeting process was fair, whereas 38 percent disagreed. It is necessary to assess the effect of incentives on equity in access to MCH care and resource distribution across socioeconomic classes, rural and urban women, and marginalized populations.

The study identified that understanding mechanisms of payment to providers is important since increasing demand without commensurate supply-side support may actually damage quality. For example, on user fee study from South Africa showed a decrease in ANC service-use when fees for curative care were removed. The authors attributed this decrease in preventive care-use to increased congestion in clinics and reduced consultation times (Hernandez, 2003). The evidence on the impact of user fee exemptions on quality suggests that policymakers should exercise caution, given that fee exemption policies may directly reduce facility revenues. Averting negative supply-side effects relates to "whether policies were effectively put into place to ensure that facility operating budgets and provider incomes did not decrease, as well as the pre-existing infrastructure, human resources, and supply chain systems in place prior to the policy change" (Hatt, et al.,2013).

Table 3 Evaluation of CCT: Program Targeting Mechanism was fair

District Wise		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total	$\mathcal{X}^2$
Swabi	**N**	4	52	28	19	2	105	86.54 (0.00)
	%	3.81	49.52	26.67	18.10	1.90	100%	
Peshawar	**N**	8	41	20	11	1	81	
	%	9.88	50.62	24.69	13.58	1.23	100%	
Malakand	**N**	20	51	28	19	6	124	
	%	16.13	41.13	22.58	15.32	4.84	100%	

Kohat	**N**	5	9	8	11	1	34
	%	14.71	26.47	23.53	32.35	2.94	100%
Nowshera	**N**	0	1	27	31	3	62
	%	0.00	1.61	43.55	50.00	4.84	100%
Total	**N**	37	154	111	91	13	408
	%	9.11	37.93	27.34	22.41	3.20	100%

Source: Author's own calculation based on primary data

As highlighted, programs should be established from the start to maximize equity and quality (World Bank, 2013; Rob et al., 2011). In payment schemes for providers, incentives for growing the quantity of services should be conditional on their quality, and efforts should be made to better target benefits to the poorest and most difficult-to-reach populations. This can be accomplished in a variety of ways, including by restricting eligibility to low-income persons or regions, as well as by rewarding providers for serving in disadvantaged areas (Rob et al., 2011). Our results indicate that respondent perceptions of the procedure for program targeting are statistically significant across districts. Additionally, it is evident that respondent perceptions of the procedure for program targeting are statistically significant across districts as well.

The source of information, or how individuals learned about the program, is a significant component in the program's high participation rate. Throughout the data collection process, it was noted that members of the community routinely imitated what others did in their community. It has previously been demonstrated that community ideas and norms on health habits have a significant impact on individuals' decisions to seek care (Stephen et al., 2006). If a woman participated in a program and received cash, she contacted other women in her community about the program and encouraged them to enrol as well. Additionally, as seen in the table 3, neighbours/relatives and health workers were found to be key sources of knowledge about the program in selected five districts. i.e., 36 percent of total program recipients learnt about the program from their neighbours and family, followed by 35 percent from LHW/CMW.

Participants frequently highlighted the role of the CMW/LHW in their community as crucial in ensuring that women seek delivery in a CCT-certified facility. Thus, human-created sources of information played a crucial role compared to electronic or print media as only 12 percent of program beneficiaries receive program information via electronic or print media. Additionally, all these sources of information on the program are statistically significant across districts.

Table 4: Evaluation of CCT: How do you get know about the CCT program?

District Wise		Newspaper	Television	Neighbour/ Relatives	Health Worker	Radio	Mobile	Others	Total	χ^2
Swabi	**N**	2	6	32	43	5	10	7	105	59.60
	%	1.90	5.71	30.48	40.95	4.76	9.52	6.67	100 %	(0.00)
Peshawar	**N**	5	8	25	24	6	11	2	81	
	%	6.17	9.88	30.86	29.63	7.41	13.58	2.47	100 %	
Malakand	**N**	0	15	42	39	5	23	0	124	
	%	0.00	12.10	33.87	31.45	4.03	18.55	0.00	100 %	
Kohat	**N**	0	3	14	19	1	6	0	34	
	%	0	8.82	41.18	29.41	2.94	17.65	0	100 %	
Nowshera	**N**	3	33	26		0	0	0	62	
	%	0	4.84	53.23	41.94		0	0	100 %	
Total	**N**	7	35	146	142	17	50	9	408	
	%	1.72	8.62	35.96	34.98	4.19	12.32	2.22	100 %	

Source: Author's own calculation based on primary data

Responses were noted on a five-point likert scale with a range of strongly disagree to strongly agree. As indicated in table 4, almost half of the respondents stated that forum offered by the CCT program at health facilities was improper.

Table 5: Evaluation of CCT: Forum provided at health facilities by CCT program was appropriate

District Wise		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total	χ^2
Swabi	**N**	7	59	30	9	0	105	129.1
	%	6.67	56.19	28.57	8.57	0	100 %	(0.0)
Peshawar	**N**	1	42	32	5	1	81	
	%	1.23	51.85	39.51	6.17	1.23	100 %	
Malakand	**N**	3	74	44	3	0	124	
	%	2.42	59.68	35.48	2.42	0.00	100 %	
Kohat	**N**	1	21	10	2	0	34	
	%	2.94	61.76	29.41	5.88	0.00	100 %	
Nowshera	**N**	0	1	31	26	4	62	
	%	0.00	1.61	50.00	41.94	6.45	100 %	
Total	**N**	12	197	147	45	5	408	
	%	2.96	48.52	36.21	11.08	1.23	100 %	

Source: Author's own calculation based on primary data

The study assessed whether the respondents received cash for the initial payment or for all subsequent instalments. They were asked as to how the CCT money helped them. They were also asked whether they spent money on medical, transportation, child health, or domestic uses. As reported in table 5, 38 percent of respondents indicated that it aided them in the purchase of medicine and almost 30 percent of respondents indicated that it assisted them in covering transportation costs.

Table 6: Evaluation of CCT: What aspect CCT program helped you?

District Wise		Purchasing medicine	Transportation cost	Child Health	Household chaos	Others	Total	χ^2
Swabi	**N**	34	43	12	9	7	105	166.6
	%	32.38	40.95	11.43	8.57	6.67	100%	1
Peshawar	**N**	42	23	6	8	2	81	(0.00)
	%	51.85	28.40	7.41	9.88	2.47	100%	
Malakand	**N**	56	34	3	8	3	124	
	%	53.85	32.69	2.88	7.69	2.88	100%	
Kohat	**N**	13	9	7	5	0	34	
	%	38.24	26.47	20.59	14.71	0	100%	
		0.00						

Nowshera	**N**	0	4	32	26	0	62
	%	0.00	6.45	51.61	41.94	0.00	100%
Total	**N**	145	113	60	56	12	408
	%	37.56	29.27	15.54	14.51	3.11	100%

Source: Author's own calculation based on primary data

Table 6 indicates the majority of respondents reported that 40 percent of their cash is spent on domestic uses. Finally, 38 percent stated that they purchased medicine thus spending money on their own health. Also, 12 percent paid to cover their transportation costs. Receiving cash immediately is one of the most tempting features of a cash incentive program for behaviour modification (Mazumdar, et al., 2011). This becomes even more crucial if the funds are required to other medical expenditures, transportation, and other expenses beneficial to the mother, such as nourishing food throughout the post-natal period. Other CCTs' literature does not particularly examine the impact of these concerns on program utilization (Rawlings, 2004). Additionally, statistically significant differences across districts in all variables from various sources are evident.

A recent study in Mali discovered that wealthier women received a considerably bigger share of free institutional deliveries than poor women. However, there were persistent geographic, transportation, and cultural barriers to seeking and accessing facility-based care (Mazumdar, et al., 2011). Mazumdar, Mills, and Powell-Jackson (2011) claimed that in India that an unpublished review of JSY found that the program was more beneficial for less-educated, poor, and ethnically marginalized women (Criel, 1999).

Table 7: Evaluation of CCT Program: Where did you spend the amount of CCT?

District Wise		**Own Health**	**Child Health**	**Transportation Health**	**Household chaos**	**Others**	**Total**	χ^2
Swabi	**N**	37	13	6	48	1	105	175.49
	%	35.24	12.38	5.71	45.71	0.95	100 %	(0.00)
Peshawar	**N**	42	6	1	27	5	81	
	%	51.85	7.41	1.23	33.33	6.17	100 %	
Malakand	**N**	53	2	2	42	5	124	
	%	50.96	1.92	1.92	40.38	4.81	100 %	
Kohat	**N**	13	7	1	11	2	34	
	%	38.24	20.59	2.94	32.35	5.88	100 %	
Nowshera	**N**	0	3	33	26	0	62	
	%	0	4.84	53.23	41.94	0	100 %	
Total	**N**	145	31	43	154	13	408	
	%	37.56	8.03	11.14	39.90	3.37	100 %	

Source: Author's own calculation based on primary data

As indicated in table 7 below nearly 36 percent of respondents stated that the amount received was insufficient. It needs to be increased. And around 42 percent of respondents indicated that the quantity was neither insufficient nor sufficient. And 13 percent stated that the amount received was completely inadequate. If we examined the appropriateness of the amount received for each visit, almost 43 percent of respondents indicated that the amount received for each visit was insufficient. And almost 40 percent were indifferent to the monetary compensation they received for each visit.

Table 8: Evaluation of CCT: what do you think the CCT amount was sufficient?

District Wise		Completely Insufficient	Insufficient but coping	Neither insufficient nor sufficient	Sufficient	Quite Sufficient	Total	χ^2
Swabi	**N**	21	43	27	14	0	105	123.3 (0.00)
	%	20.00	40.95	25.71	13.33	0.00	100%	
Peshawar	**N**	5	30	44	2	0	81	
	%	6.17	37.04	54.32	2.47	0.00	100%	
Malakand	**N**	13	35	54	1	0	124	
	%	12.62	33.98	52.43	0.97	0	100%	
Kohat	**N**	5	9	11	7	2	34	
	%	14.71	26.47	32.35	20.59	5.88	100%	
Nowshera	**N**	6	20	27	9	0	62	
	%	9.68	32.26	43.55	14.52	0	100%	
Total	**N**	50	137	163	33	2	408	
	%	12.99	35.58	42.34	8.57	0.52	100%	

Source: Author's own calculation based on primary data

The majority of those who enrolled in the CCT program assumed that the program's distribution would be cashless (JSY, 2006). However, the majority of our survey respondents said that they have incurred out-of-pocket (OOP) expenses. While they did not believe the increased OOP costs outweighed the benefits of receiving the monetary incentive and having a TBA, addressing these bureaucratic procedural obstacles and ensuring women receive their money relatively simply and promptly may be crucial for the program's longevity (Sidney et al., 2012).

Table 9. Evaluation of CCT: what do you think amount allocated for each visit was appropriate?

District Wise		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total	χ^2
Swabi	**N**	17	44	33	11	0	105	43.58
	%	16.19	41.90	31.43	10.48	0	100%	(0.00)
Peshawar	**N**	5	37	37	1	1	81	
	%	6.17	45.68	45.68	1.23	1.23	100%	
Malakand	**N**	8	48	48	0	0	124	
	%	7.69	46.15	46.15	0	0	100%	
Kohat	**N**	6	12	9	7	0	34	
	%	17.65	35.29	26.47	20.59	0	100%	
Nowshera	**N**	3	26	26	7	0	62	
	%	4.84	41.94	41.94	11.29	0	100%	

Total	**N**	39	167	153	26	1	408
	%	10.10	43.26	39.64	6.74	0.26	100%

Source: Author's own calculation based on primary data

When considering the reasons for participation in the program, it is clear from the table 9 that almost 40 percent of total respondents expressed concern about their child's health. About 26 percent stated that they engaged only for the monetary prize. However, nearly 15 percent of participants were enrolled in the program owing to poverty. Additionally, it is obvious that each of these motives for participation is statistically significant across multiple districts.

Table 10: Evaluation of CCT: what was the main reason for you to participate in CCT program?

District Wise		**Complication in Previous pregnancy**	**Poverty/ Low income**	**Receive Cash Incentive**	**Concerned about child health**	**Concerned about own health**	**Total**	χ^2
Swabi	**N**	19	26	25	28	7	105	46.83
	%	18.10	24.76	23.81	26.67	6.67	100 %	(0.00)
Peshawar	**N**	12	9	22	35	3	81	
	%	14.81	11.11	27.16	43.21	3.70	100 %	
Malakand	**N**	17	11	28	43	5	124	
	%	16.35	10.58	26.92	41.35	4.81	100 %	
Kohat	**N**	1	4	6	16	7	34	
	%	2.94	11.76	17.65	47.06	20.59	100 %	
Nowshera	**N**	2	8	19	33	0	62	
	%	3.23	12.90	30.65	53.23	0.00	100 %	
Total	**N**	51	58	100	155	22	408	
	%	13.21	15.03	25.91	40.16	5.70	100 %	

Source: Author's own calculation based on primary data

Discussion of Results

Various aspects of the CCT program have been examined district wise using descriptive analysis. We found that the CCT beneficiaries are older, married later, and have better education, notably in Swabi and Kohat. Their partner also had higher education. Whereas their total number of children is around 5, and most of them have a joint family system. The CCT beneficiaries also have more ANC and PNC visits. There were 75 percent public hospital births and only 13 percent home births among the beneficiaries. Non-beneficiaries, on the other hand, only 58 percent delivered in a public health institution, while 25 percent delivered at home. In terms of delivery help, we found that program participants received over 85 percent more SBA aid than non-participants. The analysis shows that the CCT program has greatly improved the MHSU. Premature births, obstructed labour, and high blood pressure were the most common pregnancy problems. Further, most respondents have miscarriages and neonatal death. Access to health facilities is a crucial element in CCT enrolment. The

study indicated that those with easy access to healthcare facilities participated more in the CCT program. Compared to non-participants, over 43 percent of program participants reported easy access to health facilities (36 percent). In Peshawar and Kohat, health facilities are easily accessible. A key factor of program participation, according to empirical research, is transportation costs.

Present study mainly focused on the program key factors to evaluate the program across districts and among the program beneficiaries. To evaluate the program, respondents were asked about the program performance indicators. Regarding program performance, almost 50% of the program participants claimed that the amount they received was insufficient and inappropriate, thus failed to motivate them for institutional deliveries. Besides this the respondents claimed that the forum provided at health facility by the CCT program was inappropriate and the targeting mechanism found to be not fair.

Apart from the factors outlined previously, the program has a substantial impact on ultra-poor households for whom this minimum amount was even sufficient. The study discovered that approximately 30 percent of respondents received enough money to cover their transportation costs. However, when we examine how the income is spent, we find that roughly 40 percent of respondents spent it on home consumption needs and 38 percent on medicine, implying that they spent it on their own health too. Regarding the source of information, the survey discovered that the CMW and neighbors/relatives were the most significant sources of information for respondents.

The key inference of the present study is that such program should first target ultra-poor women living specifically in marginalized areas of KP. Further, better results could be achieved if the program is better advertised so that more expecting woman become a part of this program and money better spent too. This study contributes to a growing body of knowledge concerning demand-side interventions' effectiveness and best practices.

CONCLUSION AND POLICY RECOMENDATION

We examined the characteristics of the participants in the CCT program and related it to their participation in the CCT program as well their decision regarding the healthcare decisions. The study indicated that geographical variables such as the difficult terrain or distance of health facilities and communities, can impact access to care, the availability of critical supplies, and the motivation of health professionals. The findings of this study, which are among the first systematic evaluations of maternal health incentive payments in KP will have policy consequences for the province and for Pakistan as a whole. Along with establishing the critical role of CCT in promoting MHC uptake, the evaluation of the program's key performance indicators is important. The findings will assist policymakers in creating and implementing health care programs targeted at boosting health care access especially to the marginalized segment of the population.

The study concludes that prior to implementation of cash incentives, careful planning is required to ensure that sufficient administrative and financial resources are mobilized to ensure timely processing and disbursement of vouchers and incentive payments, as well as that enrolment criteria are contextually appropriate and understood. Where local health service capacity is insufficient, a demand-side strategy may be unsuccessful in the absence of significant increase of health facility service delivery capacity. Finally, when evaluating a program that lasts only five years, the findings cannot be appropriately deduced. The CCT program reveals a complex view of experiences that reflects the impact of financial and other social, geographical, and health system barriers to treatment access. Careful program design as part of broader mother and new-born health programs would need to take these impediments, staff practices, and the quality of care in health facilities into account. There is still a need for research on the policy context of such initiatives to determine how they can be made sustainable and how they fit, or do not fit, into plans to achieve equitable universal health care (UHC). KP has a long way to go in terms of allocating sufficient public funds to accomplish UHC. It will also find fiscal space once it becomes a fiscal priority. Additionally, payments for increased service volume should be conditional on provider quality, and efforts are made to better target benefits to the poorest and most difficult-to-reach populations. This can be accomplished in a variety of ways, including by restricting eligibility to low-income individuals or regions, as well as by compensating providers for serving in disadvantaged areas.

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