Reducing Financial Barriers for the Poorest of the Poor in Accessing Health Services: The Case of Demand Side Financing (DSF) in Wamba LGA

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Abstract

Introduction: Within the Results-Based Financing (RBF) Project in Nigeria, Demand Side Financing (DSF) pilot is implemented to increase the delivery and use of high impact maternal and child health indicators. The DSF strategy implores a conditional cash transfer (CCT) and Transport voucher schemes.

Objective: To investigate how Demand Side Financing reduces financial barriers for the poorest of the poor in accessing health care services in Wamba LGA, Nasarawa State.

Methods: This explanatory case study aimed at analyzing the experiences of Nasarawa State in implementing DSF using the World Bank DSF framework for Health Projects.

Design: We performed a document review and interviews with various stakeholders (n D 30) and then conducted thematic analysis of interview recordings. We carried out 10 Focused group discussions each in the 10 wards of the Wamba LGA piloting DSF. Informants were selected according to variables such as sub-group (Women of Child Bearing age, Health Facility Staff, LGA PHC directors, Ward development Committee (WDC) and Community Based members), Transporters, knowledge of their community, experience with the HC, past or current experience on DSF implementation etc., to allow for maximum variation in the sample.

Results: Study results indicated that, DSF has contributed in reducing financial and geographical barriers for the poor and high risk groups to access health services in PBF health facilities, increased the coverage of maternal child and child health indicators, promoted social inclusion to complement the supply-side components of the NSHIP, and enhance the achievements of the RBF intervention.

Conclusion: This study concisely demonstrates that when supply-side subsidies and demand side subsidies are combined greater gains for the poor and vulnerable populations are achieved.

Keywords: Demand-side financing; Vouchers; Conditional Cash Transfers; Maternal health; Maternal and child health; Implementation; cash transfers; financial barriers, Geographical barriers, High risk groups.

Introduction

With funding from the World Bank, the Nigerian government has been implementing the five-year Nigeria State Health Investment Project (NSHIP) in three states – Ondo, Nasarawa and Adamawa – since 2011. This results-based financing (RBF) project has two distinct components: 1) strengthening service delivery mainly at the health facility level and 2) strengthening institutional performance at the federal, state and local government area (LGA) levels. To provide technical assistance (TA) to the implementation of NSHIP, the National Primary Health Care Development Agency (NPHCDA), which is charged with the general coordination of the implementation of the project – contracted a Results Based Financing – Technical Assistance (RBFTA) firm-Oxford Policy Management (OPM).

As part of strengthening institutional performance the RBF-TA in Nasarawa State assisted the NSHIP Project Implementation Unit (PIU) to implement and document Demand Side Financing.

The NSHIP project received additional financing in 2015 to enable the Government of Nigeria (GON) to pilot-test transport vouchers and conditional cash transfers (CCTs) for high risk groups - mothers and under-five children living around primary healthcare centers (PHCs) implementing performance-based financing (PBF) in three pre-pilot Local Government Areas (LGAs), each in Adamawa, Nasarawa and Ondo States of Nigeria.
In Wamba LGA in Nasarawa State, CCTs and Transport Vouchers schemes were meant to address the major demand-side barriers to access and improve the utilization of essential health services, especially among the poor households. In an earlier survey carried out by the World Bank to assess the barriers to health care access, financial inaccessibility stood out as the major impediment(WORLD BANK NIGERIA, 2015).

Over the past 10 to 15 years, results-based financing (RBF) has gained increased prominence in global health(Witter, Fretheim, Fl, & Ak, 2012). Though the term RBF encompasses a variety of demand- and supply- side incentives to increase output or enhance access and quality(Fritsche, Soeters, & Meessen, 2014), the focus of this special issue and our commentary is on incentives that target service consumers.

Results Based Financing is an arm in achieving Universal Health Coverage and the world Bank hopes that poorest countries will scale up results-based financing programs as they are already producing dramatic improvements in maternal and child health(Jim Yong Kim, 2013). Universal health access will not be achieved unless women are cared for in their own communities and are empowered to take decisions about their own health in a supportive environment. This will only be achieved by community-based demand side interventions for maternal health access(Elmusharaf, Byrne, & O’Donovan, 2015).

The PBF pre-pilot in Wamba LGA that started in 2011, led to substantial improvement in utilization of essential health services, but there still remain gaps to the end targets. During the pilot phase, it was identified that, as supply-side issues improve, demand-side barriers can be a bottleneck in increasing facility utilization. Analytical work identified demand-side incentives as promising approaches to address major demand-side barriers.(WORLD BANK NIGERIA, 2015)

The objective of DSF implementation is to increase the delivery and use of high impact maternal, child, reproductive and disease control health interventions, particularly among the poor, and improve the quality of care provided in publicly-financed health facilities within project States.(WORLD BANK NIGERIA, 2015)

To achieve the said objective, common demand side strategies are usually grouped into three categories:(i) Financial incentives/ subsidies; (ii) Enhancing patient transfer to health facilities, and; (iii) Community involvement (Elmusharaf et al., 2015). These three strategies are factored into the DSF design in Nasarawa State.

“Results-based approaches (RBA) to development financing have mushroomed in recent years”(Grittner, 2013). Two main types of RBF can be distinguished. Performance-based financing (PBF) targets the supply side, whereas conditional cash transfers target the demand side of a given market. There are a number of comprehensive reviews and studies on CCTs.

Conditional cash transfer programs are a widely applied social protection scheme that has achieved some extend of success in fighting poverty worldwide.(Manley, Gitter, Slavechevska, & Manley, 2011) But performance-based financing has received more attention in recent RBF projects. Conditional cash transfers (CCTs) are programs that transfer cash, generally to poor households, on the condition that those households make pre-specified investments in the human capital of their children. Health and nutrition conditions generally require periodic checkups, growth monitoring, and vaccinations for children less than 5 years of age; perinatal care for mothers and attendance by mothers at periodic health information talks(Bank, 2009)

The concept of Demand Side Financing (DSF) in health originated in response to developing countries’ felt need to improve access to and utilization of health services, particularly among the poor (poorest of the poor or indigents in the case of Performance Based Financing)(Gupta, William, & Rudra, 2010).

DSF was therefore seen as a tool that could improve the utilization of under-used services among the needy and under-served populations by placing purchasing power, as well as the choice of provider (where possible), directly in the hands of the recipients. The services considered most relevant in this context were those that qualified as merit goods, and had significant externalities such as immunization, maternal and child services, use of bed nets for malaria control etc.(Gupta et al., 2010)

In Nigeria and other LMIC countries there are demands for out-of-pocket formal fees and informal payments for care services or supplies such as medicines, sutures, gloves and diagnostic tests(Hunter & Murray, 2017). A study in Nigeria revealed that, 60% of all health spending is financed directly by
households without insurance (out of pocket). This is way above the 15% threshold beyond which households risk being pushed into poverty by health care expenses (WHO)(Declaration, 2013). Women and their families can face multiple barriers to accessing maternity care services, and financial barriers are a well-documented concern. (Amakom & Ezenkwe, 2012)(Hunter & Murray, 2017)

Benefits of community health financing

For every dollar spent on key interventions for reproductive, maternal, newborn and child health, in demand side schemes, about US$20 in benefits could be generated through producing healthy children who enjoy better cognitive development, achieve more at school and become healthy, productive adults. (Declaration, 2013)

Demand side financing creates the institutional foundations, the building blocks of the Community empowerment, which will allow sluicing money to the grass root structures for one key deliverable only: decreasing demand side barriers to health care services. (Version, 2009) Altogether, community financing experiences from the health sector allow us to gain insights into the working mechanisms and challenges of RBF schemes and provide valuable lessons regarding other sectors. (Grittnner, 2013).

In other countries, Demand Side Financing is being implemented to increase the use of key services by reducing demand-side barriers. To improve maternal health, women who participate in regular antenatal clinics receive free institutional deliveries. This protects against the financial risk imposed by health expenses and to encourage routine use of health services. (Rusa, Schneidman, Fritsche, & Musango, n.d.)

Thus, this community focused financing, in collaboration with other PBF schemes, could provide the broader health system with synergies in terms of MNCH services (Matsuoka, Obara, Nagai, Murakami, & Lon, 2017). Study results indicate that Demand Side Financing is a useful tool to increase quantity of health services Although acknowledging that PBF has a role in improving health worker performance, there is caution that results-based and economically-driven interventions may not, on their own, adequately respond to patient and community needs. (Honda, 2013) Analytical work identified demand-side incentives as promising approaches to address major demand-side barriers. As supply-side issues improve, demand-side barriers can be a bottleneck in increasing facility utilization. (5,11)

This study therefore aims to ascertain the level of elimination or reduction of demand-side barriers and the level of increase in the coverage of Maternal and Child Health Indicators for Demand Side Financing in PBF Health Facilities in Wamba LGA.

Study questions

- Does the DSF intervention reduce financial barriers for the poor and vulnerable groups to access health services in PBF health facilities?
- Does DSF increase the coverage of high impact Maternal and child Health Indicators?
- How does DSF promote social inclusion?
- How does DSF complement the supply-side components of the NSHIP, and enhance the achievements of the PBF intervention?

Significance of documenting DSF in nasarawa state

DSF approach in Nasarawa was adapted to meet the field demands in Structure and Practical Approach in its implementation. It is therefore important to document the achievements, lessons learned and the way forward.

Methodology

Study design

The study is an explanatory qualitative case design. The case is defined as the NSHIP program in Nasarawa State, Nigeria piloting DSF in Wamba LGA.
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**Instruments, Sample and data collection**

The study implores two concurrent methods: Qualitative data collection methods on the one hand, and Quantitative data analysis from the OpenRBF on the other hand to support and triangulate the qualitative findings.

**Documents review**

A thorough document was carried out to inform on the DSF design and implementation in Nasarawa State-Nigeria.

These documents provided background and context. It allowed for the identification of key context experiences and equally provided supplementary data that served as a means for tracking level of implementation and updates. This also allowed triangulation of data to other DSF qualitative data and quantity data from the OpenRBF portal.

Health facility documents were useful to gather data on events that could no longer be observe and information that had been forgotten.

A total of 30 documents were reviewed including contractual documents, DSF design documents, implementation guidelines (DSF Project implementation Manual-PIM), Strategic Meeting reports, Community Based Targeting Reports, DSF monitoring reports and Health Facilities Registers.

**Individual in-depth interviews**

Using a structured questionnaire, a total of thirty actors involved in the DSF implementation process interviewed. These key informants were selected using a purposive approach that was aimed at providing contrasting views in terms of work, level of activity (Regulatory, Service provision, Supervisory, Partners) and categories of actors. The main selection criterion was their involvement in the DSF pilot.

Respondents included, managers of health services at the State and LGA level and Health care providers working in the twenty Health Facilities piloting DSF and Transporters.

Qualitative data was also collected through focus group discussion (FGD) to compliment findings of the in-depth interviews (IDI) of key informants. Sampling for IDI and FGD was purposive. Informants were selected according to variables such as sub-group (Women of Child Bearing age, Health Facility Staff, Local Government Area Primary health care department (LGA PHC) directors, Ward development Committee (WDC) and Community Based members), Transporters, knowledge of their community, experience with the Health Centre, past or current experience with DSF implementation, etc. to allow for maximum variation in the sample.

**Data analysis**

Patterns and categories emerging from the literature were used to develop predefined themes. A two-day workshop was organizing to train the research team and to ensure a common understanding of the themes. All interviews were conducted in both Hausa and English transcribed and analyzed using QDA Miner Lite (Provalis Research free online). The coding of the data was organized around conceptual categories. A thematic analysis was carried out, guided by the conceptual frame- work and knowledge of PBF and DSF, to extract the main themes from the documentation and the in-depth interviews. A hybrid deductive–inductive approach allowed the research team to assign data to predefined themes and to derive new themes from the data. Data analysis started in the field, forming an iterative relationship with document analysis and interviews.

Therefore, the research team was able to constantly compare the value of emerging categories for sorting the collected data. At the same time, this provided an opportunity to share and confirm findings and subsequent interpretations with participants as advised by Hartley and Miles and Huberman (Service, 2015). Moreover, combining the initial transcription of collected data with early analysis helped to gain insights and plan strategies for collecting additional data as suggested by Marshall and Ross- man(Sieleunou et al., 2017). The analysis was conducted through a stepwise process. First, the research assistants analyzed the in-depth interviews. Then, the principal investigator conducted synthesis of the findings and all discrepancies were discussed among the team of researchers. Quantitative Data downloaded on MS Excel from the OpenRBF portal was analyzed using excel pivot...
tables and Epi Info 7 statistical package. Quantitative data was obtained from the “All in ONE MPA” routine data set of the OpenRBF portal of the Nigerian State Health Investment project (NSHIP). The downloaded excel data sheet for the period November 2016 to June 2017 was analyzed using pivot tables and the trends of three scenarios presented below: Service coverage based on supply side financing production alone; service coverage based on DSF production alone; and lastly coverage based on both supply and DSF.

**Ethical considerations**

The study protocol was reviewed and authorized by the Executive Chairman of the State Primary Health Care agency and the State Ministry of Health. The NPHCDA and World Bank that are providing oversight in the implementation of RBF in Nigeria were also dully informed. All respondents provided verbal or written informed consent of six months (June– December 2017).

**Results**

**Quantitative data**

![Graph showing coverage contributed by DSF to the total coverage of wamba](image)

**Figure 1.** Coverage contributed by DSF to the total coverage of wamba

The Demand Side Financing intervention contributed averagely 40% to the coverage of Children completely vaccinated in the LGA. The graph below shows the proportion of clients who visited the health facility as a result of Demand Side Financing. There was a crescendo presentation of the coverage proportion due to DSF from November 2016 to June 2017.

With the introduction of DSF the number of women visiting the Health facilities for Post Natal Visits increased. As can be seen in fig. 4 below, the monthly percentage point difference of the post-natal coverage from November 2016 to June 2017 was averagely +10%.
The coverage for ANC is particularly low in Wamba LGA. This is so because most of the clients do not comply with the Focused ANC approach. Averagely DSF services contributed 5% to the coverage of ANC services in Wamba LGA. The number of women who benefitted from ANC 1-4 CCT increased from 12 in November 2016 to 48 in March 2017. Generally there has been an upward trend. This is reflected in the trends for Wamba in QIV 2016 as seen below.

In fig. 6 below the monthly proportion contribution of the DSF services to the total ANC standard visits (2-4) coverage is averagely 5%.

Institutional deliveries, just like ANC 1-4, equally had an upward trend for both the DSS (CCT) and the LGA coverage’s for Q IV 2016 immediately after the launch. Averagely DSF contributed 60% coverage to the Normal Assisted Delivery Coverage of the LGA.
Qualitative data analysis

The Focused Group discussions and In-Depth Interviews were transcribed and analyzed using QDA Miner Lite (Provalis Research free online). The coding of data was oriented by organizing the data around conceptual categories. A thematic analysis, guided by our conceptual frame- work and our knowledge of PBF and DSF was used to extract the main themes from the documentation and the in-depth interviews. A hybrid deductive–inductive approach allowed us to assign data to predefined codes and to derive new codes and sub-themes from the data.

Definition of demand side financing

During the FGDs and the IDIs every respondent could explain contextually the Demand Side financing intervention. A woman between the ages of 25-35 in Kwara Catchment explained DSF to the gathering as:

“This intervention is basically in six areas, for example if a woman starts going for check-ups (antenatal) the number one step taken is what we called focus ante-natal care; before delivery.

Basically everything has to be in the hospital to benefit from these sources”.

Increasing financial accessibility through demand side financing

Sub themes from responses indicated that DSF has increased financial and geographical accessibility to Health services by providing transportation, paying for hospital bills and reaching out to the poor and vulnerable who need access to health services. The respondents stated that, all catchment communities are now able to access the facilities because of the program. They admitted that DSF has improved the financial status of both the women and transporters. Even husbands of beneficiaries were happy with the program because it reduces the financial burden of taking care of their women and children's hospital bills. They brought out statements like:

“There is an increase in financial status of the jobless youths in the community”.

DSF has reduced poverty rate in the community by providing free services during delivery except in the case of a complicated delivery. In most cases money given to the women is used to pay for drugs and even provide food for the family. This is because free delivery is provided in the health facility. Respondents said he program is beneficial to some clients who could not access the HF because of poverty. The community usually paid for health services but instead, the community are paid. No incentives were given to women before now but they are now benefitting.
Reaching the poor and vulnerable through demand side financing

Through the DSF intervention many poor and vulnerable women now have access to prevention services in the various health facilities.

“On the aspect of those that can’t afford drugs, this program has really helped in filling the vacuum by giving free drugs to the poor on top of the money given to us. For example, this woman’s husband faces a lot of challenges like having his children sick one after the other, coupled with having a pregnant wife. If not for the advent of this program, it would have been more than these. So the program has helped him a lot” (Male Respondent Sisinbaki)

Assisting clients in the payment of ‘hospital bills’

The demand side incentives have helped communities to pay for health services even beyond the health centers where the scheme is being implemented.

“Let me give you an instance of Amina Abdullahi whose husband died. She came early for ANC, when examined her I noticed she was anemic. I directed a bike rider to pick her to the General Hospital and equally she benefitted N1000 from DSF to use in buying medication after referral to the General Hospital there in the General Hospital. After investigation at the General Hospital, she was infused with blood. For that she came over severally for her consultation.” [Health facility Manger Ambaka].

Improving geographical access through demand side financing

Demand Side Financing has increased financial access to health services through the provision of transport vouchers to transporters. The community is well informed through community mobilization by the Ward Development Community members. This mobilization breaks the geographical barriers as people get informed of the services provided in the Health Facility. Within the DSF scheme pregnant women requiring referral are transported to the next referral level. The following are specific responses following sub-codes for geographical access.

“The DSF program has helped those in hard to reach areas to access the health facilities. The monies gotten from the DSF program is used to clothe and feed the babies because most services are offered free. The transporters help to convey clients to the hospital who otherwise will not have accessed the health facility. This has increased geographical access by paying for transportation and paying women when they have been rendered some services.” (Male Respondent Nakere)

Enhancing patient transfer to next referral level through DSF

All the respondent confirmed that DSF has been enhancing patient transfer.

WDC Chairman Wude Kurmi: “If the delivery is a complicated delivery, usually they are referred to the General Hospital and they are transported free to the hospital. I wish to plead that if the delivery turns out to be a CS, the program should be able to assist the woman.”

“Before DSF intervention, you hardly see woman that come for ANC at least Four (4) times. They only come once. But with DSF enticement, you see them coming even beyond four (4) times. So Demand Side Financing has increase access to services and our MPAs. It has also helped in reducing number of defaulters for RI and ANC.” (PHC Coordinator Wamba)

Factors influencing the choice of health facility to receive DSF services

During the interviews some participants indicated that they had a preference for receiving DSF services in particular health facilities. Cordial relationship or attitude of the service providers were some of the reasons advanced. Respondents reported that some health facilities overcharge clients but the DSF Health Facilities do not charge clients for services, rather the clients are given some money. The quality of care and the amount charged by the health Facility determines the choice of Health facility by the women. Community empowerment and community voice in the choice of services provided in the healthcare facility also influence the demand of healthcare services.

The following are the reasons they advanced by the community for patronizing a facility over the other.
“We go to Health facilities that staff are readily available. Transportation is provided to women. We are paid instead of them paying the Health worker for services provided. The client’s opinions are honored in these Health Facilities.” Woman Wude Kurmi:

“Our opinion as a community is sought on the quality of services that should be provided in the health facility. We directly determine what we want and how we should be treated in the health facility. The community contributed to building the structure in the health facility because they wanted privacy. If the staff continue with the good reception of clients, quality services, and good relationship between the transporters and the health facility, attendance in the health facility will increase.” (Community leader Mugu)

**What is the quality of health care services provided in DSF facilities?**

The community affirmed that the quality of care in DSF facilities was good and met the expectations of the populations.

“There are days we come and feel highly encouraged especially with the way they work, they work with so much strength in that what we are seeing daily we are excited. The cleaners and attendants do their work effectively by sweeping out every dirt and washing the place spotlessly clean; we feel happy seeing them carryout such duties well” [WDC member Gbata]

The community assessment the quality of the services offered by DSF facilities can be summarized in the sub teams and codes below

**Suggestion for improvement**

The Wamba community gave the some suggestions on how the implementation of Demand Side Financing can be improved in this LGA. These responses were analyzed under the codes indicated on the chart and documented by subgroups below.

![Distribution of codes (Frequency)](image)

**Figure 5.** Distribution of codes on suggestions for improvement of DSF implementation

**DSF should be extended to other curative services**

“I want to plead with the government to expand the hospital, this is because there are situations where pregnant women came in number at a time and the maternity ward is insufficient, the reason why I decided to lay complains. And because the number of patients has been on the increase as they come
from different places that is why I plea that the hospitals should be included in the program so all women can benefit.” (WDC Wude Kurmi)

“My suggestion is that trained midwives be engaged to place charge of deliveries and more money be reserved for women who come to clinic to access service.” (Community member)

“The DSF program should extended to rural clinics will help to revitalize the clinics. If it is possible curative services should be paid for and the sick women are transported to the health facility.” (Community member)

Increase unit cost for DSF indicators

The program can be improved by increasing the unit cost for CCT. Transporter Vouchers should be increased to N1000 instead of N500 being paid now to compensate for difficult terrain. The transporters greatly appreciated the effort of the sponsors of the DSF program.

WDC Chairman Nakere: “The program will be better if the WDCs receive incentives for community mobilization for DSF”

Including caesarean sections as DSF indicators

The community submitted a plea for Caesarean Sections to be included in the least of indicators for DSF. Women usually feel discouraged when they are referred for to the hospitals for Cesarean Sections.

Immediate payment of beneficiary of the CCT and transport vouchers

The need for immediate payment of beneficiary of the CCT and transport vouchers was emphasized during the interviews and discussions. Usually, the beneficiaries come and the facility staff say money is not available.

Discussion

This study aimed to explore the views and experiences of various stakeholders of the contextual and implementation factors on the Demand Side Financing Scheme. We aimed to assess how the DSF scheme has addressed demand side barriers to health care by eliminating or reducing financial barriers and to consider how we might improve on the implementation. To the best of our knowledge, this study is the first to explore these factors in the Wamba LGA pilot context and to explore the influence of contextual and implementation factors on the effectiveness of Conditional Cash Transfers and Transport Vouchers.

We found that the Demand Side Financing scheme has increased the coverage of maternal and Child Health Indicators, reduce Financial and geographical barriers for the poor and vulnerable and that, the scheme is widely understood, accepted and appreciated in the community.

Eliminating financial barriers for the poor and vulnerable in accessing health care services through demand side financing

The study revealed that the DSF scheme has reduced financial barriers for the women and children to access health care by addressing rich poor inequalities and reaching the poor and vulnerable through the conditional cash transfers. In Tanzania a similar scheme reduced the probability of women paying for delivery care (-4.5 percentage points) which mediates the total effect of P4P on institutional deliveries (by 48%) and on deliveries in a public health facility (by 78%).(Anselmi, Binyaruka, & Borghi, 2017)

The community indicated that, their voice participation was given consideration in the DSF implementation. Their opinions were relevant in improving the quality of care offered in the Health Facilities. A study in Rwanda showed that drivers of improved health care performance include Community participation and demand side financing through insurance schemes. (Sayinzoga & Bijmakers, 2016) Factors of community involvement are considered to have contributed positively to the achievements in the Demand side Pilot in Wamba LGA. The results also indicate the importance of other health system features, such as managerial skills and the culture of continuous verification of DSF indicators. This was the case in a study carried out in selected Health districts in Ghana(Dalinjong & Laar, 2012). In addition, there are factors beyond the health sector per se, such as the widespread
determination of people to increase performance and achieve targets(Domelen, 2007; Priedeman Skiles, Curtis, Basinga, & Angeles, 2013; Sayinzoga & Bijmakers, 2016)

This was demonstrated by the willingness of the community to continue benefitting from the project, and the commitment of the Ward development committee members and the Village leaders to continue with community sensitization.

Increase coverage of maternal and child Health Indicators in PBF facilities

Pay for performance (P4P) programs have generated interest as a mechanism to improve health service delivery and accountability in resource-constrained health systems.(Menya et al., 2015) Pay for Performance (P4P) mechanisms to health facilities and providers are currently being tested in several low- and middle-income countries (LMIC) to improve maternal and child health (MCH).(Das, Gopalan, & Chandramohan, 2016)

In this study, Qualitative findings demonstrated that Demand Side Financing reduced geographical and financial accessibility to preventive health care services. This was backed up by quantitative findings indicating DSF contribution to the ANC coverage by 5%, Postnatal Consultation by 10%, Vaccination by 40% and Delivery by 60%.

A cluster randomized trial carried out in Afghanistan to test whether P4P could improve maternal and child (MCH) services and reported, substantial increases in the quality of history and physical examinations index (P ¼ 0.01); client counselling index (P ¼ 0.01); and time spent with patients (P ¼ 0.05).(Engineer et al., 2016)

The community perception on the quality of care in DSF health facilities had a very high rating. This is in accordance with a systematic review in LMIC which showed that the P4P mechanism is effective to improve process quality of ante natal care(Ahmed & Khan, 2011).

Social inclusion level of acceptability of the DSF intervention in wamba LGA.

The community attested that they were enjoying the DSF program because they were all beneficiaries directly and indirectly. They indicated that they will want the project to continue and willing to continue benefitting from the project. The respondents indicated that, if the demands of the community are respected by the health facility they will always visit these Health facilities.

The provision of a means of transport from other communities made it easier to access the health facility and reduced geographical access. The population is motivated by the provision of transportation. The community affirmed that the quality of care was good and met the expectations of the populations but indicated that they had a preference for receiving DSF services in particular health facilities. Most importantly there they stated that there is better quality of care provided in DSF health facility than non-DSF Health facilities.

The respondents said the difference between visiting a DSF facility and a non-DSF facility is that in DSF facilities there is a good reception of clients, and no payments are required for preventive services.

There were no, religious, traditional and cultural practices that prevent the community from benefitting from DSF services. If DSF schemes are used to change the behavior of the beneficiary then evaluation also has to take into consideration the cultural and behavioral settings in the country before replication. Clearly, varying socio-cultural factors and traditional outlook determine the extent to which a particular scheme will be effective(Gupta et al., 2010)

The Wamba community gave the some suggestions on how the implementation of Demand Side Financing can be improved in this LGA. These responses were analyzed under the codes documented by subgroups: DSF should be extended to other Curative Services, Increase unit cost for DSF Indicators, Including Caesarean Sections as DSF indicators and immediate payment of beneficiary of the CCT and transport vouchers.

The need for timely payment of beneficiary of the CCT and transport vouchers was emphasized during the interviews and discussions. It happens that the beneficiaries could get to the facility for redemption of their vouchers and the staff would say “money is not available”. In the Nasarawa design the PBF Verifier is charged with the responsibility of verifying and validating claimed CCTs and Vouchers. This is a positive attribute of voucher schemes that enables regular monitoring of Health facilities, and give fairly accurate data on program outputs and outcomes, which can then be used by
the stakeholders and/or the donor to evaluate this intervention. Verification challenges also result in delays in re-imbursements, which delink effort and reward. Additionally, in a similar project in India, the limited integration of the verification activities of district teams with their routine tasks causes a further virtualization of the health system. (Antony, Bertone, & Barthes, 2017)

Obviously, the verification of results plays a key role in such schemes and has indeed been termed a ‘cornerstone’ of RBF programs (Federal Ministry of Health, 2012; Fritsche et al., 2014).

In this scheme verification ensures that services, for which a payment request (invoice) is made, have been actually provided and that they are of good quality. The rational for carrying out a detailed verification of both quality and quantity of services provided lies, first of all, in the practical necessity of calculating the re-imbursement accrued by facilities and pay them a bonus in a transparent manner (which enhances their trust), as well as promptly and regularly based on their effort and performance. It also entails the opportunity for detecting frauds and for signaling to providers a real threat of sanction in case of irregularities, such as gaming on quantity of services, lowering quality of services and reducing patients’ satisfaction (Primary et al., 2015; WORLD BANK NIGERIA, 2015).

Ideally, verification of results also creates positive spill-over effects at system-level and at the community level. Within this implementation, a community client satisfaction survey was carried out by the technical assistants. If the verification procedures include a patient satisfaction survey (as it is the case in Benin), they could also be seen to play an important role to channel the “voice” of the communities, which may in theory allow for increased provider accountability (Dalinjong & Laar, 2012).

Eliminate geographical barriers for the poorest of the poor in accessing health care services

All the respondents confirmed that DSF has been enhancing patient transfer. Initial pilot assessments of reproductive health voucher programs suggested that they can increase access, reduce inequities, and enhance program efficiency and service quality. (Bellows et al., 2011) Factors that influence the community’s perception on quality of care include: Reception of Clients;

Financial Incentives; Transportation of the clients to the Health Facilities; Closeness of the health facility to their settlements; Presence of DSF Incentives and Availability of a means for transport.

The provision of a means of transport from other communities makes it easier to access the health facility and reduces geographical access. The population was motivated by the provision of transportation. Demand Side Financing proves to be a promising approach in strengthening and maintaining quality service delivery in the sub-Saharan district hospitals. (Janssen, de Dieu Ngirabega, Matungwa, & Van Bastelaere, 2015)

Strengths and limitations

This study was timely, occurring within 1 year of implementation of the program. The study also had immediate utility, contributing to planning and rollout of the P4P scheme in Nigeria.

It is important to acknowledge some limitations of the study. Data from the interview were collected and analyzed by the RBF-TA as part of action research within the RBF project. Which could be subjective. There is a potential researcher and respondent bias, small sample, and the fact this study was only done in Wamba and therefore not clear if findings and results transferable at scale. However, the process followed a systematic and transparent approach. In addition, the RBF-TA team lead checked segments of data and coding to ensure rigor. Also, the RBF-TA did not master the language of the interviews ‘HAUSA”. We relied on the co-authors for translation and transcription.

In addition, demographic data such as the age and sex of the all participants were not recorded as we did not consider it to be relevant to the main focus of the research, which was to find out how demand side financing can eliminate or reduce financial barriers to health care services within the context of PBF in Wamba LGA. Information from the other two pilots in Ondo and Adamawa State and further demographic data of participants might have provided further insight to the study.
Implications and conclusions

There is increasing awareness that supply subsidies for health and education services often fail to benefit those that are most vulnerable in a community (Ensor, 2004). This study concisely demonstrates that when supply-side subsidies and demand side subsidies are combined greater health outcome gains for the poor and vulnerable populations are achieved.

The economy of Demand Side Financing show, among others, that the effect of introducing demand-side financing depends on the degree of competitiveness. (Murray, Hunter, Bisht, Ensor, & Bick, 2014) The Results –Based Financing project in Nigeria already demonstrates a competitive market, and introducing demand–side financing led to higher welfare of the population and/or lowering of ‘out of pocket expenditure’.

Study results indicated that DSF:
• Has eliminated or reduced financial and geographical barriers for the poor and vulnerable to access health services in PBF health facilities;
• Increased the coverage of high impact maternal child reproductive and disease control health services;
• Improved the quality of care rendered to the population;
• Focused on the poor and vulnerable without using community-based targeting for equity;
• Promoted social inclusion to complement the supply-side components of the NSHIP, and enhance the achievements of the PBF intervention.

This is contrary to a study in India were some of the limitations of RBF scheme were the inability to target the poor, lack of user choice, and the absence of linkages between provider payments and performance (Bhatia, Yesudian, Gorton, & Thankappan, 2006)

References


