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Article

The context in conditional cash transfer (CCT) programs: A royal road to health service utilization to the poor?

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MANAGEMENT | RESEARCH ARTICLE

The context in conditional cash transfer (CCT) programs: A royal road to health service utilization to the poor?

Massami Denis Rukiko^{1*}, Adam Ben Swebe Mwakalobo² and Joel Johnson Mmasa²

Abstract: This study addresses the challenges facing Conditional Cash Transfer Programs (CCT) by investigating whether recipients are satisfied with health services and how contextual factors affect the utilization of health services. The study used binary logistic regression to determine households' satisfaction with health facility services and was guided by the theory of change and expectation disconfirmation theory, with independent variables being the contextual factors. Generally, 68.66% of health facility service recipients are satisfied, compared to 31.34% who are not. At 95% confidence interval, an increase in household head education and household members is likely to increase satisfaction with health facility services, while service delays and beliefs in traditional medications are likely to negatively affect satisfaction to around 30% or more. The study calls for constant and continual collaboration between CCT program designers and implementers and health facility service providers, who have a significant role to play in reducing service delays. Moreover, it emphasizes the necessity for contextual factors to be considered in

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Mr. Rukiko is an assistant lecturer and Ph.D. candidate currently completing research on the impact of Conditional Cash Transfer (CCT) programs on health outcomes in rural Tanzania. With a background in Food Science and Technology and Agribusiness, his research interests include food and nutritional aspects for poor communities, financial inclusion of rural communities, and sustainable development.

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PUBLIC INTEREST STATEMENT

Conditional Cash Transfer (CCT) programs have the potential to alleviate poverty and promote better health outcomes among disadvantaged rural populations. This study examines the effectiveness of CCT programs in improving health service utilization for the rural poor, which is crucial for promoting preventive health practices and creating a healthy community, as well as enhancing economic productivity. The findings of this research have significant implications for policy-makers, health practitioners, and other development stakeholders in designing and implementing successful CCT programs that prioritize the public interest for the poor. By increasing access to health services and empowering vulnerable populations, CCT programs can achieve its potential to foster a healthier and more equitable society. Therefore, this study contributes to the broader global effort to reduce poverty and inequality

promoting health utilization, which is at the heart of CCT program health conditionality compliance. The study's outcome highlights the need for additional efforts to be focused on the design and implementation of the CCT program, particularly in improving contextual factors, which are often given less attention.

Subjects: African Studies; Rural Development; Statistics for Social Sciences

Keywords: Context; health utilization; cash transfer; TASAF; poverty reduction

1. Introduction

Conditional cash transfer programs (CCT) have been implemented throughout the world in different geographical areas (Budlender, 2014; Fiszbein & Schady, 2009; Handa et al., 2022; Millán et al., 2019) which makes different operating environment—the context (Alvarado et al., 2021; Onwuchekwa et al., 2021). Contextually, CCT faces an environment that defines the type of people and the nature of the operating environment including individuals and households' characteristics, health facility service delivery characteristics as well as the surrounding environment with regard to health (Aydin, 2018; Onwuchekwa et al., 2021). In developing countries, CCT has been put in place to reduce poverty and inequality among poor households with conditions to be adhered to (Bastagli et al., 2016; Fiszbein & Schady, 2009; Glassman et al., 2013).

Conditions are at the heart of CCT design and are made up of behavioral requirements that facilitate reducing poverty—a major goal of CCT—when beneficiaries comply with the conditions, whether for their own benefits or for their environment. This ensures sustainability of the program (Alvarado et al., 2021; Budlender, 2014; Rukiko et al., 2022; Zhang et al., 2022). However, designing and implementing CCT is a challenge for realizing its effectiveness in achieving its major goal (Baird et al., 2009). Since adherence to the set conditions, such as health services utilization, is repetitive, satisfaction with health services becomes a key factor in health service utilization and compliance with health conditions, which needs to be addressed to ensure positive health behavior (Jain, 2018; Wirtz, 2003). Satisfaction involves individuals' or households' expectations and evaluation of the service, which is key to health service utilization. The operating context—contextual factors—is inevitable due to the complexity of understanding individuals' expectations regarding health services (Lakin & Kane, 2022).

Many studies have been looking at internal and direct factors related to CCT health operations to ensure smooth utilization of health services, one of the health conditions that must be complied with (Bastagli et al., 2016; Ibarrarán & Cueva, 2017). Great attention is mostly directed towards CCT health outcomes rather than the flip side of CCT, which captures the design and implementation (Glassman et al., 2013; Jain, 2018; Owusu-Addo et al., 2019). Little attention has been given to contextual factors—mostly from the perspective of beneficiaries and non-beneficiaries—even though they play an important role in social interventions that involve behavior changes, such as health service utilization (Babitsch et al., 2014; Onwuchekwa et al., 2021). This creates a disconnected link towards behavior change for sustainable health outcomes for beneficiaries, which impairs the major goal of CCT programs. Given the context through which CCT is implemented, this study aims to improve the details of CCT design and implementation by determining whether recipients are satisfied with health services and how contextual factors affect utilization of health services—a key health condition that requires compliance. With smooth health utilization, preventive health measures for beneficiaries can be ensured, allowing the poor to engage in all the developmental activities that are friendly to the environment (Burki et al., 2021; Jevtic et al., 2021; Zhang et al., 2022).

1.1 The context for conditional cash transfer program

Conditional cash transfer (CCT) programs are social welfare programs that provide cash or in-kind transfers to low-income households. These programs are conditional on the recipients meeting certain behavioral requirements, such as attending school or receiving medical care with the

primary role of reducing poverty (Baird et al., 2013; Budlender, 2014; Ibarrarán & Cueva, 2017). In reducing poverty, health behavior attached to CCT programs has important implications for environmental friendliness and sustainability (Fuller et al., 2022; Gaan et al., 2023; Zhang et al., 2022).

Poor households—especially in developing countries—often resort to unfriendly practices to earn their living without taking note of the impact on the environment (Burki et al., 2021; Khan et al., 2022). CCT programs play a great role in encouraging the adoption of sustainable practices that ensure the environment remains suitable for future generations and beneficiaries health remains stable away from illnesses like respiratory diseases, heart disease, and some types of cancer, which require preventive measures (Fuller et al., 2022; Jevtic et al., 2021; WHO, 2022).

CCT programs operate in different contexts around the world, but they serve the same purpose of reducing poverty and inequality among poor households (Cecchini & Madariaga, 2012; Owusu-Addo & Cross, 2014; van Daalen et al., 2022). To accommodate these different contexts, CCT programs emphasize different aspects of environmental sustainability. For instance, some CCT programs incentivize the use of renewable energies and recycling of recyclable materials (Bastagli et al., 2016; Ibarrarán & Cueva, 2017). By encouraging these practices, CCT programs encourage poor households to adopt more environmentally friendly and sustainable practices, which in turn protect them from health hazards and illnesses derived from the use of hazardous energies (Fuller et al., 2022; Jevtic et al., 2021; Zhang et al., 2022).

Moreover, CCT programs emphasize preventive health measures for poor households. This is achieved through promoting sustainable agriculture and forestry practices, which can help preserve biodiversity, protect ecosystems, and combat climate change, especially in rural areas where the poor mostly reside (Branca et al., 2022; Linde et al., 2021; Milheira et al., 2022; W. Qin et al., 2019). Apart from working with beneficiaries, CCT programs also work with other stakeholders to reduce environmental risks and promote resilience to climate change. This is achieved through supporting disaster preparedness, providing cash transfers to households affected by natural disasters, and supporting climate adaptation measures (Fernandez et al., 2011; Pega et al., 2015; Pfitze, 2021).

The vast body of literature focuses on the expected direct outcomes of CCT. The design and implementation of CCT acts as a beam for their success, which requires improvements from time to time based on evidence obtained. The evidence must indicate the changes expected or made to arrive at the desired outcome (Armand & Carneiro, 2018; Browne, 2013). However, contextual factors are given less attention, even though they are the major assumptions that need to be made and confirmed on how they influence CCT outcomes (Browne, 2013; Collins, 2015; Gertler et al., 2016; Kilburn et al., 2018). Contextual factors can inform on how CCT effectiveness and efficiency is supported by the environment. On the other hand, CCT can affect the environment when combating poverty and its effects—as part of a means to attain Sustainable Development Goals (SDGs) in Africa and the world (Alvarado et al., 2021; Fuller et al., 2022; Roelen et al., 2017; WHO, 2017) indicating a bi-directional behavior. For example, improving the context in which CCT operates may lead to the success of the program, while the success of the CCT program may also improve the context in which it operates (Ahmed et al., 2022; Collins, 2015; de Souza et al., 2021; Kilburn et al., 2018). This study examines how contextual factors affect compliance with health conditions—specifically, the utilization of health services—and looks at the sustainability of the expected change in behavior through satisfaction with the health facility service provided.

Based on the literature reviewed, it is clear that CCT plays a crucial role in promoting environmentally friendly practices and activities. Moreover, it is evident that only a healthy individual can effectively participate in the activities designed for individuals or the community (Pronk et al., 2021). Additionally, it has been observed that CCT beneficiaries can influence their environment, which in turn affects their health and compliance with health conditions. Conversely, the

environment—the context—can also impact beneficiaries' ability to comply with health conditions and utilize health services. This study focuses on the contextual factors that affect compliance with health conditionality, specifically the utilization of health services, within the framework of sustainability. This is important because contextual factors have received little attention with respect to their impact on expected changes and desired health outcomes.

1.2 Theory underpinnings

The study was generally driven by the theory of change—a flexible methodology, which informs of how and why the change regarding CCT has happened (Browne, 2013). In its flexibility, the theory of change has been used to inform on how contextual factors—where CCT has been implemented—facilitate or hinder the expected health outcome achievements that are guided by health conditions (Browne, 2013; LAC, 2016; Serrat, 2017); thus, the importance of contextual factors consideration. On the other hand, specific guidance details were provided by the two group of theories; marketing theories—concept borrowed to describe a possibility for buying again after customer's satisfaction together with patients satisfaction theories (Yüksel & Yüksel, 2008).

Derived from the expectation disconfirmation theory by Oliver (1980) individuals are satisfied after comparing what has been perceived in their mind or expected before to what has been offered as a service and hence satisfaction or otherwise—neutral or dissatisfaction. From disconfirmation, which is the result of comparison of what has been expected and what has been experienced there could be positive disconfirmation, confirmation or negative disconfirmation, which will result into satisfaction, neutral or dissatisfaction, respectively.

In marketing perspective, the outcome of satisfaction will be customer loyalty as well as repetitive buying—similar to repeat in utilization of health services (Prakash, 2010; Wirtz, 2003). A repetition in utilization of health services can cover both preventive health service—mostly discussed in CCT—as well as curative services when one faces health challenges. The disconfirmation theory was used together with patient evaluation and judgement based on expectation and that customer loyalty can be achieved with health service satisfaction (Amporfro et al., 2021; Fatima et al., 2018; Linder-Pelz, 1982; Oliver, 1980; Prakash, 2010).

2. Material and methods

The study used administrative data—secondary data—from TASAF PSSN as a guide to identify and locate both treatment and control groups. Random selected households were interviewed using a structured questionnaire as a survey method through the help of Village chairperson and community health officer. A questionnaire with 5-point Likert scale questions was used to interview a total of 335 households to obtain the satisfaction position given health facilities around the local area and other belief variables. This was supplementary information not found in the TASAF PSSN accessed data. The analysis was done using both descriptive statistics and binary logistic regression where satisfaction with the health services was the dependent variable—coded satisfaction or otherwise. Satisfaction with health facilities services has been divided into head characteristics, health beliefs, health facility factors, and household characteristics grouping guided by other studies (Aydin, 2018; Naidu, 2009; Nyakutombwa et al., 2021).

Independent variables used were the contextual factors grouped as household characteristics, household characteristics, health facility characteristics as well as household health beliefs. The grouping was guided by (Andersen & Newman, 2005; Chikhungu et al., 2014; Hsu & Gallinagh, 2001) where household characteristic, household characteristics, health beliefs in comparison with traditional medications and health facility characteristics were considered.

Binary logistic regression was used to determine how contextual factors influence health facility service satisfaction, while descriptive statistics were used to inform whether or not service recipients are satisfied with the health service. The nine factors were grouped into four categories. The first three factors, namely household head education, household head education, and household

head sex, were grouped as household factors. Health beliefs involved two factors, similar to household factors, and the last factors covered health facility factors, such as health service delays, services, and the number of health facilities around, with an average of 30 min walking distance. Satisfaction with health facility services (Aydin, 2018; Naidu, 2009; Nyakutombwa et al., 2021) has been divided into household characteristics, health beliefs, health facility factors, and household characteristics for independent variables in health facility satisfaction.

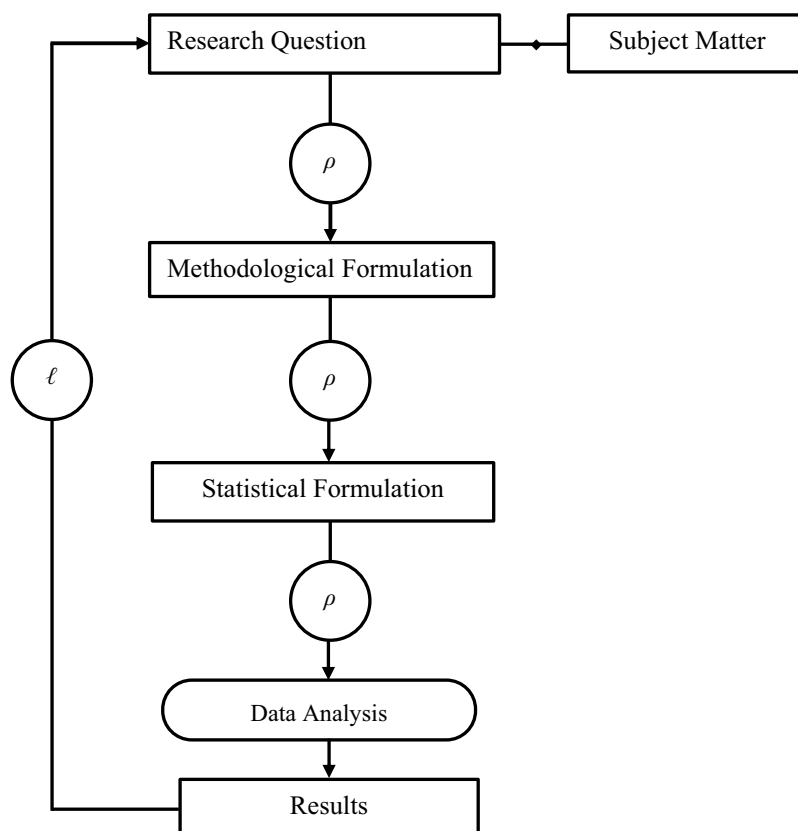
2.1 Graphical methodology

Graphical methodology as presented by Ader (1999) has been adopted for clarity expression of how the study was done. The study has relied on marketing concepts where satisfaction determines continuation of use of services or purchase of products (Amporfro et al., 2021; Fatima et al., 2018; Linder-Pelz, 1982; Oliver, 1980). Conditions in CCT require utilization of health services around the community, which encourages positive behavior for coming out of poverty. Being out of poverty helps to adopt safe, healthy, and environmentally friendly practices, especially in rural areas (Burki et al., 2021; Linde et al., 2021; Zhang et al., 2022). The methodology in graphical presentation has been indicated in Figure 1 for each 2.1 subsection.

2.1.1 Research question and the subject matter

The study asks whether recipients are satisfied with health services given, and how contextual factors behind designing and implementation of CCT affect the utilization of health services. Utilization of health services—a key health condition—was a subject matter and a key topic throughout this study (Bastagli et al., 2016). It is the crucial health condition that requires continuous compliance throughout the program's implementation for households to remain enrolled and for the program to achieve its goals (Budlender, 2014; Ibararán & Cueva, 2017).

Figure 1. Graphical representation of the methodology used.



Source: Ader (1999)

2.1.2 Methodological formulation

The methodological formulation was based on the research questions asked and the contextual factors behind design and implementation of CCT program—TASAF PSSN, which keeps the data—administrative data (PSSN, 2016; TASAF, 2013). The administrative data contained the necessary variables used in the study, excluding beliefs and satisfaction with health facility services. This required making the best use of the available information and supplementing it with any other information that could possibly be accessed or collected, similar to what was done by Benavente et al. (2012) and Bauhoff et al. (2011).

2.1.3 Statistical formulations and Results

Based on the available data—both accessed and supplementary information collected—statistical formulations were made, including descriptive and inferential statistics. The study results from these analyses can contribute to reducing poverty, particularly by increasing the utilization of health facility services, which is crucial for implementing preventive health measures and enhancing economic productivity. Results were presented in tabular form from the analysis results obtained. The discussion followed the obtained results in view of what other studies have found to obtain proper interpretation and make the appropriate recommendations. Furthermore, these findings can aid in strengthening the implementation of conditional cash transfer programs to achieve the desired health outcomes.

3.0 Results

4. Discussion

The discussion in this section is twofold, covering both descriptive statistics using percentages and inferential statistics derived from binary logistic regression. Descriptive statistics presented in Table 1 indicate that 68.66% of both the treatment and control groups were satisfied with the health facility services, while 31.34% were dissatisfied. This information suggests the presence of a good-quality health facility environment and good service offered by health workers, on average, as reported by Tesfaye et al. (2019). Additionally, for both the treatment and control groups, the results are similar in that more participants were satisfied with the service than those who perceived it otherwise. In Table 2, the results show the general satisfaction with health services statistically for both the treatment and control groups, which can affect the utilization of health services. Tables 3 and 4 indicate the utilization of health services for the treatment and control groups, respectively. Each group's results have been presented separately.

4.1 Household factors

The results, when controlling for other variables, reveal that the odds of being satisfied with health services are likely to be 1.03 times larger for each additional year of education. These findings are consistent with those of Adhikari et al. (2021), which also found that an increase in education is likely to increase satisfaction. This may be due to a wider understanding of health services, particularly when encountering unexpected service. However, other studies (Afzal et al., 2014;

Table 1. Descriptive statistics for health facility service satisfaction

Satisfaction with health facility service	Treatment	Control	Total
Not satisfied	13.43%	10.15%	23.58%
Neutral	1.79%	5.97%	7.76%
Otherwise	15.22%	16.12%	31.34%
Satisfied	29.85%	27.16%	57.01%
Highly satisfied	6.27%	5.37%	11.64%
Satisfied	36.12%	32.54%	68.66%
Total	51.34%	48.66%	100.00%

Source: TASAF PSSN Administrative data & researchers field survey data 2021

Table 2. Health facility service satisfaction for treatment and control group

Satisfaction factor	Odds ratio	z values	p values
Household head education	1.033	0.890	0.3740
Household head age	0.989	−1.230	0.2190
Household head sex	0.816	−0.770	0.4440
Traditional medications are better	0.697	−3.810	0.0000
Traditional healers are the same as medical specialists	0.939	−0.640	0.5230
Number of household members	1.043	0.960	0.3380
Household annual income	1.000	−2.530	0.0110
Number of health facilities around	0.884	−0.450	0.6530
Health facility service delay	0.768	−2.790	0.0050
_cons	33.580	3.150	0.0020
Number of obs 333 R chi ² (9) 34.61	Prob > chi ² 0.0001		Pseudo R ² 0.0837

Source: TASAF PSSN Administrative data & researchers field survey data 2021

Table 3. Health satisfaction for treatment group

Satisfaction factor	Odds ratio	z values	p values
Household head education	1.131	2.040	0.042
Household head age	0.985	−1.090	0.274
Household head sex	0.758	−0.730	0.465
Traditional medications are better	0.722	−2.360	0.018
Traditional healers are the same as medical specialists	1.005	0.030	0.975
Number of household members	1.095	0.910	0.364
Household annual income	1.000	−0.230	0.818
Number of health facilities around	0.908	−0.240	0.814
Health facility service delay	0.848	−1.190	0.236
_cons	10.726	1.330	0.182
Number of obs 172 LR chi ² (9) 12.62	Prob > chi ² 0.1806		Pseudo R ² 0.1442

Source: TASAF PSSN Administrative data & researchers field survey data 2021

Kelarijani et al., 2014; S. Qin & Ding, 2021) have observed different results, where less educated individuals are more likely to be satisfied than their educated counterparts.

On the other hand, the likelihood of a person being satisfied shrinks by 0.01 for each increase in age, implying that the odds of satisfaction for a person one-year older are 0.99 times larger. The

Table 4. Health satisfaction for control group

Satisfaction factor	Odds ratio	z values	p values
Household head education	0.974	−0.540	0.587
Household head age	0.988	−0.920	0.356
Household head sex	0.767	−0.650	0.516
Traditional medications are better	0.671	−2.690	0.007
Traditional healers are the same as medical specialists	0.852	−1.110	0.268
Number of household members	1.033	0.650	0.514
Household annual income	1.000	−2.560	0.010
Number of health facilities around	0.967	−0.080	0.936
Health facility service delay	0.678	−2.800	0.005
_cons	96.631	2.860	0.004
Number of obs 161 LR chi ² (9) 29.41	Prob > chi ² 0.0006		Pseudo R ² 0.1442

Source: TASAF PSSN Administrative data & researchers field survey data 2021

reason for this could be due to the higher expectations of older individuals, based on past experiences, which are difficult to meet (Oliver, 1980). These results are consistent with those of other studies (Stepurko et al., 2016; Footman, et al., 2013). However, this contradicts what other researchers have observed regarding age and satisfaction (Adhikari et al., 2021; Rahmqvist, 2001; S. Qin & Ding, 2021), where health service satisfaction is likely to increase with age. Furthermore, Makgobela et al. (2018) found no difference in health service satisfaction with age.

Similarly, when viewing satisfaction in terms of sex, females are likely to have lower satisfaction than males when controlling for other variables. The odds that a female will be satisfied are 0.82 times larger than those of males. This may be due to the fact that females attend health services more often for themselves and their children and thus are more likely to encounter poor services. Similar results have been reported by James et al. (2018), where women preferred traditional medications over visiting health facilities, indicating different overall evaluations of health facility services. Other studies have also reported similar results (Jacobsen & Hasumi, 2014; Rahmqvist, 2001), while some have found no difference in health service satisfaction between males and females, or found that females have a higher likelihood of satisfaction than males (Adhikari et al., 2021; Kelarijani et al., 2014; Makgobela et al., 2018).

4.2 Health belief factors

The use of health facility services as compared to traditional medication and the services offered have been analysed and discussed with regards to personal beliefs in health facility services. In rural areas, traditional medication is a common alternative treatment (Fokunang et al., 2011; James et al., 2018; WHO, 2013) rather than in urban areas. The results indicate that satisfaction for those who believe that traditional medications are better is 0.70 times lower than those who do not hold this belief and is highly significant at 95% CI ($p < 0.0001$) when controlling for other variables. When someone believes in and relies on traditional medicine, there is a 30% likelihood that they will be dissatisfied with health services. This might be due to a reliance on alternative medications and being unable to tolerate any discrepancies, which leads to lower satisfaction—a finding consistent with previous studies (Ekor, 2014; Oliver, 1980; Simon & Gómez, 2014) that have

reported a decrease in satisfaction with current products or services under the influence of rival services or products.

When comparing traditional practitioners and medical specialists as the same, agreeing with this comparison is likely to reduce health satisfaction by 0.06%, but it is not statistically significant at 95% CI (0.94, $p = 0.523$) when controlling for other variables. Believing in traditional practitioners is likely to lower satisfaction with health facility services, and may be considered an alternative contributing factor. Consistent with this finding, other studies (James et al., 2018; Pengpid & Peltzer, 2019; Simon & Gómez, 2014) have reported that beliefs in traditional medication or practitioners, whether as rivals or alternatives, negatively affects satisfaction with the current health service offered.

4.3 Household factors

Household factors, such as household size and total annual household income, were included in the analysis. Holding other variables constant, the odds of satisfaction were found to be 1.04 times larger for every unit increase in household size, although this was not statistically significant (OR = 1.04, $p = 0.338$). It is possible that this result could be influenced by the fact that larger households are more likely to have members who are sick and therefore visit health services more frequently, resulting in more experience and a higher ability to handle unexpected service quality. Unfortunately, some studies that have investigated household factors in relation to health service satisfaction do not report household size (S. Qin & Ding, 2021; Makgobela et al., 2018; Dong et al., 2017; Stepurko et al., 2016; Footman, et al., 2013).

Household income showed no association with the likelihood of household satisfaction with health services, although it was statistically significant (OR = 1.00, $p = 0.011$). This is consistent with other studies, such as Makgobela et al. (2018), which found no association between household income and health satisfaction. This may reflect the difficulties faced by the poor in accessing health services, where the experience of the service becomes difficult to assess due to limited opportunities to test the service. Difficulties in accessing health services have been reported by Okunrintemi et al. (2019). In contrast to these findings, other studies (S. Qin & Ding, 2021; Okunrintemi et al., 2019; James et al., 2018; Dong et al., 2017; Stepurko et al., 2016; Footman, et al., 2013) have indicated that higher income is associated with an increased likelihood of satisfaction. Additionally, Afzal et al. (2014) found that lower income was associated with a higher likelihood of satisfaction with health services, making the results regarding income and health service satisfaction mixed, although skewed towards the idea that higher income leads to higher satisfaction with health facility services.

4.4 Health facility factors

The health facility access factor and the nature of service have been determined by the number of health facilities around within a 30-min walking distance and service delay perception at 95% confidence interval. When there is a unit increase in the number of health facilities around, the likelihood that a person will be satisfied shrinks by 0.12%, though not significant (OR = 0.88, $p = 0.653$). This might be contributed to by raising the expectation of the quality of service given the alternative. An individual or the entire household would expect and require better service compared to the current service provided, similar to what was observed in other studies (Ekor, 2014; Oliver, 1980; Simon & Gómez, 2014). These studies compared products and services of the current service provider and the rivals, with expectations in mind. Additionally, other studies that reported health service satisfaction in connection with health facilities in rural areas did not inform of the number of health facilities in a specific location (Dong et al., 2017; Stepurko et al., 2016; Afzal et al., 2014; Footman, et al., 2013).

The other factor—health service delay—is significant in reducing health service satisfaction; the odds that a person will be satisfied shrinks by 0.23 when service delay becomes more often than previously, given other variables (OR = 0.77, $p = 0.005$). This might be attributed to frustration,

increased health risk, and reduced likelihood to survive, which is perceived when a health problem remains unattended, similar to the observation by Robinson et al. (2012). This is in line with results reported elsewhere by other studies where delays in service or long waiting times affect satisfaction negatively, resulting in dissatisfaction (Alrasheedi et al., 2019; Jacobsen & Hasumi, 2014; Robinson et al., 2012; Xie & Or, 2017). There is no evidence of mixed results even for studies on satisfaction with the health system in general (McIntyre & Chow, 2020; Xesfingi & Vozikis, 2016).

4.5 Comparison between treatment and control in health facility service satisfaction

A comparison between the treatment and control groups in terms of health facility service satisfaction reveals that the results for the nine factors discussed in Tables 3 and 4 are similar for both groups when they are considered together. The effect of each factor appears to be consistent within each group, and the results are similar in direction and magnitude between the treatment and control groups, with the exception of a few factors related to health facility and household factors.

Specifically, the results suggest that an increase in the number of health facilities around the community is likely to decrease the odds of household satisfaction by 0.09% for the treatment group and by 0.03% for the control group. This represents a three-fold higher decrease for the treatment group. In addition, an increase in service delay frequency is likely to decrease satisfaction by 0.15% for the treatment group and by 0.32% for the control group, reflecting an effect that is twice as strong for the control group. These findings suggest that the treatment group is highly sensitive to the availability of alternatives and is more likely to switch to alternatives (Amani, 2022; Nimako, 2012), which negatively impacts the utilization of health services and compliance with CCT conditions.

Furthermore, the treatment group appears to be half as affected by service delay frequency compared to the control group. This suggests that the treatment group may be more considerate and have lower service expectations (Oliver, 1980) compared to the control group. However, the likelihood of a decrease in health facility service satisfaction is still detrimental to the utilization of health services and may increase noncompliance with CCT health conditions. In summary, the comparison between the treatment and control groups in terms of health facility service satisfaction reveals that the groups have similar results within each factor, except for a few related to health facility and household factors. The treatment group is highly sensitive to the availability of alternatives and service delay frequency, which may negatively impact utilization of health services and compliance with CCT conditions.

4.6 Conclusion and recommendation

As discussed above, recipients are generally satisfied with the health facility services for each group and all groups combined. However, the design and implementation of CCT programs need to consider contextual factors to ensure smooth health service utilization when the recipient is satisfied with the offered health facility services. Among the three household characteristics that influence CCT health service satisfaction, only an increase in education is likely to increase individual and household satisfaction with health services offered. The other factor, household head's age, has the possibility of reducing the likelihood of being satisfied as age increases. This highlights the higher possibility of reduced health service utilization with time when other variables are constant. Education has been found to be vital in ensuring health facility service satisfaction, thus leading to the smooth utilization of health facility services. The results show that an increase in education increases the likelihood of health facility service satisfaction. Therefore, designing and implementing any CCT supplementary or complementary programs that improve knowledge through training is likely to be beneficial in health facility service satisfaction.

Strong beliefs towards traditional medication and traditional healers, which are alternative medications, reduce the possibility of satisfaction with health services. Therefore, maintaining and increasing awareness of health facility service benefits in tandem with quality of the health

facility services is necessary to improve contextual factors. The increase in the number of health facilities in the locality reflects alternatives for obtaining medical services and increases the likelihood of dissatisfaction, as higher expectations might be created, and thoughts to meet the health service facility needs might be generated via alternatives. Similarly, an increase in service delays negatively affects household satisfaction, and as both negatively affect satisfaction with health facility services, they negatively affect health visits and thus affect compliance with health conditions—utilization of health services.

The study reveals that while compliance with program conditions must be ensured, a careful look must be in place for contextual factors to smooth the utilization of health services, a health condition that requires compliance. The environment and the nature of people served inform the expected health utilization services as a condition in CCT. Utilization of health facilities has been a key factor in ensuring the well-being of household beneficiaries and gradually moving out of poverty. To ensure health service satisfaction, this study recommends that education (through training sessions) be emphasized in tandem with program implementation for both health service recipients and providers to ensure a positive belief towards health facility services when compared to beliefs in traditional medications—improving the contextual factors.

The benefits of health facilities must be communicated tirelessly to help the recipient. On the other hand, health service provider's side will increase care to the delicate in receiving health service (females and the elders) to accommodate their sensitivity to health services, which in turn might reach a loving relationship between service provider and service recipient, strengthening, sustaining, and smoothing utilization of health facility services. Moreover, unnecessary delays might be reduced, leading to a higher possibility of health facility service satisfaction, which finally smoothens health service utilization and crystallizes health conditions compliance set by CCT.

The outcome and recommendation of this study will help in stressing additional efforts to the design and implementation of CCT programs, which might be overlooked, and making great attention to the outcomes—improving the contextual factors. Policy makers and designers of CCT programs might incorporate the improvement of contextual factors during the design of the program. In that regard, compliance to health conditions involving health service utilization will be increased, thus increasing the effectiveness of the program. This will not only reduce poverty but enhances environmental friendly daily activities to the poor and contributing to achievement on SDGs.

The study was limited to rural areas where most poor people are located. However, further research by other scholars could enhance the evidence by examining health facility service utilization among the urban poor, who comprise around 20% of the poor in low-income countries (Knudsen et al., 2020; UNSD, 2023; World Bank, 2020). The poor in urban areas face different contextual factors relating to health service access and CCT program implementation, and as such, new and expanded insights may be obtained. Additionally, the contextual factors explored in this study were limited to the design and implementation of CCT programs, particularly the health conditionality aspect, and the available data kept administratively by the program.

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