Research agenda-setting on cash programming for health and nutrition in humanitarian settings

Version: 17 October 2017

Table of Contents

Acknowledgements

This report was written by Aniek Woodward (independent researcher) who also led the data collection and analysis. The research agenda setting exercise was supported by an Advisory Group, co-chaired by Andre Griekspoor (WHO) and Kevin Savage (World Vision). Other members included: Claire Beck (World Vision), Ann Burton (UNHCR), Shannon Doocy (John Hopkins School of Public Health), Lara Ho (International Rescue Committee), Josephine Ippe (UNICEF), Fernando Maldonado (Royal Tropical Institute (KIT) Amsterdam), Ruth McCormack (Cash Learning Partnership), Egbert Sondorp (Royal Tropical Institute (KIT) Amsterdam), and Paul Spiegel (John Hopkins School of Public Health).

For further information please contact Andre Griekspoor: griekspoora@who.int

Abbreviations

AG = Advisory group

CaLP = Cash Learning Partnership

CHNRI = Child Health and Nutrition Research Initiative

CTP = Cash Transfer Programming

GHC = Global Health Cluster

LMICs = Low- and middle-income countries

LSHTM = London School of Hygiene & Tropical Medicine

MPG = Multi-purpose Grant

TT = Task Team

TWG-HS-FCAS = Thematic Working Group on Health Systems in Fragile and Conflict Affected States

WHO = World Health Organization

Executive Summary

Background

While the evidence base for cash transfer programming (CTP) in humanitarian contexts is more established for food security, it is very limited for health. The aim of this study was to develop a research agenda on CTP for health and nutrition in humanitarian settings.

Methods

This exercise adopted a qualitative descriptive approach using three stages over an eight-month period (Oct 2016 to June 2017): 1) Establishment of an advisory group (AG) and the development of the methodological approach; 2) Consultation on research questions; and 3) Clarification and prioritisation of research questions and categories. Data was collected using two methods: an online survey and face-to-face group session. AG members were asked to judge questions based on four criteria (answerability/feasibility, fills important knowledge gap, maximum potential for improving health or nutrition outcomes, effect on equity) using a 5-point scale. Content analysis was used to identify and rank research categories.

Results

In total 189 research questions were developed in the consultation stage (n=40 online survey; n= 30 group session). Identified questions could be divided into 22 research categories, which again were further combined into nine overarching categories. The category covered most often by consulted research questions was Modalities (41%), followed by Outcomes & impact (31%), Intermediate outcomes (27%), Initial considerations (19%), Effectiveness (19%), Pathways (14%), Methodologies & indicators (13%), Types of diseases or health issues (6%), and Context (5%).

Conclusions

The agenda of research areas, with examples of questions, could serve as guidance for researchers, policy makers, implementers and funders when selecting which of the many gaps in the current evidence base on this topic to start addressing first.

Background

Cash transfer programming (CTP) is increasingly used and promoted as default in humanitarian responses in low and middle income countries (LMICs) (ODI 2015; Agenda for Humanity 2016). CTP is generally understood as interventions that provide cash or vouchers directly to affected individuals and households (CaLP 2016) (a glossary of terms is found in Annex 1). It implies a shift from goods and services delivered by humanitarian agencies, to beneficiaries buying what they need and when they need it on local markets, and thus empowering individuals and strengthening national capacities and systems. It is acknowledged that cash cannot meet all needs, and that 'investments in public goods, including protection, education and health will still be needed' to effectively respond to emergencies (Agenda for Humanity 2016).

It is important for such investments in 'cash' to be supported by research; to know what works and does not work, if there are sectoral specifications that need to be taken into account, and to be able to efficiently use available resources. While the evidence base for CTP in humanitarian contexts is more established for food security (ODI 2015), it is very limited for health (The World Bank 2016a; Pega et al. 2015; Harrison et al. 2013; UNHCR 2015).

Research priority setting is a useful way to guide the focus and investments of researchers, donors, policy-makers and implementers (Viergever et al. 2010). Resources to invest in humanitarian research are still scarce, even as donors and actors are increasing their commitments to research-based evidence.

Identification of research areas and prioritisation is needed to ensure that the limited and precious resources for humanitarian research are used to answer the most important questions and those that could not be answered in more stable environments. As a result, the international community is investing through collaborations such as the Research for Health in Humanitarian Crises (R2HC) Evidence Reviews (Blanchet et al. 2013), the Cash Learning Partnership work in

summarising the current state of CTP (CaLP 2017), and global cluster efforts such as this one, to identify and validate research agendas to guide investments.

To the best of our knowledge, so far there is no consensus on a research agenda on the use of CTP for health in humanitarian contexts at the global level. For this reason, a research agenda setting exercise was commissioned by World Health Organization (WHO) and the Global Health Cluster (GHC). This exercise is part of the work plan of the GHC Task Team (TT) on Cash. This report describes the process of developing such a research agenda and presents the results on research categories identified and ranked in this study.

Methods

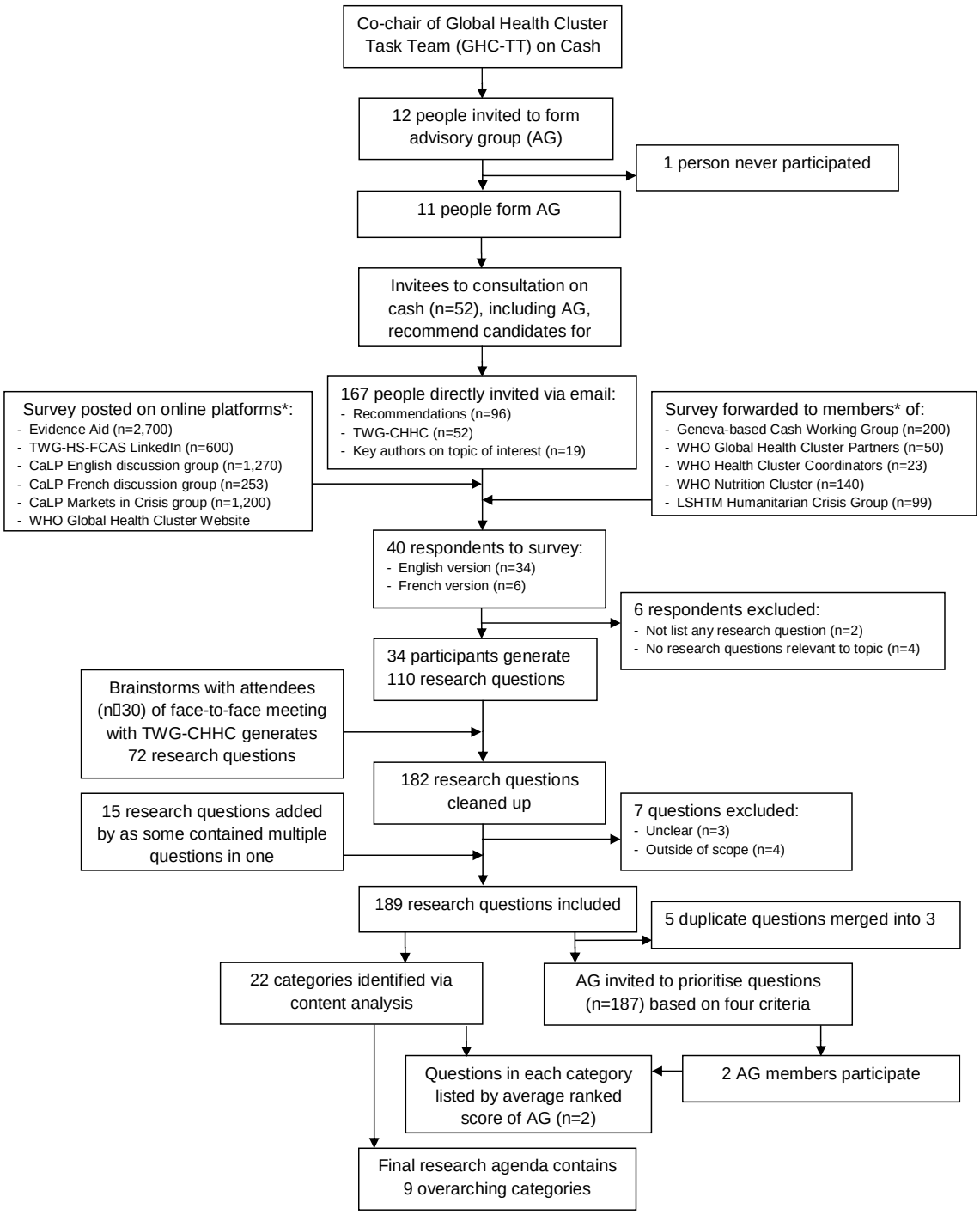
This study adopted a qualitative descriptive approach using three stages. Data was collected using two methods: an online survey and face-to-face group session. An overview of the stages, methods, purpose and timeline is found in Table 1.

Table 1: Overview of study's stages, including purpose, approach and time-line

Stage	Purpose	Approach	Time-line
1. Establishment of advisory group and development of methodological approach	To guide the methodological approach	Members from the advisory group discussed methodology and criteria for prioritisation via Skype and email.	Three 60-90 minute Skype discussions (Oct '16 - Feb '17); 30-minute face-to-face meeting during consultation on cash (4 Nov '16); Email feedback (Oct '16 - June '17).
2. Consultation on research questions a) Online survey b) Face-to-face group session	To identify key research questions on this topic	a) Sample of global stakeholders was invited to complete the survey. b) Attendees of a consultation session on cash were asked to list research questions.	a) 10-minute survey was open for 3 weeks (28 March - 19 April '17) b) 1 hour face-to-face session on 4 Nov '16
3. Clarification and ranking of research questions and categories	To refine and rank research questions and categories	Members of the advisory group were asked to prioritise research questions based on four criteria. Content analysis was used to develop and rank research categories.	About 1.5 hours during one month (11 May - 11 June '17)

Under stage 3 there was a change of strategy from prioritisation of research questions (by use of criteria applied by the AG) to ranking by counting of research categories (using content analysis) due to an insufficient response rate.

A flowchart of this exercise, including its participants at each stage, is displayed in Figure 1.



*estimates available on group webpage or provided by group manager

Figure 1: Flowchart of the research process.

Ethical approval from the WHO Research Ethics Review Committee was sought. This Committee determined that a full review of the project was not required because it did not fell into the category of human subjects. Anonymity and confidentiality of participants were ensured throughout the study. Each stage will be described in more detail in a journal article (to be developed) and the survey can be found in Annex 2.

Results

Table 2 provides an overview of the 22 categories identified via content analysis and how often these were covered by consulted research questions (n=189). Each category includes a research question as illustration. Questions selected as examples most clearly reflect the relevant category. Annex 3 contains all research questions for each category in order of combined ranking by two AG members. These 22 categories could be further combined into nine overarching categories. Figure 2 shows our understanding of how sub-categories relate to overarching categories (displayed in **bold**), and whether and how categories are interconnected.

Initial considerations include questions that require researching prior to the implementation of CTP, such as about the health system preconditions and humanitarian response preferences of affected households. *Modalities* covers questions about the different types of cash transfer programming (i.e. conditional cash, restricted cash/vouchers, unrestricted and unconditional cash/multipurpose grants (MPGs)) and how they compare with each other and with direct support to access health and nutrition services and goods. *Pathways* encompasses questions on how CTP influences *Intermediate outcomes*, *Outcomes and impact*, as well as routes to *Effectiveness*[1]. Outcomes and impact has a feedback loop with Intermediate outcomes because, for example, improved social and financial protection reduces financial access barriers and may encourage beneficiaries to seek care or access goods, and this again improves health and nutrition outcomes. Effectiveness includes questions around (cost) effectiveness of CTP, and variations in the amount of cash, in influencing both intermediate and eventual outcomes. *Context* refers to questions on where CTP takes place such as stage and type of the emergency. *Methodologies & indicators* and *Types of diseases or health issues* are displayed as separate from the other categories as they respectively involve best ways to measure research questions in other categories and what health or nutrition issues require focus.

[1] This can also be linked to the pathways of underlying causes of an outcome, such as the UNICEF conceptual framework for malnutrition, how different CTP affects the various elements in it. https://www.unicef.org/nutrition/training/2.5/4.html

Table 2: Number of consulted research questions for each category, including examples of research questions.

Categories	Number of times covered in research questions (%)*	Examples of research questions
Health & nutrition outcomes	44 (23%)	How can CTP best be designed so that they will have a positive effect on child nutritional status?
Comparison modalities	36 (19%)	How can use of CTP instead of delivering in kind improve health and nutrition indicators in LMICS?
Unrestricted & unconditional cash	36 (19%)	Does the inclusion of an average health cost in the Minimum Expenditure Basket improve the health of beneficiaries?
(Cost) effectiveness	32 (17%)	How does the effectiveness of different cash modalities and payment mechanisms to tackle nutrition/health issues compare?
Access to & utilisation of care and goods	29 (15%)	What effect do cash transfers have on accessing and utilising health services?
Pathways	27 (14%)	How do cash transfers work to protect undernutrition in humanitarian crisis?
Methodologies & indicators	24 (13%)	What are appropriate methodologies to research cash for health in humanitarian crises?
Demands & needs of cash beneficiaries	16 (8%)	Do people affected by conflict prefer cash or in-kind support for the treatment of their children or family members?
Appropriateness of cash in response	16 (8%)	What is the appropriate place for cash based assistance as one response option to deliver health programming?
Conditional cash	12 (6%)	Does labelling a cash grant for nutrition have the same impact as a conditional cash grant for nutrition?
Types of diseases or health issues	12 (6%)	How do various types of cash transfers affect nutrition, HIV, and maternal health?
Restricted cash/ Vouchers	11 (6%)	What is the evidence that cash or vouchers may incentivise care or utilisation?
Behaviour change	11 (6%)	Can CTP be used to incentivise health outcomes and/or health behaviours?
Context	9 (5%)	In what type of contexts are different cash transfer modalities likely to work?
Social & financial protection	9 (5%)	How can social protection nets be developed for health or nutrition?
Sustainability & link development	9 (5%)	What are the longer-term effects of cash transfers on undernutrition?
Quality of care	7 (4%)	How can quality of care be guaranteed during CTP?
Health & nutrition systems	6 (3%)	How do different cash modalities strengthen the health system and contribute to longer term equitable health financing?
Health system & market preconditions	6 (3%)	What health system preconditions are necessary for the implementation of cash for health and nutrition programming?
Amount of cash	3 (2%)	How does the amount of the cash transfer affect its impact upon undernutrition?
Influence on gender roles	3 (2%)	Do cash transfers positively or negatively affect gender roles?
Empowerment	2 (1%)	How do cash transfers compare to specific patient free health vouchers in terms of empowerment of patients?
Total	*189 (100%)**	

*Each research question could be coded with multiple categories (and up to four). In total 360 codes were assigned to 189 research questions. On average, each question was coded 1.91 times.

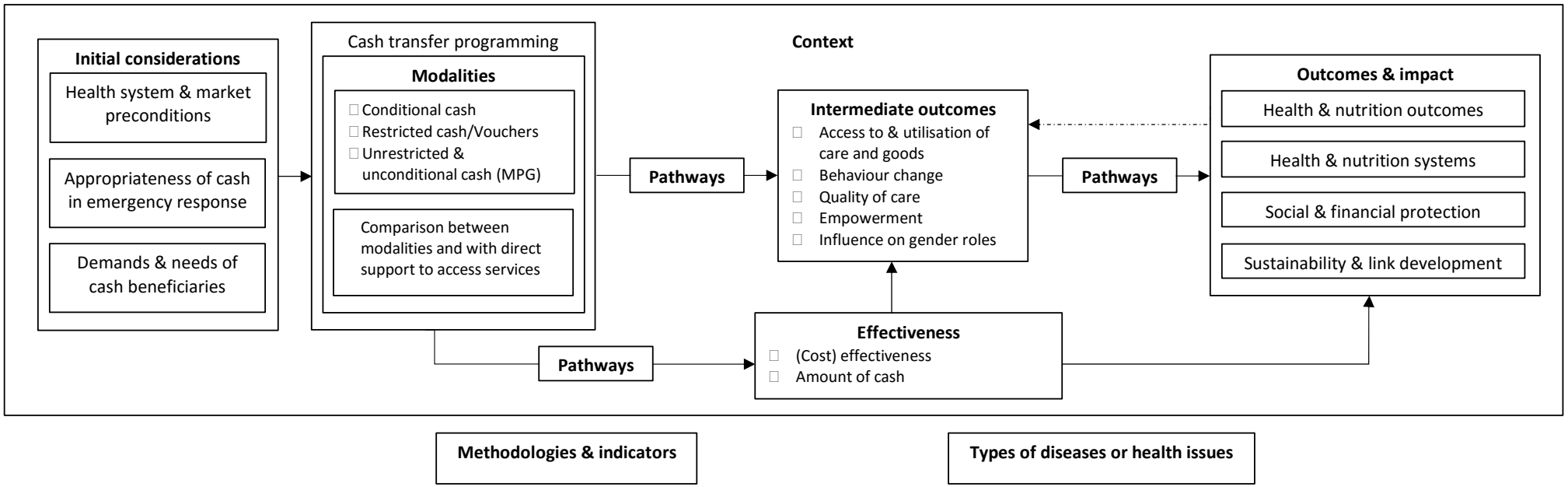


Figure 2: Overview of our understanding of the relationships between the identified categories.

Table 3 shows the counts of research questions covered by the nine overarching categories.

Table 3: Number of consulted research questions for each overarching category.

Overarching categories	**Number of times covered in research questions (%)***
Modalities	77 (41%)
Outcomes & impact	58 (31%)
Intermediate outcomes	51 (27%)
Initial considerations	36 (19%)
Effectiveness	35 (19%)
Pathways	27 (14%)
Methodologies & indicators	24 (13%)
Types of diseases or health issues	12 (6%)
Context	9 (5%)
Total	*189 (100%)**

*Each research question could be coded with multiple overarching categories (and up to four). In total 329 codes were assigned to 189 research questions. On average, each question was coded 1.74 times.

The top three categories are Modalities (41%), Outcomes & impact (31%), and Intermediate outcomes (27%). This means most questions fell into these three categories. Some questions within each category were quite similar. For example, *"How do unconditional cash transfers impact health and nutritional status?"* and *"What is the impact of multipurpose cash transfers on health outcomes?"* Since in the end counting was used to rank categories, all questions (including duplicates/similar ones) were included for analysis.

Limitations

This study has several limitations that should be taken into account when interpreting these findings.

First, participation in the survey was based on self-selection. This means research questions present the knowledge and interests of those with time to participate and an interest in the topic. In addition, self-selection might have meant some contributed to both the online survey and face-to-face group session, which limits the variety of people consulted.

Second, while the survey was advertised widely, the response rate was lower than expected, which is common in online surveys (Evans & Mathur 2005). A limited response rate was also prevalent in the prioritisation stage, likely because the time required for this stage was perceived by members of the AG as too lengthy and complex. Future priority setting exercises for CTP in health should consider ways to overcome this, for example by adding another workshop with the AG. This study shows that a flexible approach is required when resources and capacity are limited.

Third, although a gender balance was achieved and a good mixture of people from different geographical areas participated, the types of stakeholders was less equal. Especially academics were underrepresented amongst survey participants.

Fourth, cash beneficiaries were not consulted. During the development of the methodological approach it was explored to conduct facilitated discussions with beneficiaries in selected humanitarian settings in LMICS. In the end, this appeared not feasible within project restrictions.

Fifth, the survey was available in English and French, which might have been a barrier for those not fluent in these languages to participate. However, since most people in the humanitarian field speak at least one of these languages, it is very unlikely anyone did not participate for this reason.

Lastly, ranking of research categories reflect the number of research questions falling into each category and not the number of participants. Research questions for group discussants were not linked to individuals, which meant it was difficult to take this into account in the analysis. On average participants listed only 3 questions; it is unlikely that doing so would have significantly influenced the results.

Conclusions

The research agenda presented in this report is the product of a three-stage agenda setting process. To the best of our knowledge, this is the first ever exercise that consults a range of global stakeholders to develop a research agenda on CTP for health and nutrition in humanitarian settings.

Categories and research questions identified in this study are not exhaustive. Limitations in the process, combined with the complexity of the topic and limited current understanding of the added value of CTP in the health sector based on evidence in humanitarian contexts, did not allow the formulation of the top two or three research questions by category. Listed questions should be seen as illustrative, meaning they are already useful to inform researchers and practitioners, while they need to be further refined and made appropriate to the context in which they are going to be applied.

The agenda, with its ranked categories, could serve as guidance for researchers, policy makers, implementers and funders when selecting which of the many gaps in the current evidence base on this topic to start addressing first. Once an overarching category is chosen as focus for the research, the list of questions related to the categories, will provide insight in the type and range of research questions. A research team, in collaboration with practitioners, can then use these examples to formulate the most appropriate questions to research for its context.

Once the evidence starts to grow, this agenda will become outdated. Priority setting is recommended to be conducted regularly (Viergever et al. 2010) as understanding increases through research and practise. It is therefore recommended for this exercise to be repeated after 3-5 years.

Proposed next steps are:
1) This report will be turned in a brief, which can be shared amongst the Cash TT and posted on the GHC website for immediate dissemination;

2) The results of this study will be used to develop a journal paper. In this paper identified research categories will be discussed based on the existing literature on CTP for health and nutrition in unstable and stable settings. Linking our findings to the available evidence will further refine the research prioritisation as this means it become clear whether there are knowledge gaps in all consulted research categories or whether some topics are already more developed;
3) The Cash TT will hold another consultation to select a limited number of about 3-5 most appropriate research questions for each identified category. This should make it easier for those wanting to conduct or fund research to select a question;
4) the GHC is planning to keep track of ongoing research on this topic as well as to document relevant practice. This should give a better understanding of what knowledge and practice gaps are being filled and what remains left to explore further.

References

Agenda for Humanity, 2016. *The Grand Bargain: A Shared Commitment to Better Serve People in Need*, Instanbul. Available at: http://www.agendaforhumanity.org/initiatives/3861.

Blanchet, K. et al., 2013. *An evidence review of research on health interventions in humanitarian crises*, London. Available at: http://www.elrha.org/r2hc/evidence-review.

CaLP, 2016. *Glossary of cash transfer programme terminology*, Oxford. Available at: http://www.cashlearning.org/resources/library?keywords=glossary&region=all&country=all&year=all&organisation=all&sector=all&modality=all&language=all&payment_method=all&document_type=all&searched=1.

CaLP, 2017. Welcome to the State of the World's Cash Report Practitioner Survey. Available at: http://www.cashlearning.org/news-and-events/news-and-events/post/466--welcome-to-the-state-of-the-worldas-cash-report--practitioner-survey [Accessed September 14, 2017].

Evans, J.R. & Mathur, A., 2005. *The value of online surveys*, Available at: http://www.emeraldinsight.com/doi/10.1108/10662240510590360.

Evidence Aid Priority Setting Group, 2013. Prioritization of Themes and Research Questions for Health Outcomes in Natural Disasters , Humanitarian Crises or Other Major Healthcare Emergencies. *PLoS Currents Disasters*.

Harrison, S. et al., 2013. "Against all odds": UNHCR's mental health and psychosocial support programme for Iraqi refugees and internally displaced Syrians. *Intervention*, 11(2), pp.190–194. Available at: http://search.proquest.com/docview/1442396739?accountid=14182.

Heiervang, E. & Goodman, R., 2011. Advantages and limitations of web-based surveys: evidence from a child mental health survey. *Social Psychiatry and Psychiatric Epidemiology*, 46(1), pp.69–76. Available at: http://dx.doi.org/10.1007/s00127-009-0171-9.

Morof, D.F. et al., 2014. Neonatal survival in complex humanitarian emergencies: setting an evidence-based research agenda. *Conflict and Health*, 8(1), p.8. Available at: http://conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-8-8.

ODI, 2015. *Doing cash differently. How cash transfers can transform humanitarian aid. Report of the High Level Panel on Humanitarian Cash Transfers*, London. Available at: www.odi.org%5Cnwww.odi.org/facebook%5Cnwww.odi.org/twitter.

Pega, F. et al., 2015. Unconditional cash transfers for assistance in humanitarian disasters: effect on use of health services and health outcomes in low- and middle-income countries. *The Cochrane Collaboration*, (9), p.CD011247. Available at: http://www.ncbi.nlm.nih.gov/pubmed/26360970.

Prudhon, C. et al., 2016. Research priorities for improving infant and young child feeding in humanitarian emergencies. *BMC Nutrition*, 2(1), p.27. Available at: http://bmcnutr.biomedcentral.com/articles/10.1186/s40795-016-0066-6.

ReliefWeb, 2008. *Glossary of Humanitarian Terms*, Geneva.

Rudan, I. et al., 2006. A systematic methodology for setting priorities in child health research investments. In T. Huda, ed. *A new approach for systematic priority setting*. Dhaka: Child Health and Nutrition Research Initiative, pp. 1–11. Available at: http://www.chnri.org/secured/uploads/publications/files/0535210001249198837-604_file_PRIORITY_SETTING_.pdf.

Rudan, I., 2016. Setting health research priorities using the CHNRI method: IV. Key conceptual advances. *Journal of Global Health*, 6(1), p.10501.

Rudan, I. et al., 2008. Setting Priorities in Global Child Health Research Investments: Guidelines for Implementation of the CHNRI Method. *Croatian Medical Journal*, 49, pp.720–733. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2621022/ [Accessed June 18, 2014].

Silverman, D., 2010. *Doing Qualitative Research* 3rd ed., London: SAGE.

The World Bank, 2016a. *Cash Transfers in Humanitarian Contexts*, Washington, DC.

The World Bank, 2016b. World Bank Country and Lending Groups. Current classification by income in XLS format. Available at: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups [Accessed October 12, 2016].

Tol, W.A. et al., 2011. Research priorities for mental health and psychosocial support in humanitarian settings. *PLoS medicine*, 8(9), p.e1001096. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3176752&tool=pmcentrez&rendertype=abstract [Accessed May 23, 2014].

UNHCR, 2015. *Cash-based interventions for health programmes in refugee settings. A review*, Geneva.

UNISDR, 2009. *UNISDR Terminology on Disaster Risk Reduction*, Geneva.

Vaismoradi, M., Turunen, H. & Bondas, T., 2013. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences*, 15(3), pp.398–405.

Viergever, R.F. et al., 2010. A checklist for health research priority setting: nine common themes of good practice. *Health Research Policy and Systems*, 8(36). Available at: http://www.health-policy-systems.com/content/8/1/36.

WHO, 2017. Cash based interventions for health in humanitarian contexts: November 2016. Available at: http://who.int/health-cluster/news-and-events/news/en/ [Accessed September 3, 2017].

Woodward, A. et al., 2016. Health systems research in fragile and conflict affected states: a research agenda-setting exercise. *Health Research Policy and Systems*.

Annex 1: Glossary

Cash Transfer Programming (CTP)

"CTP refers to all programs where cash (or vouchers for goods or services) is directly provided to beneficiaries. In the context of humanitarian assistance the term is used to refer to the provision of cash or vouchers given to individuals, household or community recipients; not to governments or other state actors. CTP covers all modalities of cash- based assistance, including vouchers. This excludes remittances and microfinance in humanitarian interventions (although microfinance and money transfer institutions may be used for the actual delivery of cash)" (CaLP n.d., p1). This term is often used interchangeably with Cash Based Interventions and Cash Based Transfers but here CTP will be used.

All modalities (cash/voucher, unconditional/conditional, labelled unconditional, unrestricted/restricted, multi-purpose/multi-sector/sector-specific) of CTP are considered. Definitions, and a helpful diagram, of these modalities can be found in the CaLP glossary (CaLP 2016).

As outlined by the definition, microfinance is excluded. Reason are that microfinance: a) is often provided in the form of a loan instead of a gift; and b) it focuses on longer-term livelihoods needs as opposed to immediate health needs, which is the interest in this exercise.

Humanitarian assistance

Humanitarian assistance (often used interchangeably with relief and aid) is "aid that seeks, to save lives and alleviate suffering of a crisis- affected population." (ReliefWeb 2008, p31).

Disaster

A serious disruption of the functioning of a community or a society involving widespread human, material, economic and environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources (UNISDR 2009).

Crisis

A crisis is a change in conditions that causes local or national systems to be overwhelmed, so that they are unable to provide the basic needs for survival. (WHO/HAC IB8, April 2004)

Low- and middle-income countries (LMICs)

Countries classified by The World Bank (2016) as 'low-income', 'lower-middle-income', 'upper-middle-income' economies are called LMICs here.

Emergency

"A situation impacting the lives and well-being of a large number of people or a very large percentage of a population and often requiring substantial multi-sectoral assistance. For a WHO response, there must be clear public health consequences." (Adapted from: Interagency Standing Committee. *Definition of Complex Emergencies,* 1994)

Refugee

"A person, who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, or for reasons owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge outside his country of origin or nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of his country of origin or nationality." (ReliefWeb 2008, p45)

Internally displaced persons (IDPs)

"Persons or groups of persons who have been forced or obliged to leave their homes or habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border." (ReliefWeb 2008, p36)

Annex 2: Online survey

Welcome

Welcome to this survey for research priority setting on cash transfer programming for health and nutrition in humanitarian settings.

Your decision to complete this survey is voluntary. We will maintain complete confidentiality and anonymity of your responses.

It should take you about 10 minutes to complete this survey, which consists of 2 sections:
1. Research questions
2. Your information

Research questions

We are requesting you to briefly outline what you think are the main research questions that will help to strengthen the evidence base for cash transfer programming for health and nutrition in humanitarian crises in low- and middle income countries (LMICs). Please keep the following in mind when formulating your research question:

- Write your research question in the format of a question
- Consider questions that strengthen knowledge and evidence on the link between cash transfer programming and health and/or nutrition in humanitarian crises
- Consider questions relevant to the context: humanitarian crises in LMICs
- Based on your own experience
- List at least 1 question and up to maximum of 5
- Questions do not have to be placed in order of priority

Research question 1:

Research question 2:

Research question 3:

Research question 4:

Research question 5:

Your information

1. Sex (*tick male/female)*

2. Which of the following options most accurately defines your **current** background? *(select one of following options)*

- National NGO
- International NGO
- Red Cross Movement
- UN agency

- Donor
- Academic
- Health authority in country affected by crisis

Membership organisation

Other (*please specify*):

2. In which country or territory do you **currently** work (if more than one list the one you work most with)? *(select answer from drop-down list)*

3a. What is the geographical area of focus in your **current** work? *(select one of following options)*

- National
- Regional
- Global
- Not applicable

3b. If national *(select answer from drop-down list)*

If regional *(select answer from drop-down list of regions)*

4. How did you hear about this survey? *(select one of following options)*

- Email
- Online platform (e.g. LinkedIn, CaLP discussion group, Global Health Cluster website)
- Other *(please specify)*:

Thank you

Thank you for completing this survey on research priority setting on cash transfer programming for health and nutrition in humanitarian settings!

The final research agenda will be made available on the WHO Global Health Cluster website in due time.

Annex 3: List of consulted research questions by category

This Annex includes lists of consulted research questions for each of the 22 categories. Each question is accompanied by an average score. This score is calculated by averaging the score given by each participant (n=2) on four criteria (1. answerability/feasibility; 2. fills important knowledge gap; 3. maximum potential for improving health and nutrition outcomes; 4. effect on equity) using a 5-point scale (strongly agree=1; somewhat agree=0.75; don't know=0.5; somewhat disagree=0.25; strongly disagree=0). Scores are between 0-1 with '1' being the most favourable and '0' least.

Categories covering most research questions are listed first and those with the least last. Research questions are in descending order by average score.

Table 4: Health & nutrition outcomes

	Research question	Score
1	Does the inclusion of an average health cost in the Minimum Expenditure Basket improve the health of beneficiaries?	0.88
2	What is the impact of a cash transfer programme, alongside a water and sanitation intervention, on diarrhoea (which is closely linked to malnutrition)?	0.84
3	How do unconditional cash transfers impact health and nutritional status?	0.81
4	What is the impact of multipurpose cash transfers on health outcomes (in terms of well-being, access to preventatives services, access to curative services)?	0.81
5	How can cash interventions best be designed so that they will have a positive effect on child nutritional status?	0.78
6	How does the amount of the cash transfer affect its impact upon undernutrition?	0.78
7	Can the adoption of cash programming in aid delivery in health and nutrition programmes accelerate the achievement of desired health and nutrition outcomes in LMICs?	0.78

8	What is the cost effectiveness of conditional/unconditional cash transfers with regards to impact on nutrition/health?	0.78
9	What is the impact of unconditional cash transfers on the mental health of beneficiaries in a humanitarian crisis?	0.78
10	How can cash strengthen public health outcomes?	0.75
11	What are the effects of unconditional cash transfers on health?	0.75
12	Does cash affect mental health outcomes?	0.72
13	How to explore better the potential of multipurpose cash to achieve health outcomes?	0.72
14	What is the impact of a variation of the amount of the cash transfer on the prevention of childhood undernutrition and morbidity?	0.69
15	What are the impact pathways of cash based interventions on nutrition outcomes (e.g. wasting)?	0.69
16	What is the pathway to link cash and health outcomes?	0.69
17	What health outcomes can be positively impacted by cash programming?	0.66
18	What health outcomes can be appropriately addressed with cash in different contexts?	0.66
19	Can cash transfer programs be used to incentivise health outcomes and/or health behaviours?	0.66
20	How do programmes focused on only health vs. only cash vs. both integrated compare in terms of impact on health (including mental health)?	0.66
21	How does cash work to affect undernutrition?	0.66
22	What is the pathway of cash to achieve health outcomes?	0.66
23	What is the overall health impact of unconditional cash transfers?	0.66
24	What are the health outcomes in the current practice of cash based programming?	0.63
25	Should the amount of the cash transfer be adapted to the size of the family to have more impact on nutrition and morbidity?	0.63
26	Do unconditional cash transfers impact health and nutritional status?	0.63
27	Does an unconditional cash transfer lead to a decrease in prevalence of acute malnutrition among children under five?	0.63
28	How is cash programming helping to support the psychosocial status of families or individuals affected by humanitarian crisis?	0.63
29	How can short-term multi-purpose, unconditional cash be leveraged to support long term health and nutrition impacts?	0.63
30	Do cash transfers maintain health/nutrition of young children and households when faced with a humanitarian crisis?	0.59
31	What are the longer-term effects of cash transfers on undernutrition?	0.59
32	Do cash transfer programmes lead to better health outcomes?	0.56

33	What is the impact of cash transfers targeting families from the beginning of pregnancy on the nutritional status and morbidity of the children?	0.56
34	What is the impact of multi-purpose, unconditional cash on older women and men's nutritional outcomes?	0.56
35	What is the impact of conditional/unconditional cash transfers on the nutrition and health of children under five?	0.56
36	Is there a relationship between mortality and morbidity patterns and the use of cash transfers?	0.53
37	How long are the cash transfers effects on undernutrition sustained after the final cash distribution?	0.53
38	What monitoring criteria should be used to assess the pathway of cash to achieve health outcomes?	0.53
39	What are the pathways and proportional attribution of the various factors for multipurpose cash transfers to improve health outcomes?	0.53
40	What documented instances of using unconditional or conditional cash transfers have negatively impacted on health or nutritional health status?	0.47
41	Where (context) does unrestricted/unconditional/multipurpose cash have a positive or negative impact on health outcomes/health/health services?	0.44
42	How does the conditionality of the cash transfer affect nutrition outcomes?	0.41
43	Is there a relationship between the characteristics of the cash transfer recipient and the ultimate effect on child nutritional status?	0.38
44	How will cash transfer programming impact beneficiaries in the long term in relation to the provision of healthcare and nutrition services?	0.34

Table 5: Comparison modalities

	Research question	**Score**
1	Does labelling a cash grant for nutrition have the same impact as a conditional cash grant for nutrition?	0.78
2	What is the cost effectiveness of conditional/unconditional cash transfers with regards to impact on nutrition/health?	0.78
3	How does the effectiveness of different cash modalities and payment mechanisms to tackle nutrition/health issues compare?	0.78
4	How can use of cash programming instead of delivering donations in kind (DIK) improve health and nutrition indicators in LMICS?	0.78
5	How do various types of cash transfers affect nutrition, HIV, and maternal health?	0.78
6	Can labelling of unconditional multipurpose cash transfer have a similar effect on health/nutrition as a conditional cash transfer?	0.78
7	What is the effect of the use of various conditionalities of cash transfers for health in different contexts?	0.72
8	What is the relative effectiveness of cash transfers, compared with in-kind transfers?	0.72
9	Is cash transfer more efficient/effective to reduce financial barriers compared to direct support to service provider?	0.72
10	Do people affected by conflict prefer cash or in-kind support for the treatment of their children or family members?	0.72

11	How does direct distribution of cash for health to beneficiaries compare with subsidies to health facilities?	0.69
12	In what type of contexts are different cash transfer modalities likely to work?	0.69
13	Do beneficiaries prefer to receive support in-kind or via cash for attending sessions on nutrition?	0.69
14	Is it better to receive money or a voucher to seek and receive care?	0.69
15	In a context where user fees are charged and that has a high proportion of out of pocket payment of the total health financing, what are the different effects on access between investing a similar amount of per capita in an unconditional cash transfer versus a direct intervention at the provider side to reduce the user fees?	0.66
16	How do programmes focused on only health vs. only cash vs. both integrated compare in terms of impact on health (including mental health)?	0.66
17	Is a package of interventions more effective than an individual cash-for-health intervention?	0.66
18	When all health services are free at the point of delivery, is there a difference in access to and/or utilisation of services between groups that do and do not receive an unconditional/multipurpose cash transfer? And if so, why?	0.66
19	What are the operational differences, advantages and disadvantages, of providing vouchers to obtain specific services or drugs, compared to direct support to the provider to make the same service/drugs free of charge at the point of delivery?	0.66
20	How do different cash transfer modalities strengthen the health system and contribute to longer term equitable health financing (that aims at less than 15% private funding)?	0.66
21	Why do programme designers perceive cash programming to be riskier and prone to misuse by recipients than provision of donations in kind?	0.63
22	What is the effectiveness of cash transfers for improving health and nutrition, compared with no cash transfers?	0.63
23	How do beneficiaries perceive cash transfer programming vs service delivery programming in LMIC?	0.63
24	What conditions of health markets would make cash or vouchers an appropriate modality of response?	0.63
25	If unconditional/multipurpose cash replaces vouchers or distribution of health goods (bednets, condoms, female hygiene kits, etc), how does this affect the availability of such goods for households?	0.63
26	What modalities of using cash to pay for medical or nutrition services are most effective?	0.59
27	What is compared advantage/disadvantage of cash transfer (in terms of utilisation, financial access, and quality of care received by patients) compared to interventions improving service delivery or financial access without cash transfers (such as subsidies to assure free (no patient fee) care)?	0.59

28	In the context where quality health services are available what is the cost effectiveness of giving cash (labelled) compared to reimbursement of services or vouchers?	0.59
29	What is the relative effectiveness of conditional cash transfers, compared with unconditional cash transfers?	0.59
30	How do cash transfers compare to specific patient free health vouchers in terms of empowerment of patients to negotiate their access and demand their right for free care?	0.53
31	What types of conditions and diseases prompt a regular forecastable expenditure and can therefore be managed via vouchers, subsidy or insurance system?	0.53
32	What is a comparative value of cash based interventions and non-cash based interventions options?	0.50
33	Which interventions aimed at reducing financial access barriers have the largest impact on the budget of a household in a humanitarian crisis?	0.47
34	How do the transaction costs of cash transfers for health compare with those for other interventions?	0.47
35	What do people in need of humanitarian assistance think about modalities for implementation of health programmes?	0.44
36	What is the indicator that we can use to assess on the adequateness of a modality to access health and nutrition services through cash?	0.38

Table 6: Unrestricted & unconditional cash transfers (MPG)

	Research question	**Score**
1	Does the inclusion of an average health cost in the Minimum Expenditure Basket improve the health of beneficiaries?	0.88
2	How do unconditional cash transfers impact health and nutritional status?	0.81
3	What is the impact of multipurpose cash transfers on health outcomes (in terms of well-being, access to preventatives services, access to curative services)?	0.81
4	What essential pre-conditions need to be fulfilled to provide equitable access to health services in a humanitarian crisis context through an unconditional cash transfer scheme?	0.81
5	What is the impact of unconditional cash transfers on the mental health of beneficiaries in a humanitarian crisis?	0.78
6	Can labelling of unconditional multipurpose cash transfer have a similar effect on health/nutrition as a conditional cash transfer?	0.78
7	Is the minimum expenditure basket (MEB) a good tool to calculate the (monthly) monetary value of good health for a household?	0.78
8	What are the eventual advantages of multi-purpose (unconditional) cash transfers to improve access to health services in a humanitarian crisis?	0.75

9	What are the effects of unconditional cash transfers on health?	0.75
10	How to explore better the potential of multipurpose cash to achieve health outcomes?	0.72
11	What percentage of unconditional cash transfers are used for out-of-pocket expenditure to access health services?	0.69
12	How cost-effective are multi-purpose grants?	0.69
13	What are appropriate outcome measures for multi-purpose cash programming?	0.69
14	What is the overall health impact of unconditional cash transfers?	0.66
15	In a context where user fees are charged and that has a high proportion of out of pocket payment of the total health financing, what are the different effects on access between investing a similar amount of per capita in an unconditional cash transfer versus a direct intervention at the provider side to reduce the user fees?	0.66
16	When all health services are free at the point of delivery, is there a difference in access to/utilisation of services between groups that do and do not receive an unconditional/multipurpose cash transfer? And if so, why?	0.66
17	If an unconditional cash transfer is used for an out of pocket expenditure, what is the proportion of the out of pocket expenditure covered by the non-conditional cash transfer?	0.63
18	If an unconditional cash transfer was used to cover (partially or fully) an out of pocket expenditure, what is the breakdown of the out of pocket expenditure: medicines, lab fees, transportation, etc.	0.63
19	Do unconditional cash transfers impact health and nutritional status?	0.63
20	Does an unconditional cash transfer lead to a decrease in prevalence of acute malnutrition among children under five?	0.63
21	If multipurpose cash through an electronic transfer replaces a targetted in-kind distribution of supplementary feeding for moderate acute malnutrition, how does this affect direct contact for screening/case finding of morbidity?	0.63
22	How can short-term multi-purpose, unconditional cash be leveraged to support long term health and nutrition impacts?	0.63
23	If unconditional/multipurpose cash replaces vouchers or distribution of health goods (bednets, condoms, female hygiene kits, etc), how does this affect the availability of such goods for households?	0.63
24	What impact do existing multi-purpose grants have on utilisation of basic preventative healthcare?	0.63
25	How/what to include health costs in the minimum expenditure basket for multipurpose cash transfers?	0.63
26	What is the relative effectiveness of conditional cash transfers, compared with unconditional cash transfers?	0.59

27	What is the impact of multi-purpose, unconditional cash on older women and men's nutritional outcomes?	0.56
28	If multipurpose cash through an electronic transfer replaces a targetted in-kind distribution of supplementary feeding for moderate acute malnutrition, how does this affect monitoring of nutrition status?	0.56
29	What is the impact of conditional/unconditional cash transfers on the nutrition and health of children under five?	0.56
30	What are the pathways and proportional attribution of the various factors for multipurpose cash transfers to improve health outcomes?	0.53
31	What are the disadvantages of providing unconditional cash transfers to give access to health services for people affected by a humanitarian crisis?	0.50
32	What documented instances of using unconditional or conditional cash transfers have negatively impacted on health or nutritional health status?	0.47
33	If multipurpose cash through an electronic transfer replaces a targetted in-kind distribution of supplementary feeding for moderate acute malnutrition, how does this affect referral to inpatient care?	0.44
34	Where (context) does unrestricted/unconditional/multipurpose cash have a positive or negative impact on health outcomes/health/health services?	0.44
35	When people receive multipurpose unconditional cash transfers, does an Infant and Young Child Feeding programme (IYCF) or other nutrition messaging influence purchase choices (i.e. healthier foods)?	0.41
36	What percentage of unconditional cash transfers are used for out-of-pocket expenditure to access public vs. private health facilities?	0.34

Table 7: (Cost) effectiveness

	Research question	**Score**
1	What is the cost effectiveness of conditional/unconditional cash transfers with regards to impact on nutrition/health?	0.78
2	How does the effectiveness of different cash modalities and payment mechanisms to tackle nutrition/health issues compare?	0.78
3	How do cash transfers for health influence service costs and cost-effectiveness?	0.78
4	What is the relative effectiveness of cash transfers, compared with in-kind transfers?	0.72
5	What is the cost-effectiveness of cash transfers to achieve increased utilisation of health services?	0.72
6	Is cash transfer more efficient/effective to reduce financial barriers compared to direct support to service provider?	0.72
7	What tools are most useful to assess the effectiveness of cash interventions within a health programme?	0.69
8	How cost-effective are multi-purpose grants?	0.69
9	How effective are conditional cash transfer programmes in promoting compliance in chronic disease treatment?	0.69

10	Is a package of interventions more effective than an individual cash-for-health intervention?	0.66
11	To what degree do cash transfer programmes for health promote utilisation of healthcare?	0.66
12	What is the effectiveness of cash transfers for improving health and nutrition, compared with no cash transfers?	0.63
13	Are cash transfer programs sufficient for addressing health access/service provision issues in LMICs?	0.63
14	What are the operational differences (including costs) between giving vouchers for receiving similar services from a private for profit, private not for profit and a public health service provider?	0.59
15	In the context where quality health services are available what is the cost effectiveness of giving cash (labelled) compared to reimbursement of services or vouchers?	0.59
16	How effective is cash as an incentive for health seeking behaviour (e.g. to attend antenatal services)?	0.59
17	How effective is cash in strengthening access to sexual and reproductive, maternal, new-born and child and adolescent health care?	0.59
18	What modalities of using cash to pay for medical or nutrition services are most effective?	0.59
19	What is the relative effectiveness of conditional cash transfers, compared with unconditional cash transfers?	0.59
20	Do cash transfers (including for health) lead to reduced out-of-pocket expenditure at household/patient level?	0.56
21	What are the success factors of studies already done about cash for health?	0.56
22	Do cash transfer programs cause increases in health service costs?	0.53
23	What is the cost-benefit of using cash for specific health outcomes across different humanitarian contexts?	0.53
24	How effective are the use of market based cash approaches for health commodities?	0.50
25	What is a comparative value of cash based interventions and non-cash based interventions options?	0.50
26	How effective is cash as an incentive for health seeking behaviour?	0.50
27	How do the transaction costs of cash transfers for health compare with those for other interventions?	0.47
28	How effective are cash transfers in addressing the nutrition issues of families affected by humanitarian crises?	0.47
29	Which interventions aimed at reducing financial access barriers have the largest impact on the budget of a household in a humanitarian crisis?	0.47
30	What is the effectiveness of cash transfer programming to respond to large scale health emergencies (e.g. Ebola, cholera)?	0.38
31	Is there a relationship between the characteristics of the cash transfer recipient and the ultimate effect on child nutritional status?	0.38
32	How effective is cash as an incentive for service providers to then remain in the affected area and deliver health care?	0.25

Table 8: Access to & utilisation of care and goods

	Research question	Score
1	What is the impact of multipurpose cash transfers on health outcomes (in terms of well-being, access to preventatives services, access to curative services)?	0.81
2	What effect do cash transfers have on accessing and utilising health services?	0.78
3	Are conditional cash transfers feasible in sudden onset disaster (SOD) to improve coverage and utilisation of free services?	0.75
4	Does support to costs linked with health (e.g. transport, per diem for the care taker, meals) contribute to better case management in particular for children and pregnant and lactating women?	0.75
5	What are the eventual advantages of multi-purpose (unconditional) cash transfers to improve access to health services in a humanitarian crisis?	0.75
6	Given that access to food is only one driver of malnutrition, what is the evidence that cash or vouchers may incentivise care or utilisation?	0.72
7	What is the cost-effectiveness of cash transfers to achieve increased utilisation of health services?	0.72
8	Is cash transfer more efficient/effective to reduce financial barriers compared to direct support to service provider?	0.72
9	What percentage of unconditional cash transfers are used for out-of-pocket expenditure to access health services?	0.69
10	Is it better to receive money or a voucher to seek and receive care?	0.69
11	When all health services are free at the point of delivery, is there a difference in access to/utilisation of services between groups that do and do not receive an unconditional/multipurpose cash transfer? And if so, why?	0.66
12	To what degree do cash transfer programmes for health promote utilisation of healthcare?	0.66
13	In a context where user fees are charged and that has a high proportion of out of pocket payment of the total health financing, what are the different effects on access between investing a similar amount of per capita in an unconditional cash transfer versus a direct intervention at the provider side to reduce the user fees?	0.66
14	Do cash transfers improve access/reduce barriers for health access?	0.63
15	Are cash transfer programs sufficient for addressing health access/service provision issues in LMICs?	0.63
16	If multipurpose cash through an electronic transfer replaces a targetted in-kind distribution of supplementary feeding for moderate acute malnutrition, how does this affect direct contact for screening/case finding of morbidity?	0.63

17	What impact do existing multi-purpose grants have on utilisation of basic preventative healthcare?	0.63
18	If unconditional/multipurpose cash replaces vouchers or distribution of health goods (bednets, condoms, female hygiene kits, etc), how does this affect the availability of such goods for households?	0.63
19	What is the proportional weight of barriers (related to health care access and utilisation) that can be reduced by a cash transfer?	0.59
20	What is compared advantage/disadvantage of cash transfer (in terms of utilisation, financial access, and quality of care received by patients) compared to interventions improving service delivery or financial access without cash transfers (such as subsidies to assure free (no patient fee) care)?	0.59
21	How effective is cash in strengthening access to sexual and reproductive, maternal, new-born and child and adolescent health care?	0.59
22	If multipurpose cash through an electronic transfer replaces a targetted in-kind distribution of supplementary feeding for moderate acute malnutrition, how does this affect monitoring of nutrition status?	0.56
23	How do cash transfers compare to specific patient free health vouchers in terms of empowerment of patients to negotiate their access and demand their right for free care?	0.53
24	What are the disadvantages of providing unconditional cash transfers to give access to health services for people affected by a humanitarian crisis?	0.50
25	Will beneficiaries of cash transfers use the health services available in their locality or do they prefer to go elsewhere?	0.44
26	If multipurpose cash through an electronic transfer replaces a targetted in-kind distribution of supplementary feeding for moderate acute malnutrition, how does this affect referral to inpatient care?	0.44
27	What is the indicator that we can use to assess on the adequateness of a modality to access health and nutrition services through cash?	0.38
28	What percentage of unconditional cash transfers are used for out-of-pocket expenditure to access public vs. private health facilities?	0.34
29	Do patients receiving cash/vouchers chose a health facility on the basis of the quality of services or simply on its availability?	0.25

Table 9: Pathways

	Research question	**Score**
1	How do cash transfers work to protect undernutrition in humanitarian crisis?	0.84
2	How can cash based interventions have an effect on health behaviour change?	0.81
3	How do unconditional cash transfers impact health and nutritional status?	0.81

4	How can use of cash programming instead of delivering donations in kind (DIK) improve health and nutrition indicators in LMICS?	0.78
5	How do cash transfers for health influence service costs and cost-effectiveness?	0.78
6	What are the pathways by which cash transfers have an impact on health during humanitarian crises?	0.78
7	What are the barriers in health humanitarian programming and how can cash address this?	0.78
8	How does the amount of the cash transfer affect its impact upon undernutrition?	0.78
9	How do various types of cash transfers affect nutrition, HIV, and maternal health?	0.78
10	What is the link between cash transfers in emergencies and health?	0.75
11	How can cash strengthen public health outcomes?	0.75
12	What are the impact pathways of cash based interventions on nutrition outcomes (e.g. wasting)?	0.69
13	What is the pathway to link cash and health outcomes?	0.69
14	How cash transfers influence underlying determinants of malnutrition?	0.66
15	How does cash work to affect undernutrition?	0.66
16	What is the pathway of cash to achieve health outcomes?	0.66
17	How do different cash transfer modalities strengthen the health system and contribute to longer term equitable health financing (that aims at less than 15% private funding)?	0.66
18	How is cash programming helping to support the psychosocial status of families or individuals affected by humanitarian crisis?	0.63
19	What are the implementation pathways of cash transfers for health and nutrition in humanitarian disasters?	0.56
20	What are the pathways and proportional attribution of the various factors for multipurpose cash transfers to improve health outcomes?	0.53
21	How do cash transfers to families or individuals influence decision-making and power dynamics in the household?	0.53
22	How can cash transfers affect the role of the local government or ministry of health in strengthening health systems?	0.53
23	What monitoring criteria should be used to assess the pathway of cash to achieve health outcomes?	0.53
24	How can cash transfers strengthen or improve the quality of care?	0.50
25	How does the conditionality of the cash transfer affect nutrition outcomes?	0.41
26	How will cash transfer programming impact beneficiaries in the long term in relation to the provision of healthcare and nutrition services?	0.34
27	What are the pathways of possible/potential impact of cash transfers during humanitarian crises?	-

Table 10: Methodologies & indicators

	Research question	Score
1	Does the inclusion of an average health cost in the Minimum Expenditure Basket improve the health of beneficiaries?	0.88
2	Is the minimum expenditure basket (MEB) a good tool to calculate the (monthly) monetary value of good health for a household?	0.78
3	Which tools and key indicators should we use to understand the adequacy and quality of existing health services when implementing CTP?	0.72
4	What are appropriate methodologies to research cash for health in humanitarian crises?	0.72
5	How to explore better the potential of multipurpose cash to achieve health outcomes?	0.72
6	What are appropriate outcome measures for multi-purpose cash programming?	0.69
7	What tools are most useful to assess the effectiveness of cash interventions within a health programme?	0.69
8	How can context and available health services be systematically documented so that the emerging evidence base can be best applied to inform future design of cash transfer programming?	0.69
9	What is the method to evaluate the impact of a cash transfer program?	0.66
10	How can cash transfer programmes best be monitored?	0.66
11	How/what to include health costs in the minimum expenditure basket for multipurpose cash transfers?	0.63
12	How can health indicators for measuring health outcomes for cash transfer programmes best be defined (in terms of structure/process/outcome)?	0.59
13	How to use or adapt market assessment and analysis tools for the health sector?	0.59
14	Which is/are the best methodologies to estimate the (monthly) monetary value of good health for a household?	0.56
15	What types of health outcomes should be targeted in cash transfer interventions for health?	0.56
16	How should we decide on what health outcomes should be the target of cash transfer interventions for health?	0.53
17	What methodologies should be used to monitor and evaluate cash for health interventions?	0.53
18	What monitoring criteria should be used to assess the pathway of cash to achieve health outcomes?	0.53
19	How can the health sector/cluster engage effectively with multi-sector coordination and cash working groups?	0.53
20	How is the quality of services, which are incentivised through cash interventions, monitored?	0.50
21	What are relevant indicators and measurements for cash transfer programming?	0.47

22	What tools are needed to do market analysis for health?	0.47
23	How to adapt health assessment tools to a market-based approach?	0.47
24	What is the indicator that we can use to assess on the adequateness of a modality to access health and nutrition services through cash?	0.38

Table 11: Demands & needs of cash beneficiaries

	Research question	**Score**
1	What impact does the gender/age/household of a recipient have on spending priorities?	0.78
2	How do people plan to compensate their livelihoods when their child is admitted in a nutrition rehabilitation centre?	0.72
3	Do people affected by conflict prefer cash or in-kind support for the treatment of their children or family members?	0.72
4	Do beneficiaries prefer to receive support in-kind or via cash for attending sessions on nutrition?	0.69
5	How would people with immediate health issues due to conflict like to be supported?	0.69
6	How are cash purchases distributed within a household, particularly in polygamous households?	0.66
7	How do beneficiaries perceive cash transfer programming vs service delivery programming in LMIC?	0.63
8	In contexts with ongoing significant charging of user fees (or high proportion of out of pocket payment of the total health expenditure) which proportion of households has a catastrophic health expenditure?	0.59
9	What negative coping mechanisms do people use (like debt) to cope with health needs/costs?	0.56
10	How do households affected by humanitarian crises prioritise their limited resources to address their health needs?	0.53
11	How can the health sector/cluster engage effectively with multi-sector coordination and cash working groups?	0.53
12	What is the average health care cost per family in a normal situation compared to the health care cost of a displaced family?	0.50
13	How do households prioritise?	0.50
14	Will beneficiaries of cash transfers use the health services available in their locality or do they prefer to go elsewhere?	0.44
15	What do people in need of humanitarian assistance think about modalities for implementation of health programmes?	0.44
16	Do patients receiving cash/vouchers chose a health facility on the basis of the quality of services or simply on its availability?	0.25

Table 12: Appropriateness of cash in emergency response

	Research question	Score
1	What conditions of health markets, or lack of health markets, would make cash or vouchers an inappropriate modality of response?	0.78
2	What are the barriers in health humanitarian programming and how can cash address this?	0.78
3	What is the adequate "social safety net package" to provide to a vulnerable household in a rural village on a monthly basis (in terms of amount of cash to distribute, safe drinking water, latrine, safe disposal of waste, food and/or vitamin & minerals supplements, social behaviour change, conditional health & nutrition consultations, sms health & nutrition education etc.)?	0.75
4	Given the extreme limits of health care markets, what kinds of care may be appropriate for voucher interventions, if any?	0.69
5	What are the elements of a health or nutrition response that are best suited to be delivered in the form of cash?	0.66
6	What is the appropriate place for cash based assistance as one response option to deliver health programming?	0.66
7	What health outcomes can be appropriately addressed with cash in different contexts?	0.66
8	What supportive interventions/conditions are required to ensure effective implementation of cash for health outcomes?	0.63
9	What conditions of health markets would make cash or vouchers an appropriate modality of response?	0.63
10	What is the adequate "social safety net package" to provide to a vulnerable household living in a slum on a monthly basis (in terms of amount of cash to distribute, safe drinking water, latrine, safe disposal of waste, food and/or vitamin & minerals supplements, social behaviour change, conditional health & nutrition consultations, sms health & nutrition education etc.)?	0.56
11	What types of conditions and diseases prompt a regular forecastable expenditure and can therefore be managed via vouchers, subsidy or insurance system?	0.53
12	What is already known about cash transfer interventions? And what can be adapted for health?	0.53
13	Given the extreme limits of health care markets, what kinds of care may be appropriate for cash interventions, if any?	0.50
14	What are the challenges of cash transfers for health and nutrition in humanitarian disasters?	0.50
15	Why should we consider cash transfers in health and nutrition programmes in LMICs?	0.41
16	How can we incorporate cash based interventions into other health financing approaches (especially social protection, universal health coverage)?	0.41

Table 13: Conditional cash

	Research question	Score
1	Can labelling of unconditional multipurpose cash transfer have a similar effect on health/nutrition as a conditional cash transfer?	0.78
2	Does labelling a cash grant for nutrition have the same impact as a conditional cash grant for nutrition?	0.78
3	Are conditional cash transfers feasible in sudden onset disaster (SOD) to improve coverage and utilisation of free services?	0.75
4	What is the effect of the use of various conditionalities of cash transfers for health in different contexts?	0.72
5	How effective are conditional cash transfer programmes in promoting compliance in chronic disease treatment?	0.69
6	What is the relative effectiveness of conditional cash transfers, compared with unconditional cash transfers?	0.59
7	In the context where quality health services are available what is the cost effectiveness of giving cash (labelled) compared to reimbursement of services or vouchers?	0.59
8	What is the impact of conditional/unconditional cash transfers on the nutrition and health of children under five?	0.56
9	What are the ethical issues with conditioning cash transfers for improving health in humanitarian disasters?	0.50
10	What effect does 'labelling' cash transfers have on spending patterns?	0.47
11	What documented instances of using unconditional or conditional cash transfers have negatively impacted on health or nutritional health status?	0.47
12	How does the conditionality of the cash transfer affect nutrition outcomes?	0.41

Table 14: Types of diseases or health issues

	Research question	Score
1	What is the impact of a cash transfer programme, alongside a water and sanitation intervention, on diarrhoea (which is closely linked to malnutrition)?	0.84
2	How do various types of cash transfers affect nutrition, HIV, and maternal health?	0.78
3	What is the impact of unconditional cash transfers on the mental health of beneficiaries in a humanitarian crisis?	0.78
4	Does support to costs linked with health (e.g. transport, per diem for the care taker, meals) contribute to better case management in particular for children and pregnant and lactating women?	0.75

5	Does cash affect mental health outcomes?	0.72
6	How effective are conditional cash transfer programmes in promoting compliance in chronic disease treatment?	0.69
7	How do programmes focused on only health vs. only cash vs. both integrated compare in terms of impact on health (including mental health)?	0.66
8	How is cash programming helping to support the psychosocial status of families or individuals affected by humanitarian crisis?	0.63
9	How effective is cash in strengthening access to sexual and reproductive, maternal, newborn and child and adolescent health care?	0.59
10	How effective is cash as an incentive for health seeking behaviour (e.g. to attend antenatal services)?	0.59
11	What is the impact of cash transfers targetting families from the beginning of pregnancy on the nutritional status and morbidity of the children?	0.56
12	What is the effectiveness of cash transfer programming to respond to large scale health emergencies (e.g. Ebola, cholera)?	0.38

Table 15: Restricted cash/Vouchers

	Research question	**Score**
1	Given that access to food is only one driver of malnutrition, what is the evidence that cash or vouchers may incentivise care or utilisation?	0.72
2	Is it better to receive money or a voucher to seek and receive care?	0.69
3	Given the extreme limits of health care markets, what kinds of care may be appropriate for voucher interventions, if any?	0.69
4	What are the operational differences, advantages and disadvantages, of providing vouchers to obtain specific services or drugs, compared to direct support to the provider to make the same service/drugs free of charge at the point of delivery?	0.66
5	What are the preconditions for the use of vouchers for cash or nutrition?	0.63
6	If unconditional/multipurpose cash replaces vouchers or distribution of health goods (bednets, condoms, female hygiene kits, etc), how does this affect the availability of such goods for households?	0.63
7	What conditions of health markets would make cash or vouchers an appropriate modality of response?	0.63
8	What are the operational differences (including costs) between giving vouchers for receiving similar services from a private for profit, private not for profit and a public health service provider?	0.59
9	In the context where quality health services are available what is the cost effectiveness of giving cash (labelled) compared to reimbursement of services or vouchers?	0.59
10	How do cash transfers compare to specific patient free health vouchers in terms of empowerment of patients to negotiate their access and	0.53

	demand their right for free care?	
11	What types of conditions and diseases prompt a regular forecastable expenditure and can therefore be managed via vouchers, subsidy or insurance system?	0.53

Table 16: Behaviour change

	Research question	**Score**
1	How can cash based interventions affect health behaviour change?	0.81
2	How effective are conditional cash transfer programmes in promoting compliance in chronic disease treatment?	0.69
3	Can cash transfer programs be used to incentivise health outcomes and/or health behaviours?	0.66
4	How effective is cash as an incentive for health seeking behaviour (e.g. to attend antenatal services)?	0.59
5	How sustainable are cash based interventions in relation to health behaviour change?	0.53
6	How effective are the use of market based cash approaches for health commodities?	0.50
7	How effective is cash as an incentive for health seeking behaviour?	0.50
8	What is the short- and long-term impact of cash transfer programming on health behaviour change?	0.47
9	What effect does 'labelling' cash transfers have on spending patterns?	0.47
10	When people receive multipurpose unconditional cash transfers, does an Infant and Young Child Feeding programme (IYCF) or other nutrition messaging influence purchase choices (i.e. healthier foods)?	0.41
11	How effective is cash as an incentive for service providers to then remain in the affected area and deliver health care?	0.25

Table 17: Context

	Research question	**Score**
1	Are conditional cash transfers feasible in sudden onset disaster (SOD) to improve coverage and utilisation of free services?	0.75
2	What is the effect of the use of various conditionalities of cash transfers for health in different contexts?	0.72
3	What phase(s) of the emergency should we focus on for cash in health – is the acute phase a lower priority since services are often free?	0.69

4	How can context and available health services be systematically documented so that the emerging evidence base can be best applied to inform future design of cash transfer programming?	0.69
5	In what type of contexts are different cash transfer modalities likely to work?	0.69
6	What health outcomes can be appropriately addressed with cash in different contexts?	0.66
7	What is the cost-benefit of using cash for specific health outcomes across different humanitarian contexts?	0.53
8	What is already known about cash transfer interventions? And what can be adapted for health?	0.53
9	Where (context) does unrestricted/unconditional/multipurpose cash have a positive or negative impact on health outcomes/health/health services?	0.44

Table 18: Social & financial protection

	Research question	**Score**
1	Does the inclusion of an average health cost in the Minimum Expenditure Basket improve the health of beneficiaries?	0.88
2	How can social protection nets be developed for health or nutrition?	0.72
3	How to deal with catastrophic expenses?	0.66
4	How/what to include health costs in the minimum expenditure basket for multipurpose cash transfers?	0.63
5	In contexts with ongoing significant charging of user fees (or high proportion of out of pocket payment of the total health expenditure) which proportion of households has a catastrophic health expenditure?	0.59
6	How can cash transfers be used to reduce catastrophic expenditures?	0.53
7	What is the adequate "social safety net governance" to sustain the effects beyond the first 2 years of life of children?	0.50
8	Which interventions aimed at reducing financial access barriers have the largest impact on the budget of a household in a humanitarian crisis?	0.47
9	How can we incorporate cash based interventions into other health financing approaches (especially social protection, universal health coverage)?	0.41

Table 19: Sustainability & link development

	Research question	**Score**
1	How do different cash transfer modalities strengthen the health system and contribute to longer term equitable health financing (that aims at less	0.66

	than 15% private funding)?	
2	How can short-term multi-purpose, unconditional cash be leveraged to support long term health and nutrition impacts?	0.63
3	What are the longer-term effects of cash transfers on undernutrition?	0.59
4	How long are the cash transfers effects on undernutrition sustained after the final cash distribution?	0.53
5	How sustainable are cash based interventions in relation to health behaviour change?	0.53
6	What is the adequate "social safety net governance" to sustain the effects beyond the first 2 years of life of children?	0.50
7	How can cash transfer programmes develop linkages to long term development?	0.47
8	What is the short- and long-term impact of cash transfer programming on health behaviour change?	0.47
9	How will cash transfer programming impact beneficiaries in the long term in relation to the provision of healthcare and nutrition services?	0.34

Table 20: Quality of care

	Research question	**Score**
1	Which tools and key indicators should we use to understand the adequacy and quality of existing health services when implementing CTP?	0.72
2	What is compared advantage/disadvantage of cash transfer (in terms of utilisation, financial access, and quality of care received by patients) compared to interventions improving service delivery or financial access without cash transfers (such as subsidies to assure free (no patient fee) care)?	0.59
3	How is the quality of services, which are incentivised through cash interventions, monitored?	0.50
4	How can quality of care be guaranteed during cash based interventions?	0.50
5	How can cash transfers strengthen or improve the quality of care?	0.50
6	Can cash transfers improve the quality of health care services?	0.44
7	How can quality in cash transfer programming be assured?	-

Table 21: Health & nutrition systems

	Research question	**Score**

1	How do different cash transfer modalities strengthen the health system and contribute to longer term equitable health financing (that aims at less than 15% private funding)?	0.66
2	What is the positive and negative impact of cash transfers on health services?	0.63
3	Would scaling up the use of cash transfers to deliver health and nutrition programmes in LMICs develop or distort the existing health and nutrition systems in those countries?	0.59
4	How can cash transfers affect the role of the local government or ministry of health in strengthening health systems?	0.53
5	Where (context) does unrestricted/unconditional/multipurpose cash have a positive or negative impact on health outcomes/health/health services?	0.44
6	Can cash interventions for health outcomes support health systems?	0.38

Table 22: Health system & market preconditions

	Research question	**Score**
1	What essential pre-conditions need to be fulfilled to provide equitable access to health services in a humanitarian crisis context through an unconditional cash transfer scheme?	0.81
2	What health system level preconditions are necessary for the implementation of cash for health and nutrition programming?	0.81
3	What conditions of health markets, or lack of health markets, would make cash or vouchers an inappropriate modality of response?	0.78
4	What conditions of health markets would make cash or vouchers an appropriate modality of response?	0.63
5	What are the preconditions for the use of vouchers for cash or nutrition?	0.63
6	If cash transfers are considered to be used by people to pay for health services, what is then the required level of service delivery?	0.63
7	What supportive interventions/conditions are required to ensure effective implementation of cash for health outcomes?	0.63

Table 23: Amount of cash

	Research question	**Score**
1	How does the amount of the cash transfer affect its impact upon undernutrition?	0.78
2	What is the impact of a variation of the amount of the cash transfer on the prevention of childhood undernutrition and morbidity?	0.69

3	Should the amount of the cash transfer be adapted to the size of the family to have more impact on nutrition and morbidity?	0.63

Table 24: Influence on gender roles

	Research question	**Score**
1	What impact does the gender/age/household of a recipient have on spending priorities?	0.78
2	Do cash transfers positively or negatively affect gender roles?	0.66
3	How do cash transfers affect gender roles?	0.53

Table 25: Empowerment

	Research question	**Score**
1	How do cash transfers to families or individuals influence decision-making and power dynamics in the household?	0.53
2	How do cash transfers compare to specific patient free health vouchers in terms of empowerment of patients to negotiate their access and demand their right for free care?	0.53