

A Case Study from Jordan

Cash & Voucher Assistance for Health



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This report was authored by Stephen Chua, with assistance and reviews by Alex Fergusson, Darine Abu Saadeh, Haneen Abu Laila, Margie Davis, Dominika Bednarova and Namseon Beck – all from Medair.

This report was reviewed by the Global Health Cluster (GHC) cash task team and the Cash Learning Partnership (CaLP). The Medair case study helps build more evidence on the use of cash transfers for health outcomes. It is a great example of how an organization integrated cash transfers into their health response and provides practical considerations on how to implement it. The GHC cash task team and CaLP would like to emphasize that any decision on cash and voucher assistance (CVA) for health in other contexts needs to be grounded in a contextual analysis of accessibility and barriers to health needs and a response option analysis.

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Cover image:

A Syrian refugee family that received CVA from Medair in Amman, Jordan.
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Executive summary

Evidence is slowly emerging on the use of cash and voucher assistance (CVA) to reach health outcomes. The key entry point for CVA in health is the strategy Healthcare 2030, which aims at Universal Health Coverage (UHC) and access to healthcare when people need it without inducing financial hardships. CVA can be useful to improve access to and utilization of health services in humanitarian settings, by reducing direct and indirect financial barriers and/or by incentivizing the use of free preventive services.

This study sheds light on the use of cash transfers by Medair in Jordan between 2017 and 2019 as part of its response to health-related needs of vulnerable populations, both refugee and host communities, living in Jordan.

The health and socio-economic impacts of the conflict and displacement meant that much of the refugee population in Jordan required access to health services. While facing different and complex health needs, refugees living in Jordan have all reported barriers in accessing required health services, of which financial constraints in paying user fees has been reported as the major one. This created a significant barrier to accessing services and is a major reason why people postpone or forego healthcare despite increased health needs.

Medair's project in Jordan aimed to reduce these financial barriers and help vulnerable populations access healthcare in a timely manner. Medair operated in the governorates where the highest number of refugees were present: Amman, Irbid, Mafraq, and Zarqa. Between January 2017 and July 2019, Medair provided CVA for health for a total of 8,848 individuals, of which 6,892 were refugees. Medair also covered emergency health needs of host Jordanian households that had been assessed as vulnerable.

Vulnerable refugees were targeted based on lack of workforce within the household, expenditure, debt levels, coping mechanisms adopted as well as lack of registration. They were identified by Medair through community health volunteers based on the project's selection criteria. Medair focused its health project on assistance to pregnant women (delivery, antenatal and postnatal care), individuals affected by non-communicable diseases, acute health needs and emergency needs of Jordanian host households.

The capacity and quality of the supply side of health services, although quite overstretched by the increasing demand caused by the inflow of refugees to the country, was found to be adequate in Jordan; Jordan's health system is one of the strongest in the region. However, the preferred option, to ensure coverage of vulnerable refugees under the national health insurance scheme, continues to experience gaps in coverage. Furthermore, when international partners contract providers directly to purchase services, they are charged foreign rates of up to three times more than if refugees pay for the services themselves. Hence, the next appropriate response option was to enable vulnerable populations to access services directly by making cash transfers to patients to overcome financial constraints to access healthcare at the time of need.

“Refugees living in Jordan have all reported barriers in accessing required health services, of which financial constraints in paying user fees has been reported as the major one.”

“Based on Medair’s experience in Jordan, it is concluded that CVA was an appropriate modality to provide health assistance.”

When further analysing the feasibility of this approach, in addition to the availability of health services of acceptable quality, Medair noted the presence of advanced banking systems and other financial service providers, familiarity of use by targeted populations of these services, and relatively low security concerns and other protection-related risks in the case of CVA. Furthermore, the existing conditions combined with the widespread provision of cash assistance for basic needs were deemed likely to provide an environment where CVA for health would be used as intended to achieve health outcomes.

For timely access to health services, Medair provided unconditional cash transfers for pregnant women to cover delivery and to Jordanian households to cover for emergency health needs; conditional cash transfers to incentivize access to essential public health services and preventive services, such as immunization, antenatal care and compliance with consultations of non-communicable diseases. Under certain conditions, Medair also provided cash transfers as reimbursement for seeking health services for acute health needs. Depending on whether these were to cover for an emergency need, a delivery or a chronic

disease, the cash transfers were made as a one-off transfer or on a recurring basis.

The cash transfers were predominantly made through pre-paid bank cards under the common cash facility umbrella and at times through physical cash, also in the case of reimbursements. The amounts were set to include the cost for the delivery, consultations or treatments, as well as transportation costs in some cases.

Medair conducted post-distribution monitoring and collected feedback from beneficiaries. Based on Medair’s experience in Jordan, it is concluded that CVA was an appropriate modality to provide health assistance. Some of the challenges Medair faced could be addressed through the following recommendations, made in the report:

1) recommendation to agencies implementing CVA for health (including Medair) and the health sector to standardize definitions of ‘quality care’ and provide tools for monitoring and quality on the supply side;

2) recommendation to the Global Health Cluster and research institutions to design and conduct research to understand the impact of CVA for health programmes on health outcomes, behaviours and coping mechanisms, cost effectiveness and adverse financial outcomes (for example, to track the proportion of the population pushed into poverty, and/or pushed further into poverty due to out-of-pocket payments for health); 3) recommendation to the Government of Jordan and the donor community to review the functioning of the Multi-Donor Account and its support in the integration of refugees (and/or other vulnerable individuals) into the national health insurance scheme, applying the same rates as for Jordanians, to achieve Universal Health Coverage.

Acronyms and Abbreviations

| | |
|--------------|---|
| ANC | Antenatal care |
| ATM | Automated teller machine |
| CBO | Community-based organization |
| CCF | Common cash facility |
| CCT | Conditional cash transfer |
| CHV | Community health volunteer |
| CS | Caesarean section |
| CVA | Cash and voucher assistance |
| FCM | Feedback and complaints mechanism |
| FGD | Focus group discussion |
| GoJ | Government of Jordan |
| HAUS | Health Access and Utilization Survey |
| ICU | Intensive Care Unit |
| JOD | Jordanian Dinar |
| JRP | Jordan Response Plan |
| MEAL | Monitoring, Evaluation, Accountability and Learning |
| MEB | Minimum Expenditure Basket |
| MoH | Ministry of Health |
| MoI | Ministry of Interior |
| MoPIC | Ministry of Planning and International Cooperation |
| MPC | Multipurpose cash |
| NCD | Non-communicable disease |
| NVD | Normal vaginal delivery |
| OOP | Out-of-pocket payment |
| PDM | Post-distribution monitoring |
| PNC | Postnatal care |
| RAIS | Refugee Assistance Information System |
| UCT | Unconditional cash transfer |
| UHC | Universal Health Coverage |
| UNHCR | United Nations High Commissioner for Refugees |
| VAF | Vulnerability Assessment Framework |
| WHO | World Health Organization |
| WFP | World Food Programme |

01. Introduction

Objective of the case study

This case study aims to present Medair's work and experience in responding to health-related needs of vulnerable populations, both refugee and host communities, living in Jordan. Medair began providing cash and voucher assistance (CVA)¹ for health in Jordan in November 2015.

The purpose of the CVA was for refugees to access² the existing public health services when they need it. Findings showed that refugees often find themselves needing to resort to out-of-pocket payments (OOP)³ to access health services. This is particularly problematic as it creates a significant barrier to accessing services and is a major reason why people postpone or forego healthcare despite increased health needs.⁴ Medair's project in Jordan has aimed to reduce these

financial barriers and support vulnerable populations access healthcare in a timely manner. Medair programme's primary focus is on assistance to pregnant women (delivery, antenatal and postnatal care), non-communicable diseases⁵, acute health needs and emergency needs of Jordanian host households.

Medair targets vulnerable populations, where the vulnerability criteria is based on the dependency ratio⁶ of the household size, expenditures, levels of debt, the coping mechanisms adopted, as well as lack of registration.⁷

The below table gives an overview of the project's scope. More detailed breakdown is provided in later sections of the study.

| Location | Beneficiaries | Health issues addressed by Medair project |
|----------|---------------|---|
| Amman | 8,289 | Antenatal care (ANC), normal vaginal deliveries (NVD), caesarian section deliveries, non-communicable disease, acute health need. |
| Irbid | 1,295 | NVD, caesarian section deliveries, non-communicable disease, acute health need. |
| Mafrq | 5,170 | ANC, NVD, caesarian section deliveries, non-communicable disease, acute health need. |
| Zarqa | 5,642 | ANC, NVD, caesarian section deliveries, non-communicable disease, acute health need. |

¹ The term CVA has several synonyms including Cash-Based Interventions, Cash-Based Assistance and Cash Transfer Programming. This case study report uses the term CVA, which is recommended by CaLP (*Glossary of terminology for cash and voucher assistance, 2018*).

² 'Access' is a broad term with varied dimensions: the comprehensive measurement of access requires a systematic assessment of the physical, economic and socio-psychological aspects of people's ability to make use of health services.

³ WHO defines OOP as 'direct payments made by individuals to health care providers at the time of service use. This excludes any prepayment for health services, for example in the form of taxes or specific insurance premiums or contributions and, where possible, net of any reimbursements to the individual who made the payments.' (WHO, 2020) https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/

⁴ *Health financing policy & implementation in fragile & conflict-affected settings: a synthesis of evidence and policy recommendations* (Jowett, et al., 2019).

⁵ NCDs addressed are hypertension, diabetes and a small number of asthma cases. These are prioritized because the prevalence in Jordan is high, treatment prevents high cost complications and to prevent morbidity.

⁶ The household ratio of dependants (non-autonomous adults, children and the elderly) to non-dependants (able-bodied, working-age members).

⁷ Unregistered refugees are particularly vulnerable because they do not receive the assistance and support that registered refugees would get.

Contextual background

Jordan, an upper-middle-income country with a population of close to 10 million people,⁸ is a host to almost 750,000 refugees of 57 nationalities, the bulk of which – over 650,000 – are from Syria.⁹ Of these, around 83% are urban refugees, residing outside of camps alongside Jordanian citizens, mostly in Amman, Irbid, Mafrq and Zarqa¹⁰ (Figure 1).

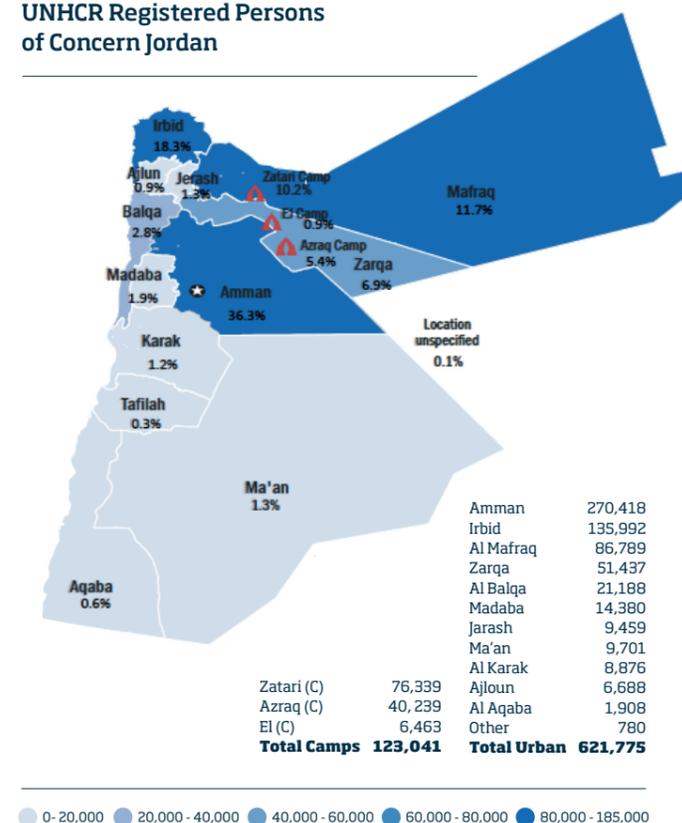
Refugees' health needs:

The health and socio-economic impacts of the conflict and displacement mean that much of the refugee population in Jordan require access to health services. A Health Access and Utilization Survey (HAUS) conducted by UNHCR in 2018 sampling 400 Syrian refugees living in non-camp settings found that 49% of Syrian refugees required healthcare, of which only 45% have access to these services.¹¹

A systematic review of prevalence surveys among 2,799 Syrian refugees (including eight studies), found that 29% had a chronic disease, 32.9% had a mental health issue and 14.4% were living with a physical disability.¹² Additionally, the 2019 Vulnerability Assessment Framework (VAF) study reported that 31% of Syrian refugee households have at least one member with a pre-existing medical condition that negatively impacts their daily life.¹³

Among non-Syrian refugees, Iraqi refugees reported the highest proportion of household members living with a chronic illness (42%) and disability (12%). This was observed to a lesser extent among other refugee communities – Yemeni (19%), Sudanese and Somali (both 18%).¹⁴ The Jordan Population and Family Health Survey (JPFHS) also found that 10.6% of Syr-

Figure 1
UNHCR Registered Persons of Concern Jordan



ian women aged 15 to 49 years were pregnant at the time of the survey, compared to 5.9% of Jordanian women. Syrians also reportedly have a much higher rate of teenage pregnancy (27.8% of Syrian women aged 15 to 19, compared to 3.1% of Jordanians), and higher fertility rate among women aged 15 to 49 (4.7 as opposed to 2.6).¹⁵

While the health needs of refugees living in Jordan are complex and comparative morbidity data show different disease profiles between the refugee

⁸ Jordan's status has oscillated between upper-middle-income and lower-middle-income in recent years, in part due to the influx of Syrian refugees. In 2019, Jordan was reclassified as an upper-middle-income country by the World Bank (Data - Jordan, 2019): <https://data.worldbank.org/country/jordan>

⁹ The Jordanian government states that it hosts about 1.3 million Syrians. However, this figure also includes Syrians who were already in the country prior to the crisis. *Jordan Response Plan for the Syria Crisis, 2018–2020* (MoPIC, 2018).

¹⁰ Statistics for Registered Persons of Concern in Jordan, as of 31 October 2019 (UNHCR, 2019).

¹¹ *Health Access and Utilization Survey* (UNHCR, 2018).

¹² *Health challenges and access to health care among Syrian refugees in Jordan: a review* (Dator, Abunab, & Dao-ayen, 2018).

¹³ *VAF Population Study* (UNHCR, 2019).

¹⁴ *Comprehensive Food Security and Vulnerability Assessment, 2018* (WFP & REACH, 2019).

¹⁵ *Jordan Population and Family Health Survey 2017–18* (DOS and ICF, 2019).

groups, all have reported barriers in accessing required health services. Financial constraints to pay user fees have consistently been reported by about two-thirds of refugees to be the greatest barrier, which also impacts retention in care.^{16,17} Despite the higher proportion of pregnancies and fertility rate, under-utilization of maternal health services among Syrians were incredibly alarming, primarily because of prohibitive costs.^{18,19} Among those who reported acute illness, 73% refrained from seeking healthcare due to economic reasons.²⁰

A 2019 VAF population study found that 78% of Syrian refugee individuals in urban areas were living below the Jordanian poverty line (96 USD per month).²¹ Moreover, a national survey reported that 89.4% of Syrian-headed households were in the two lowest wealth quintiles.²² Despite the introduction of the 'Jordan Compact' in 2016,²³ there remains limited opportunity for Syrian refugees to generate sufficient income to cover their basic needs, with many still relying on low-wage casual work as a primary source of livelihoods.^{24,25}

Persistent poverty among urban refugees has led to an increase in negative coping mechanisms, including increasing debt, reduction in food consumption, withdrawing children from school in order to work to help the family, or simply not accessing healthcare. About 86% of Syrian refugee households in non-camp settings receive some form of institutional assistance, which remains crucial to their ability to meet their ba-

sic needs.²⁶ Non-Syrian refugees are also highly vulnerable, as they have limited access to services and humanitarian assistance,²⁷ and are subject to stricter regulations in accessing livelihood opportunities.

Jordan's health system:

While Jordan's health system is one of the strongest in the region, many challenges remain in the provision of Universal Health Coverage (UHC)^{28,29} to ensure that everyone has access to required health-care services regardless of their place in society and without falling into financial ruin. For instance, public health insurance coverage remains suboptimal even among Jordanian citizens,³⁰ let alone among refugees, who are a particularly vulnerable group.³¹

The fact that over 80% of refugees live in urban settings has placed a large burden on the Jordanian public health system, since these refugees typically attend Ministry of Health (MoH) clinics, unlike those in camps. According to WHO and the MoH, the number of Syrians in public hospitals increased by almost 250%, and the number requiring surgical operations rose almost six-fold at times. Bed occupancy rates exceeded 95%, and reserve medicine stocks, usually at 100% of demand, dropped to 30%.³² With this limitation, according to 2018 HAUS, among those refugee households who sought health services (180 out of 400 household surveyed), only 14% reached public hospitals, 37% accessed private pharmacies and 35% accessed NGO/charity clinics. Key health

16 Health service access and utilization among Syrian refugees in Jordan (Doocy, Lyles, Akhu-Zaheya, Burton, & Burnham, 2016).

17 Prevalence of non-communicable diseases and access to care among non-camp Syrian refugees in northern Jordan (Rehr, et al., 2018).

18 Maternal Health Care Utilization Among Syrian Refugees in Lebanon and Jordan (Tappis, et al., 2017).

19 Health Access and Utilization Survey (UNHCR, 2018).

20 The living conditions of Syrian refugees in Jordan (Tiltne, Zhang, & Pedersen, 2019).

21 VAF Population Study (UNHCR, 2019).

22 Jordan Population and Family Health Survey 2017–18 (DOS and ICF, 2019).

23 A key target of the Compact is for the GoJ to issue up to 200,000 work permits to Syrian refugees.

24 The Jordan Compact: Lessons learnt and implications for future refugee compacts (Barbelet, Hagen-Zanker, & Mansour-Ille, 2018).

25 Still in Search of Work – Creating jobs for Syrian refugees: An update on the Jordan Compact (IRC, 2018).

26 The living conditions of Syrian refugees in Jordan (Tiltne, Zhang, & Pedersen, 2019).

27 Comprehensive Food Security and Vulnerability Assessment, 2018 (WFP & REACH, 2019).

28 In 2015, the GoJ adopted the Sustainable Development Goals (SDGs), which includes achieving UHC by 2030. Here, UHC is considered a tool to achieve financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all as a priority. The Jordan National Health Strategy for 2016–2020 has identified UHC as a long-stranding strategic goal.

29 'Coverage' of interventions is defined as the proportion of people who receive a specific intervention or service among those who need it.

30 Jordanians also struggle with poverty and lack of access to healthcare. The 2019 JRP states that about one third of the Jordanian population is not covered by health insurance, and as a result, the GoJ has mandated that NGOs provide aid to Jordanians, to lessen the impact of the Syrian crisis on host communities, and subsequently reduce tensions between host communities and refugees.

31 Health Care Cost Study at Ministry of Health and the Cost and Financial Impact of Expanding the Civil Insurance Program to Vulnerable Jordanians and Syrian Refugees (Shepard, et al., 2017).

32 Out of the spotlight and hard to reach: Syrian refugees in Jordan's cities (Healy & Tiller, 2013).

system indicators, such as the number of hospital beds and number of skilled health personnel (clinicians, nurses and midwives) per 10,000 population, decreased between 2012 and 2015.^{33,34,35} Finally, total health expenditure has also increased by 45% in primary care, 15% in hospital-based care and 22% in drug procurement since the inflow of Syrian refugees began.³⁶ The continued provision of (open and affordable) quality public services for Syrian refugees has been difficult to maintain.

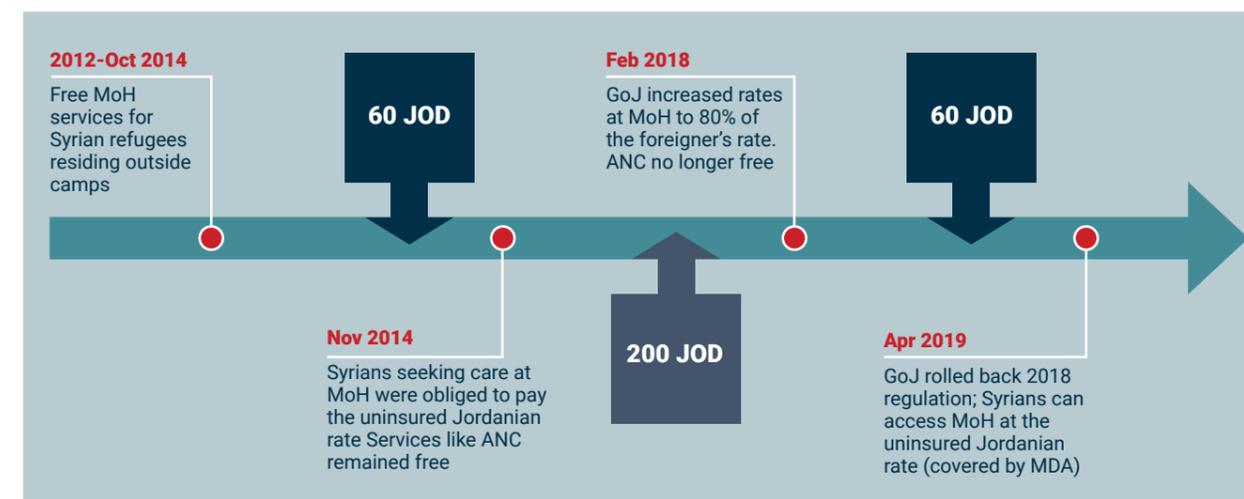
Evolution of the user fee policy in Jordan:

At the beginning of the crisis, Syrian refugees who were registered³⁷ could access free primary, secondary and tertiary healthcare through the MoH facilities. However, in November 2014,³⁸ the increase in number of Syrian refugees and the burden on the public health system led to the government of Jordan

(GoJ) enacting a policy that required Syrian refugees to pay the uninsured Jordanian rate when accessing healthcare through the public sector. In early 2018, the (GoJ) revoked these subsidies and registered Syrian refugees were required to pay 80% of the full foreigner's rate at MoH facilities (this represented a two- to five-fold increase in service rates).

A Multi-Donor Account (MDA), an initiative to pool donor funds at the government level to finance the Jordanian public health system, was set up in 2019 to reinstate the subsidies for registered Syrian refugees that were in place.³⁹ While the MDA should, in theory, reduce the financial burden of healthcare for refugees, coverage gaps remain. It is also unclear whether the MDA has been fully implemented across Jordan, and whether Syrian refugees are being charged subsidized rates. A brief timeline of these changes and their implications on rates – using the cost of a normal vaginal delivery (NVD) – is illustrated in Figure 2.

Figure 2 Timeline of changes in Jordan's healthcare policy for refugees (cost of NVD used to show implications)



33 Annual Human Resources for Health Report 2016 (HHC, 2017).

34 Eastern Mediterranean Region: Framework for health information systems and core indicators for monitoring health situation and health system performance 2018 (WHO, 2019).

35 Health care and pharmacy practice in Jordan (Nazer & Tuffaha, 2017).

36 Public Expenditure Perspectives Update (2015–2017) Working Paper on Health Sector (DAI, 2015).

37 To be registered, a Syrian refugee needs to possess the following documents: (i) a UNHCR-issued asylum-seeker certificate, and (ii) MoI service card, which is obtained from a local police station.

38 Living on the margins – Syrian refugees in Jordan struggle to access health care (Amnesty International, 2016)

39 Letter from the Jordanian Minister of Health, March 2019.

“ Unregistered Syrian refugees and refugees of other nationalities are not covered by the subsidies and are therefore charged the foreigner’s rate

Unregistered Syrian refugees and refugees of other nationalities are not covered by the subsidies and are therefore charged the foreigner’s rate.⁴⁰ This is especially concerning as these persons of concern have already been systematically excluded from livelihood opportunities (such as the Jordan Compact) and assistance under the Jordan Response Plan (JRP), and are consequently reliant on NGO-supported clinics, which are limited in both number and scope.⁴¹

High out-of-pocket payments pose a major barrier to access health services:

As a result of the policy that necessitated OOP spending,⁴² refugees rely more on NGO-supported facilities, pharmacies or simply foregoing care when ill. Studies conducted during periods when rates were not subsidized found that Jordanians were far more likely to access and use this care than refugees.^{43,44} Syrian refugee households that incurred health-related costs spent a monthly average of 82 USD out of a median annual income of 3,000–4,000 USD, with a mean household size of 5.3 persons.⁴⁵ Among non-Syrians refugees, Sudanese households reported the highest health expenditure (70 USD per month), followed by Yemeni (60 USD), Iraqi (43 USD) and Somali households (25 USD). Focus group discussions (FGDs) conducted by WFP revealed that health issues remain one of the largest causes of vulnerability affecting refugees living in host communities, with 74% of households surveyed noting ‘access to medicine and health services’ among their top three unmet needs.⁴⁶

⁴⁰ This is apart from Iraqis with legal residency rights.

⁴¹ *On the Basis of Nationality – Access to Assistance for Iraqi and Other Asylum-Seekers and Refugees in Jordan* (MCC, 2017)

⁴² WHO defines OOP as ‘direct payments made by individuals to health care providers at the time of service use. This excludes any prepayment for health services, for example in the form of taxes or specific insurance premiums or contributions and, where possible, net of any reimbursements to the individual who made the payments.’ (WHO, 2020): https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/

⁴³ *Health service access and utilization among Syrian refugees in Jordan* (Doocy, Lyles, Akhu-Zaheya, Burton, & Burnham, 2016).

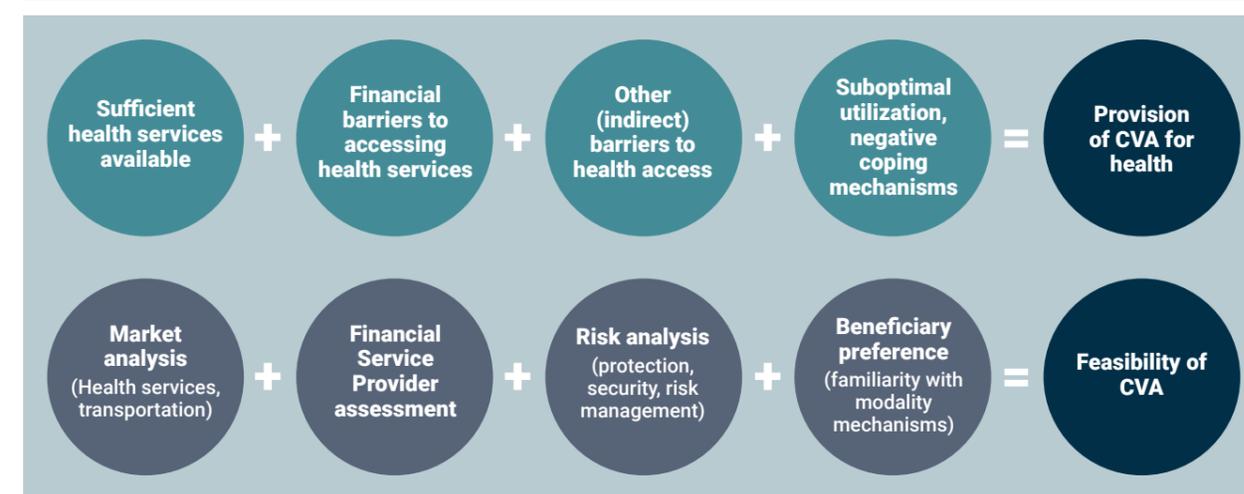
⁴⁴ *8 Years into Exile* (CARE, 2018).

⁴⁵ Fafo Institute for Applied International Studies Government of Jordan. *The living conditions of Syrian refugees in Jordan* (Tiltnes, Zhang, & Pedersen, 2019).

⁴⁶ *Comprehensive Food Security and Vulnerability Assessment, 2018* (WFP & REACH, 2019).

02. Medair’s Intervention

Figure 3 Rationale for provision of CVA for health in Jordan



A. Response option analysis

The rationale for Medair’s decision is adapted from the WHO Decision Tree, which shows the circumstances under which CVA can be a suitable modality for a health response,⁴⁷ and integrates the elements to be considered when assessing the feasibility of CVA.⁴⁸

Given that vulnerable refugees continue to experience significant OOP and barriers to access essential services – indicating that the coverage under the health insurance scheme is still not fully implemented, and that direct purchasing of services by international partners through contracts with providers (including vouchers) would significantly increase the budget requirements when having to pay foreign rates – the next best option is to provide cash to patients to com-

pensate them for their user fees and indirect costs when they were in need of a service.

To inform its decision on the feasibility of using CVA for its intervention, Medair drew from the experiences and assessments of the many other humanitarian actors having used CVA modalities in Jordan. The Cash Working Group was able to provide valuable information to Medair for its response analysis.

There are several conditions present in Jordan that support the use of CVA to reach health outcomes. These include: a number of advanced banking systems and wide distribution of ATMs; relatively low security concerns, allowing for free movement; availabil-

⁴⁷ *Working paper for considering Cash Transfer Programming for Health in humanitarian contexts* (GHC and WHO Cash Task Team, 2018).

⁴⁸ *CaLP’s Programme Quality Toolbox, 2018*: <https://www.calpnetwork.org/learning-tools/programme-quality-toolbox/>

ity of health services of acceptable quality; and value placed on seeking care from appropriate providers.

The widespread provision of cash assistance for basic needs (for instance, through multipurpose cash (MPC) assistance, offered by UNHCR or WFP vouchers⁴⁹) is also likely to provide an environment where CVA for health is used as intended to achieve health outcomes. The success of CVA programmes is 'dependent on the magnitude of the barriers to accessing services',⁵⁰ as well as the quality and availability of health services.⁵¹

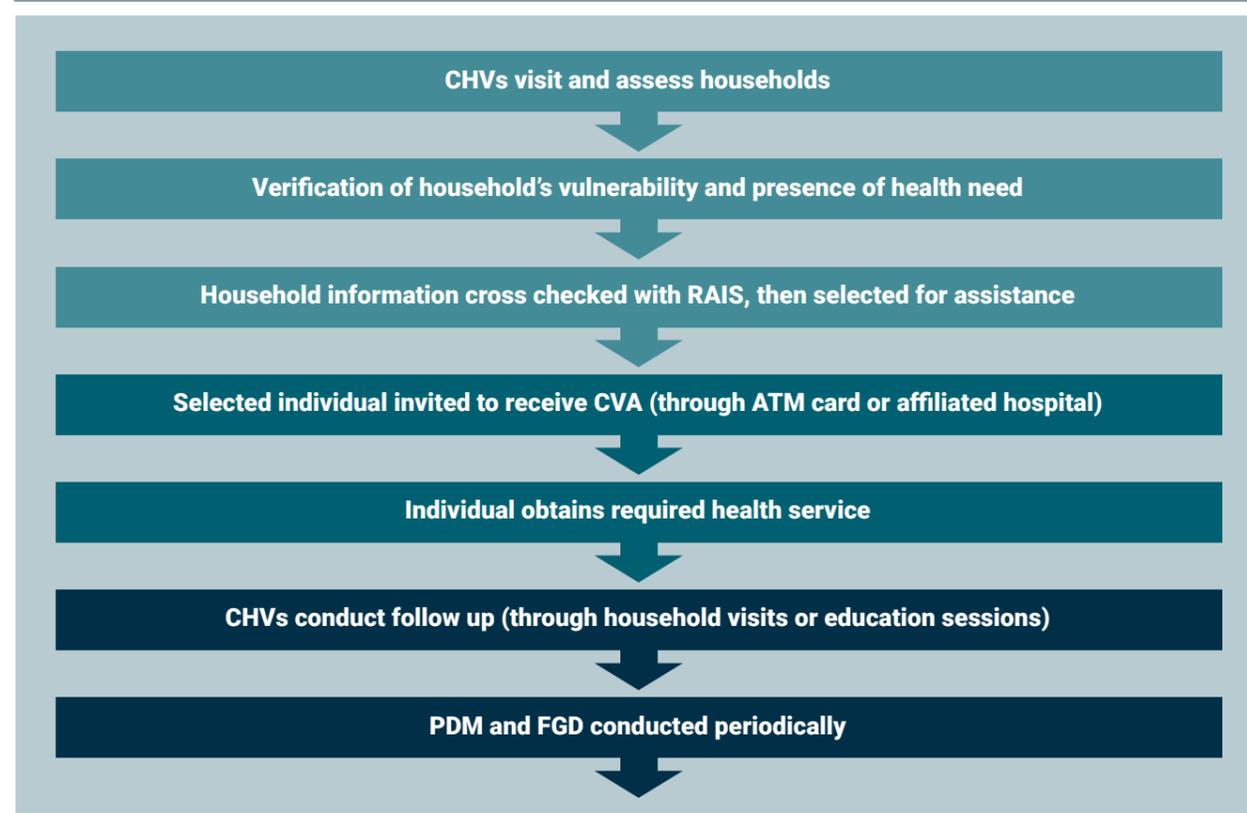
In the context of Jordan, financial considerations are

the biggest concerns on the demand side, which allows for a more successful implementation.

B. Program Design

Medair has developed Standard Operating Procedures (SOPs)⁵² based on its experience in delivering CVA for health in Jordan, which describe the selection process, conditions eligible for assistance⁵³ and the documentation required. A flowchart describing this process, from the initial contact at the household level to follow-up contacts after the cash assistance has been provided and utilized, is illustrated below.

Figure 4 Medair's process for cash transfers for health



⁴⁹ There are multiple NGO partners who are providing MPC assistance alongside UNHCR.

⁵⁰ *The impact of conditional cash transfers on health outcomes and use of health services in low- and middle-income countries* (Lagarde, Haines, & Palmer, 2009).

⁵¹ *Cash-based Interventions for Health programmes in Refugee settings – A review* (UNHCR, 2015).

⁵² *Cash-for-Health Standard Operating Procedures Medair Jordan*, 19 May 2020: <https://www.calpnetwork.org/publication/cash-for-health-standard-operating-procedures-medair-jordan/>

⁵³ Medair, in collaboration with other agencies and UNHCR, has gradually increased the number of medical conditions that are eligible to receive CVA. If a treatment is too expensive or outside of this list, Medair will refer these individuals to other organizations who are better placed to help.

1. Identification of beneficiaries:

Medair integrates its CVA for health programme into its community health activities, which is delivered through a network of Community Health Volunteers (CHVs). These CHVs are selected and trained by Medair, and are responsible for several key activities in the initial stage, including:

- **Active case-finding:** CHVs conduct door-to-door visits to households in specific neighbourhoods known to host a higher concentration of refugees. During these visits, CHVs will assess if these households meet the vulnerability criteria⁵⁴ and if they have a health need that is within Medair's scope for CVA.
- **Health promotion:** CHVs deliver key health messages that are relevant to the specific health needs of the household. For instance, if a pregnant woman is present, then the CHV will discuss the importance of ANC and postnatal care (PNC) and highlight pregnancy-related danger signs for when the pregnant woman should seek healthcare. Other topics include infant and young child feeding (IYCF), maternal and new-born care, family planning, and non-communicable diseases (NCDs).
- **Referral:** Household members with other types of needs – for example, those not in possession of the necessary legal documentation such as birth certificates or Ministry of Interior (Moi) cards – are referred by CHVs to other agencies that are able to provide the required services.

Besides active case-finding through CHVs, Medair also receives referrals of refugees who require CVA for a health need from other agencies. Medair's selection criteria has been communicated to external referring agencies (including UNHCR). Any referrals received from other agencies are first subject to Medair's verification step prior to inclusion.

2. Selection criteria and process:

As documented in Medair's SOPs, households that are identified by CHVs or referred to Medair are considered for selection to receive CVA if both the level of vulnerability and the presence of a health need meet the following criteria:

- The type of medical treatment includes infant delivery for pregnant women, other urgent health needs and high morbidity of NCDs, the details of which are listed in Medair's SOPs. Health records, including diagnostic tests and medical reports, are used to verify the presence of the health need.
- The estimated or actual costs for the required treatment do not exceed the cap of 2,115 USD per individual. However, exceptions can be made for certain lifesaving, acute needs, such as admissions to the neonatal Intensive Care Unit (ICU), if approved by Medair's technical and Senior Management staff.
- The household has not received (or has not already been selected to receive) CVA for the specified health need by other agencies. However, if the household is receiving CVA for other purposes, for instance MPC, it is still eligible for support from Medair.⁵⁵
- The household is considered vulnerable based on the adapted VAF score, which is focused on the dependency ratio of the household, expenditure and debt levels, and coping mechanisms adopted. The lack of registration (Moi service card) is also a factor to be considered in assessments of vulnerability.

This selection process is the same for both unconditional and conditional cash transfers. Medair allows the verification of pregnancies to be carried out by senior CHVs (also referred to as CHV Focal Points), as these are straightforward to do using medical reports. Other health (i.e. non-pregnancy needs), are al-

⁵⁴ Medair utilizes an adapted version of UNHCR's Vulnerability Assessment Framework assessment tool. Medair's assessment measures the following:

(i) coping strategies employed, (ii) dependency ratio, (iii) debt score and (iv) expenditure score. These composite indicators are used to classify the assessed household into one of four ratings (low, moderate, high or severe vulnerability).

⁵⁵ Health costs have been accounted for in the Minimum Expenditure Basket (MEB) for Syrian refugees in Jordan. However, the amounts are usually insufficient for OOP expenses, especially for urgent health needs.

ways verified by Medair staff, who are skilled health professionals.

The verification phase also involves cross-checking lists of households and individuals with other agencies to avoid duplications. This is typically done using the UNHCR-hosted Refugee Assistance Information System (RAIS), which Medair actively uses. Besides RAIS, Medair also liaises directly with other agencies that provide CVA for health in Jordan,⁵⁶ as RAIS only includes households registered with UNHCR, and RAIS is not always up to date.

3. Transfer modalities:

Medair's project utilizes different transfer modalities, depending on the health needs of selected refugees, including:

- **Unconditional cash transfer (UCT)** that is linked with a health need, such as a delivery. This modality targets pregnant women who are unable to cover the OOP cost of the delivery and is paid at a predefined rate, usually through an ATM card. UCT is chosen here, as we know that a woman will deliver but cannot control when and where. Medair PDMs show that over 95% of women use the cash to pay for the cost of the delivery.
- **Conditional cash transfer (CCT)** is used to incentivize access to essential public health services and preventive services, such as immunization and ANC, as well as NCDs. These cash transfers are contingent upon proof of compliance with recommended consultations, treatment and receipts of purchasing prescribed medicines. CCT is chosen to treat certain morbidities and for ANC where there is a specific and identified need.
- **Reimbursing of priority health services**, from a pooled health emergency fund if possible, based on receipts provided by the beneficiaries. This is mostly used by Medair to reimburse health services that were sought for acute health needs.

This relates to circumstance where assistance is still provided to unregistered Syrian or non-Syrian refugees at other, non-affiliated, hospitals. For example: (i) if the required treatment is not available at affiliated hospitals, (ii) if the treatment cannot be provided within an appropriate timeframe, (iii) if the individual has an existing clinical relationship with a provider at a different facility (e.g. follow-up surgery), or (iv) if the cost of treatment is lower at another facility than at the affiliated hospital.

As a separate and complementary project activity, Medair also directly purchases health services at selected affiliated facilities. In response to the increase in healthcare rates for refugees, Medair initiated partnerships with private hospitals that were previously assessed by UNHCR, so that services are sought from providers from which minimum quality standards can be ensured. This allows refugees referred by Medair to obtain the necessary healthcare service of satisfactory quality and at negotiated rates, as stipulated by the partnership agreement. Medair continues to encourage registered Syrian refugees to utilize MoH facilities for their health needs, and unregistered Syrian and non-Syrian refugees to access affiliated hospitals, for reasons related to costs, as they do not distinguish individuals based on their nationality or registration status. This activity, although a direct purchase and not a cash transfer, is an important complement to the CVA parts of the project.

4. Delivery mechanisms:

Households that meet the aforementioned criteria are then selected to receive assistance. Medair utilizes two different delivery mechanisms to provide CVA, depending on the needs and circumstances of the selected individuals: ATM cards and physical cash.

- **ATM:** Medair utilizes the common cash facility (CCF), which is provided through Cairo Amman Bank in Jordan.⁵⁷ The CCF is a system for delivering cash assistance, which draws on



An ATM card distribution at a bank in Amman.
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UNHCR's registration database. In addition to low financial service provider fees,⁵⁸ due to the economies of scale that this collaboration model offers, contracting was also made easier with this delivery mechanism, as Medair currently participates in the CCT under UNHCR's umbrella contract. While the majority of CVA recipients receive cash through iris-enabled ATMs, Medair provides its cash-for-health assistance primarily through ATM cards.⁵⁹ Individuals selected to receive CVA through ATM cards are invited to a Cairo Amman Bank branch in areas where Medair is operating. The bank provides a space on its premises for Medair to distribute ATM cards that have been pre-loaded with specific

amounts. Up to 50 individuals are invited to each distribution and are then given the appropriate ATM cards and a unique PIN number. Medair staff are present to supervise the distribution and to assist those who are unfamiliar with ATMs. Guidance on how to use ATMs is important because some individuals might require a top-up if the pre-loaded amounts were insufficient to cover treatment costs.

- **Physical cash:** While Medair prefers to avoid providing cash in hand, due to increased risks of theft or fraud, there are exceptional occasions when providing cash directly to selected individuals is warranted.

⁵⁷ Review of the Common Cash Facility Approach in Jordan (Gilert & Austin, 2017).

⁵⁸ The current bank fee for the ATM cards is 1% of the total cash amount to be distributed, which is a reduction from previous rates. This is because the CCF offers economies of scale – the more net assistance delivered, the lower the bank fees for all CCF members.

⁵⁹ ATM cards make up approximately 7–10% of the current CCF caseload. In 2016, Medair enrolled a group of beneficiaries to receive cash through CCF iris scans, however several beneficiaries experienced delays in receiving their cash assistance, as at the time, the iris method wasn't optimized for delivering cash assistance for one-off, urgent cash transfers. Medair intends to conduct another trial of the use of iris scans to deliver its cash-for-health assistance. Physical cash is usually given to the health facility on the provision of invoice and receipt, and acts in a similar way to reimbursement.

Table 1 Summary of CVA for health delivery

| Type of health need | Transfer modality | Delivery mechanism | Description |
|--|---|--|---|
| Skilled delivery, both uncomplicated (NVD) and complicated (CS) | Unconditional cash transfers ('labelled' cash to encourage use for health) | <ul style="list-style-type: none"> ATM cards (or physical cash in exceptional cases) Physical cash | <ul style="list-style-type: none"> Cash for delivery is the core of Medair's intervention, as maternal mortality can be significantly reduced through skilled care before, during and after childbirth. Selected pregnant women will receive CVA to access skilled delivery services, which can be prohibitively expensive and thus cause unsafe practices, such as home deliveries. |
| ANC and PNC | Conditional cash transfers/reimbursement (one off transfer) | <ul style="list-style-type: none"> Physical cash | <ul style="list-style-type: none"> The cash amounts provided account for costs related to accessing preventive care (ANC and PNC) as well as transportation fees. It is based upon the showing of receipts. |
| Acute health need | Reimbursement cash (one-off transfer) | <ul style="list-style-type: none"> Physical cash | <ul style="list-style-type: none"> Refugees with other acute health needs are also able to receive CVA from Medair. Eligible conditions include emergency hospitalizations (neonatal ICU admissions, acute myocardial infarction) and surgeries (appendectomy, gall bladder removal). Due to the (often) unpredictable nature of the conditions, Medair reimburses the recipient when he has accessed a non-affiliated hospital (CVA). |
| NCD | Conditional cash transfers (Recurring transfers, provided on a quarterly basis) | <ul style="list-style-type: none"> ATM cards | <ul style="list-style-type: none"> Refugees with NCDs can receive recurring CVA for ongoing treatment of their conditions. Cash transfers are provided on a quarterly basis and are contingent upon proof of compliance with recommended NCD treatment, such as consultation records at MoH facilities, and receipts of purchasing prescribed medicines. |
| Emergency cash assistance - applicable to Jordanian households only | Unconditional cash transfer (one-off transfer) | <ul style="list-style-type: none"> ATM cards | <ul style="list-style-type: none"> In accordance with GoJ requirements, Medair also provides CVA to Jordanian households that have been assessed to be vulnerable. The CVA is a one-time unconditional and unrestricted transfer. The modality and amount (183 USD) recognize the difference in needs among vulnerable Jordanian households compared to refugees in terms of healthcare access. Selected Jordanians who are pregnant are encouraged to purchase the national health insurance for pregnancy care to cover the package of delivery services, which include ANC and PNC⁶⁰ |

⁶⁰ Jordanians can either be treated as a non-insured Jordanian and pay the fees when they go to the clinic or they can buy an insurance scheme that gives them access to MoH facilities for ANC, delivery and PNC.

5. Amount of assistance

In order to decide the amount of assistance to be provided for eligible conditions, Medair's staff and CHVs conduct phone calls and visits to health facilities, both public and private, to inquire about the cost of service for registered and unregistered Syrian refugees. Where possible, Medair tries to obtain an official price list for health services. The average cost of NVDs and caesarean section (CS) deliveries are then calculated to determine the amount that should be pre-loaded onto ATM cards. Medair regularly monitors these rates through a review of receipts and the frequency of ATM card top-ups it must make. Service rates are also cross-checked and verified with other agencies, such as UNHCR.

Medair does not provide pre-loaded ATM cards to refugee individuals with acute health needs, given the breadth of conditions and treatment options available. However, for budgetary purposes, Medair uses the cost of 'emergency surgery of gallbladder removal' as a proxy for an urgent condition that is

eligible for CVA for health.

For individuals receiving conditional cash for management of their NCDs, a standard recurring amount is used regardless of the severity of their condition and comorbidities. The amounts are based on a review of receipts and feedback received during quarterly health education sessions, and because Medair covers a limited number of NCDs, the costs of the medicine are similar, allowing them to provide an equal amount to each beneficiary. Unlike other service types for which Medair provides CVA, Medair does not deliver different amounts based on the refugee's nationality and/or registration status, because of the range of NCDs and corresponding needs (for example, only regular refilling of prescriptions are required).

The pre-loaded rates are shown in Table 2 below, where the rates paid include the cost of transportation to and from the health facility.

Table 2 Amount of CVA in pre-loaded ATM cards, by service type and nationality

| Type of health need | Registered Syrian refugees (USD) | Unregistered Syrian and non-Syrian refugees (USD)project |
|---------------------------------------|----------------------------------|--|
| Uncomplicated delivery (NVD) | 84 | 353 |
| Complicated delivery (CS) | 353 | 775 |
| Non-communicable disease (NCD) | 141 | 141 |



A Medair CHV conducting a health education session on NCDs.
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6. Timing of assistance

For deliveries, Medair provides the unconditional cash transfers through ATM cards in the eighth or ninth month of pregnancy, in order to maximize the likelihood of the cash being utilized for its intended purpose. In the event that the initial amounts are insufficient, such as a planned NVD that, at a later stage, needs an emergency CS, Medair will top up payments to the respective individuals after verifying the medical report and receipt. These top-up amounts are transferred directly to the individuals' ATM cards. Reimbursements can be provided to women who have already delivered.

Medair requires medical reports and in some cases,

justification for certain procedures that are performed (e.g. CS instead of an NVD), prior to paying. This condition is included in the partnership agreements. In cases where the individual receives care from other, non-affiliated facilities, Medair can cover or reimburse the cost after reviewing the appropriate documents.

Individuals with NCDs receive conditional cash assistance on a quarterly basis through ATM card top-ups, contingent upon their compliance with treatment. This is explained further in the section on follow-up activities below.

7. Follow-up with assisted beneficiary

CHVs also conduct follow-up visits (also called 'new-born visits') to households where a woman selected to receive CVA has delivered, regardless of whether she used the CVA for the delivery or not.

Medair encourages CVA-for-delivery recipients to inform Medair when they have delivered. CHV teams then arrange a visit to assess the health of the mother and new-born, as well as to reinforce good breastfeeding practices and the importance of PNC. Medair aims to provide these 'new-born' visits within two weeks of the delivery date.

Individuals selected to receive CVA-for-NCDs are required to attend follow-up sessions on a quarterly basis. These sessions are held in a group setting at a community-based organization (CBO), where Medair staff and CHVs will monitor compliance with NCD treatment (through reviewing documents such as prescriptions and receipts) and to provide education on lifestyle modification to control their NCDs. If these conditions are met, Medair staff will then approve CVA transfers for the upcoming quarter.

03. Accountability measures: monitoring and evaluation

Medair implements a range of activities as part of assuring accountability to all its stakeholders, including individuals, CHVs and staff, donors, the MoH and the GoJ. These measures assist Medair to critically evaluate its programming and to use lessons learnt in improving its CVA programming.

- **Post-distribution monitoring (PDM):**

Medair's Monitoring, Evaluation, Accountability and Learning (MEAL) staff conduct quarterly PDMs, using trained enumerators. The exercise includes structured phone interviews with a random sample of individuals who received CVA for health within the preceding three months. The main objectives of the PDM is

1. to ensure that the appropriate amount of CVA was received;
2. to determine how the CVA was utilized;
3. whether the required healthcare services were accessed;
4. assess the overall health status of the assisted household and/or individual, and;
5. to evaluate the effectiveness of Medair's CVA transfer process.

- **Focus group discussions:**

MEAL staff also organize and facilitate FGDs two to three times a year, in which a group of 8–12 individuals are invited to participate. This activity aims to collect more qualitative feedback to supplement and verify PDM findings.

- **Feedback and complaints mechanism (FCM):**

Medair's FCM are operated by phone and managed by the MEAL teams. Calls received on the FCM hotline are received during office hours, and are then logged, categorized based on the level of urgency and assigned to the appropriate staff. The number for the FCM is distributed by CHVs during household visits and individuals attending ATM card distributions.



04. Achievements

Between January 2017 and July 2019,⁶¹ Medair trained 98 CHVs (91 female), who visited and assessed around 65,000 refugee and Jordanian host community households. The breakdown of these households by nationality and governorate is shown in Figure 5. Syrian-headed households comprise the majority of those that were visited (69.9%), followed by Jordanians (28.3%), and those headed by other nationalities (1.8%), of which Iraqis were most commonly visited.

A total of 8,848 individuals received CVA for health during this period, of which 6,892 were refugees. The breakdown of the type of refugees who received assistance is detailed in Figure 6.

A key indicator that Medair consistently measures is the proportion of recipients that used the CVA (earmarked for health) to access the health services. Based on PDM findings, over 90% utilized the CVA for its intended purpose. Non-health-related expenditure often included covering basic needs (including food and rent) and debt repayments.

Medair also consistently measures utilization of health services in regular PDMs, including health facility preference and uptake of preventive services, such as ANC and PNC. These access and utilization indicators are tracked in Figure 7



⁶¹ Medair started using an adapted version of the VAF from January 2017.

Figure 5 Households assessed, January 2017 to July 2019, by nationality and governorate



Figure 6 CVA provided, January 2017 to July 2019, by service type and nationality

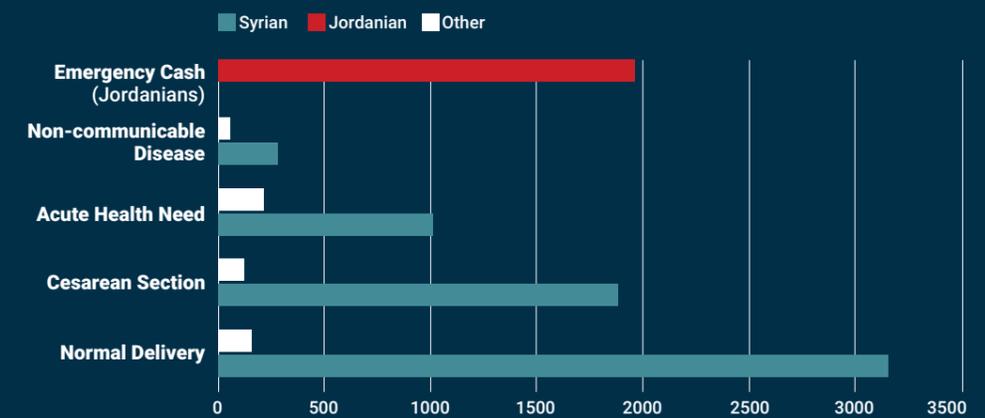
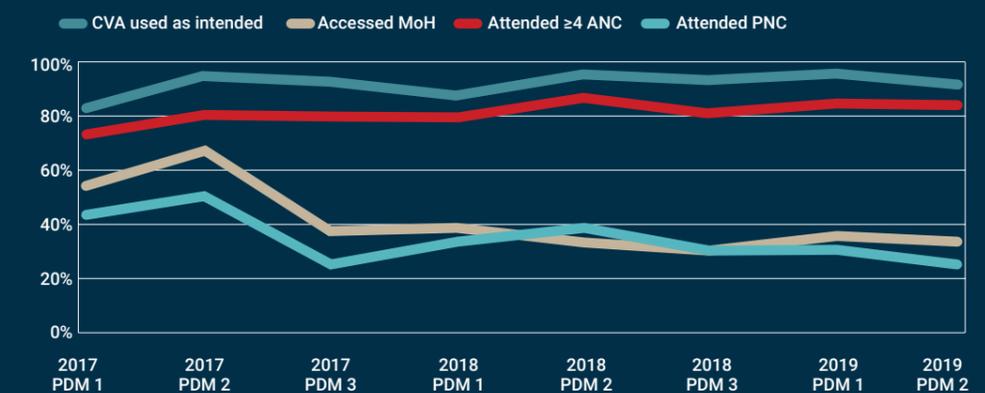


Figure 7 Access and utilization indicators, measured by PDM



05. Challenges, lessons learned, and recommendations

Based on Medair's experience in Jordan, CVA is an appropriate and feasible modality to provide health assistance.

Despite its relevance, Medair continues to confront numerous challenges in its CVA for health activities. The monitoring of the supply side remains difficult. Medair is attempting to address this in several ways. For instance, Medair insists on requiring medical justification for all planned CSs from all service providers, in order to control the high CS rate,⁶² which is 37.8% of the 5,321 refugees assisted by Medair for delivery. At affiliated hospitals, where Medair has more control, Medair monitors individual clinicians and their propensity for conducting CSs, and a clinician has since been banned from providing care for pregnant women referred by Medair. While medically justified CSs can prevent maternal and perinatal mortality and morbidity, unnecessary procedures can put women and infants at short- and long-term risk.⁶³

While contracting services to affiliated hospitals provides Medair with more control over quality, Medair continues to encourage the majority of selected individuals to access MoH facilities, in order to promote a more sustainable approach and to strengthen the Jordanian public health system. Quality of care is also monitored through PDMs, where respondents are asked about their experience at the health facilities they attended, and feedback is collected and provided to the respective facilities.

- **Recommendation to agencies implementing CVA for health (including Medair) and the Health Sector: Standardize definitions of 'quality care' and provide tools for monitoring and quality on the supply side.**

An important, longer term aspect of Medair's approach is related to health promotion and behaviour change. However, the evidence base regarding such behaviour change is limited, given the recent emergence of CVA as a modality in the health sector. More research in this area is required to better understand the sustainability of the behaviour change desired, and whether these behaviours are contingent on the financial incentive. Additionally, there is little evidence of the effectiveness of CVA for health on health outcomes, and there is a need to 'better understand how cash transfer programmes compare to, and/or adds value to complement, direct support to service delivery or supply side financing approaches'.⁶⁴

- **Recommendation to the Global Health Cluster and research institutions: Design and conduct research to understand the impact of CVA for health programmes on health outcomes, behaviours and coping mechanisms, cost effectiveness, and adverse financial outcomes (for example, to track the proportion of the population pushed into poverty, and/or pushed further into poverty due to OOP payments for health).**⁶⁵

⁶² The CS rate was 21.7% among Syrians, according to the JPFHS (2018) and 32.2% as per Tappis, et al. (*Maternal Health Care Utilization Among Syrian Refugees in Lebanon and Jordan*, 2017). The JPFHS found that the decision to have a CS delivery was made before the onset of labour pains in 15% of births (planned CS), compared to 6.7% after the onset of labour (unplanned). This is a high ratio and may indicate that a large proportion of CS deliveries were unnecessary.

⁶³ According to the WHO, the ideal rate for CS deliveries is between 10 and 15%. Above these, CS is no longer associated with reductions in maternal and new-born mortality (WHO, 2015).

⁶⁴ *Research agenda-setting on cash programming for health and nutrition in humanitarian settings* (Woodward, Griekspoor, Doocy, Spiegel, & Savage, 2018).

⁶⁵ *Tracking universal health coverage: first global monitoring report* (WHO, 2015).

Finally, a major challenge faced pertains to the sustainability of the intervention. Despite having an established programme, Medair is contending with the question of how much longer it can and should continue its CVA for health activities, especially considering the protracted nature of the crisis and the evolving political situation within Syria, as well as the uncertainty around whether healthcare subsidies will remain, particularly amid diminishing funding. While CVA can improve access and utilization of health services, it should be complementary to provider payment mechanisms that aim to reduce reliance on user fees and 'should not inadvertently contribute to a fee-charging culture for priority services, which could pose a challenge for UHC in the longer run'.⁶⁶ The situation is complicated by the lack of formal health insurance schemes available for vulnerable Jordanians and refugees.⁶⁷ While Medair is open to exploring ways to transition towards more integrated and sustainable approaches, such as health insurance schemes, it needs to do so judiciously to avoid fragmentation of health programming for refugees.⁶⁸

- **Recommendation to the GoJ and the donor community: Review the functioning of the Multi-Donor Account and its support in the integration of refugees (and/or other vulnerable individuals) into the national health insurance scheme, applying the same rates as for Jordanians, to achieve Universal Health Coverage.**

⁶⁶ *Health financing policy & implementation in fragile & conflict-affected settings: a synthesis of evidence and policy recommendations* (Jowett, et al., 2019).

⁶⁷ Shepard et al. (*Health Care Cost Study at Ministry of Health and the Cost and Financial Impact of Expanding the Civil Insurance Program to Vulnerable Jordanians and Syrian Refugees*, 2017) calculated that expanding the CIP to registered Syrian refugees living among host communities would cost 268.9 JOD per person (with an aggregated cost of 139 million JOD), and 158.4 JOD per vulnerable Jordanian (amounting to 52 million JOD).

⁶⁸ *Analysing equity in health utilization and expenditure in Jordan with focus on maternal and child health services* (Ravishankar & Gausman, 2016).

Bibliography

- Amnesty International, 2016. *Living on the margins – Syrian refugees in Jordan struggle to access health care*, London: Amnesty International.
- Barbelet, V., Hagen-Zanker, J. & Mansour-Ille, D., 2018. *The Jordan Compact: Lessons learnt and implications for future refugee compacts*, ODI.
- CaLP, 2018. *Glossary of terminology for cash and voucher assistance*, CaLP.
- CARE, 2018. *8 Years into Exile*, CARE International.
- DAI, 2015. *Public Expenditure Perspectives Update (2015–2017) Working Paper on Health Sector*, DAI.
- Dator, W., Abunab, H. & Dao-ayen, N., 2018. *Health challenges and access to health care among Syrian refugees in Jordan: a review*. *Eastern Mediterranean Health Journal*, 24(7), 680–6.
- Doocy, S. et al., 2016. *Health service access and utilization among Syrian refugees in Jordan*. *International Journal for Equity in Health*, 15(108).
- DOS and ICF, 2019. *Jordan Population and Family Health Survey 2017–18*, Amman: DOS and ICF.
- GHC and WHO Cash Task Team, 2018. *Working paper for considering Cash Transfer Programming for Health in humanitarian contexts*, Geneva: WHO.
- Gilert, H. & Austin, L., 2017. *Review of the Common Cash Facility in Jordan*, UNHCR and CaLP.
- Healy, S. & Tiller, S., 2013. *Out of the spotlight and hard to reach: Syrian refugees in Jordan's cities*. *Humanitarian Exchange*, 59, 22–5.
- HHC, 2017. *National Human Resources for Health Observatory Annual Human Resources for Health Report*, Amman: HHC.
- IRC, 2018. *Still in Search of Work – Creating Jobs for Syrian Refugees: An Update on the Jordan Compact*, IRC.
- Jowett, M. et al., 2019. *Health financing policy & implementation in fragile & conflict-affected settings: a synthesis of evidence and policy recommendations*, Geneva: WHO.
- Lagarde, M., Haines, A. & Palmer, N., 2009. *The impact of conditional cash transfers on health outcomes and use of health services in low and middle income countries (Review)*. *Cochrane Database of Systematic Reviews*, Issue 4, CD008137.
- MCC, 2017. *On the Basis of Nationality – Access to Assistance for Iraqi and Other Asylum-Seekers and Refugees in Jordan*, Akron: MCC.
- MoPIC, 2018. *Jordan Response Plan for the Syrian Crisis 2018–2020*, Amman: MoPIC.
- Nazer, L. H. & Tuffaha, H., 2017. *Health Care and Pharmacy Practice in Jordan*. *The Canadian Journal of Pharmacy Practice*, 70(2), 150–5.
- Ravishankar, N. & Gausman, J., 2016. *Analysing equity in health utilization and expenditure in Jordan with focus on Maternal and Child Health Services*, Amman: Thinkwell/UNICEF.
- Rehr, M. et al., 2018. *Prevalence of non-communicable diseases and access to care among non-camp Syrian refugees in northern Jordan*. *Conflict and Health*, 12(33).
- Shepard, D. S. et al., 2017. *Health Care Cost Study at Ministry of Health and the Cost and Financial Impact of Expanding the Civil Insurance Program to Vulnerable Jordanians and Syrian Refugees*, Amman: UNICEF Jordan.
- Tappis, H. et al., 2017. *Maternal Health Care Utilization Among Syrian Refugees in Lebanon and Jordan*. *Maternal and Child Health Journal*, 21(9).
- The World Bank, 2019. *Data – Jordan*. [Online] Available at: <https://data.worldbank.org/country/jordan> [Accessed 11 November 2019].
- Tiltnes, Å. A., Zhang, H. & Pedersen, J., 2019. *The living conditions of Syrian refugees in Jordan: Results from the 2017–2018 survey of Syrian refugees inside and outside camps*, Amman: Fafo.
- UNHCR, 2015. *Cash-based Interventions for Health programmes in Refugee settings – A review*, Geneva: UNHCR.
- UNHCR, 2018. *Health Access and Utilization Survey*, Amman: UNHCR Jordan.
- UNHCR, 2019. *Vulnerability Assessment Framework, Population Study 2019*, Amman: UNHCR Jordan.
- UNHCR, 2019. *Statistics for Registered Persons of Concern in Jordan (as of 31 October 2019)*. [Online] Available at: <https://data2.unhcr.org/en/documents/details/72128> [Accessed 11 November 2019].
- WFP & REACH, 2019. *Jordan – Comprehensive Food Security and Vulnerability Assessment, 2018*, Amman: WFP Jordan.
- WHO, 2015. *Tracking universal health coverage: first global monitoring report*, Geneva: WHO.
- WHO, 2015. *WHO Statement on Caesarean Section Rates*. [Online] Available at: https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/ [Accessed 2 December 2019].
- WHO, 2019. *National Human Resources for Health Observatory Annual Human Resources for Health Report*, Cairo: WHO Regional Office for the Eastern Mediterranean.
- Woodward, A. et al., 2018. *Research agenda-setting on cash programming for health and nutrition in humanitarian settings*. *Journal of International Humanitarian Action*, 3(7).

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