Eastern Africa Regional Cash Working Group

CVA for Health Outcomes Workshop- Towards an Action plan

8th - 9th June 2021

Contents

Introduction

Rationale for the workshop

The Regional Cash Working Group (CWG) for Eastern Africa aims to promote quality, coherence, effectiveness and accountability of (CVA) in the region. More specifically when it comes to CVA that is sector specific the role of the Regional CWG is to mainstream concepts and provide evidence and tools to promote good practice. Due to the emerging significant interest in CVA and Health, the Regional CWG with the Global Health Cluster (GHC) organized the two half-day regional workshop to facilitate sharing of CVA and health concepts, sharing of experiences and discussion of good practice for the implementation of CVA for health outcomes, and improve coordination between cash and health actors. The workshop brought together stakeholders from both the health sector and those working in cash and voucher assistance.

The primary objective of the regional workshop was to **take stock of the CVA for health outcomes activities, facilitate exchange of knowledge, explore the gaps, challenges and opportunities, and develop an action plan to better** support to humanitarian actors using CVA for health outcomes.

More specifically the workshop was intended to be collaborative space for:

- Introduction and discussion of CVA and health concepts
- Identify gaps and opportunities
- Identify the needs of CVA and health practitioners
- Identify what is needed to support learning

The intended **outputs** for the workshop included:

- Mapping of the CVA and health projects/health within the East Africa Region
- Identification of gaps and opportunities in the design and implementation of CVA and health
- Prioritization of themes for the CWG to take forward
- Development of an action and work plan for taking forward the CVA and health learning agenda

The workshop took place over a period of three days. On the first two days, half-day sessions included all invited participants. On the third day, members of the CVA for Health Outcomes Workstream met to discuss the outcomes of the workshop and develop a work plan.

Leads of the workshop

The East Africa Regional Cash and Health Workstream led designing and planning of the workshop. Members of the workstream included CaLP, NRC, UNICEF, CARE, World Vision and Global Health Cluster.

In addition to planning and facilitating the workshop, the workstream will lead in moving the action plan forward for the E. Africa Regional Working Group.

The role of the Cash and Health Workstream

The work stream was tasked by the RCWG to plan and deliver a regional workshop that will deliver an action plan on CVA for health outcomes in the region. This included:

- Developing and refining the agenda for the workshop
- Identifying the list of participants and identifying relevant stakeholders
- Support with the facilitation of the workshop

- Developing and finalization of the action plan on the 3rd day of the work based on the work done the first two days.

The role of the Health Cluster Cash Task Team:

The Health Cluster Cash Advisor supported with guidance on the development of the agenda and facilitation. This included:

- Provide technical guidance to the Cash and Health Workstream
- Support on the facilitation of the workshop
- Compile and finalize the workshop report
- Support with the delivery of the action plan

Workshop participants and expectations

For this workshop, priority was given to humanitarian actors based in the East Africa Region, who are currently using or planning to use CVA to achieve health outcomes. It also included members of the Regional Cash Working Group, National Cash Working Group Leads, Health cluster coordinators and members in the respective region.

The workshop was by invitation and was open only to the East Africa region, to keep the numbers at a manageable level in order to facilitate discussion. Also, participants had to register to participate in the workshop. Participants included teams from the following organizations: UNICEF, NRC, WHO, CARE, and included cash and health experts.
Furthermore, participants had the opportunity to provide their expectations for the workshop. Expectations are annexed in **Annex 1**

Finally, the workshop was facilitated by Sapenzie Ojiambo - CaLP East and Southern Africa Regional Representative, Sahara Ibrahim - CARE Cash & Markets Regional Advisor, Yassmin Moor – CashCap Advisor for the Global Health Cluster Cash Task Team, and Julie Lawson-McDowall – CaLP Technical Advisor.

Pre-workshop mapping exercise

The Regional CWG conducted a mapping survey ahead of the regional workshop to get a sense of the current CVA and health projects within the region. There were 29 responses from the survey. The overall observations from the survey are:

- There seems to be a misunderstanding of what CVA for health outcomes means/entails and what qualifies as CVA for health. For this reason, it was important to outline during the workshop what we mean by CVA for health outcomes (including the different types of projects and interventions).
- The responses revealed that there were six active CVA and health projects in the East Africa region.
- Respondents seemed to mix CVA for health with CVA for nutrition – which can be related but they are not necessarily the same thing.
- There seems to also be a good number of Africa based local NGO's who responded to the survey

A more detailed report is annexed in **Annex 2**

Meeting sessions

Day 1

Session 1 – CVA and health concepts

The workshop began by first introducing core CVA and health concepts. The reason for this is was to ensure that participants understood what CVA for health outcome entails and how the CVA modality has the potential to respond to health needs. The following concepts were introduced:[1]

- Universal Health Coverage:
    - This is the principle when providing health assistance during a crisis and the primary aim of health financing. In all contexts, the primary aim of health financing is to provide a social safety net to ensure access to an essential package of quality health services for individuals and households when they need healthcare, without having to suffer financial hardship. This goal is the bedrock of Universal Health Coverage.
- Challenges to achieving universal health coverage:
    - The main challenge to achieving universal health care is related to barriers to accessing health services.
- Framework for barriers to effective coverage:
    - Barriers can be grouped into three categories availability, accessibility (which includes financial accessibility), and acceptability. The reason we are using these barriers as a framework is because in the list below, all fall under and contribute to effective coverage. Addressing these issues (which are related to availability, accessibility and acceptability) contribute to the following list:
        - Improving over-arching health system performance
        - Reducing health inequities
        - Improving financial protection
        - Enhancing responsiveness to non-medical needs and ensuring patient centered care
        - Ensuring the right to health for all
- Humanitarian Development Nexus and Financing - towards a collective outcome for UHC and financing including services being provided free at the point of delivery, protection against catastrophic expenditures, and access to services without suffering financial hardship.
- How is CVA for health outcome programming important and different from other sectors
- How can CVA impact barriers to health:
    - Cash & vouchers 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 (demand-side barriers).
    - With effective coverage, CVA for health interventions can protect them from catastrophic health care costs, reducing financing barriers while enabling access to health care of sufficient quality.
    - CVA also has the potential to improve quality of services (vouchers)
- Different examples of using CVA for health outcomes

[1] The power-point presentation used for the workshop is annexed

Session 2 – Breakout Session – Challenges, Gaps and Stakeholders

This session provided the space to identify challenges, evidence and gaps and key stakeholders relating to CVA for health outcomes. Participants were broken up into three groups facilitated by members of the CVA for Health Outcomes Workstream of the CWG in which they answer the following question.

1. What are the biggest challenges with using CVA for health outcomes?
2. What are the gaps in knowledge on CVA for health outcomes in E. Africa?
3. What are the gaps in evidence on CVA for health outcomes in E. Africa?
4. Who are the main stakeholders?

The challenges, and gaps identified were then grouped into four topics as follows: (see chart below):

1. Resources
2. Capacity
3. Coordination
4. Evidence and Research

TOPIC	KEY ISSUSES
1. Resources	• Lack of funding to pilot CVA for health • Lack of understanding on what CVA and health constitutes • Lack of donor engagement • Lack of financial resources to pilot CVA and health projects
2. Capacity	• Building technical capacity and ensuring quality design • Context specific response analysis for CVA for health • How to include the health expenditures in the MEB • Lack of technical guidance e.g. health market assessments
3. Coordination	• Lack of coordination between CVA and health stakeholders • Who are the main stakeholders when it comes to CVA and health? • How to work with the government that is trying to strengthen the systems - and how do we not divert the resources • Linking to health initiatives under social protection
4. Evidence and research	• Insufficient evidence on how cash can be part of health • Evidence on most effective and efficient modalities • What a CVA for health package would look like. • At what level should we be trying to work? - the primary, or the tertiary level? • What does a response analysis for CV and health look like?

At this stage, this was a mapping of the key issues from the group discussions, but still needed further discussion and prioritisation. The next step was to identify the areas that required urgent attention and those that could wait. This was done via Miro board exercise on day two.

Day 2

The original agenda for Day 2 was amended to allow more time to introduce the response option analysis and discussion as well as prioritization of the emerging key issues, which could not take place on day one due to time constraints. Discussions on day one had showed interest by participants to increase their understanding of the decision tree for CVA and health options, as well as what potential responses could look like.

Session 3 – Introducing Response Option analysis

The GHC Cash Advisor introduced the draft[2] CVA for Health Outcomes Response Option Analysis tool[3] using the barriers for effective coverage. The tool is designed as a decision tree keeping in mind the first and optimal response is to ensure the availability and accessibility of health services, that health services are operational and accessible.

CVA has the potential to reduce financial barriers in accessing health services and is therefore at the bottom of the tree. Several examples of cash for health outcomes interventions were also discussed, including different modalities, such as vouchers, and unconditional cash.

Participants discussed the complexity of cash and health programming and ensuring the quality of health first and cash being complementary to address the financial barriers. It was noted that within health and CVA, cash tends to be part of a cash plus program.

Session 4 & 5: Prioritization Exercise & Development of Action Plan

This session was a continuation of the 2nd session (Day 1) – where the group outlined challenges, gaps and trending topics and issues were identified.

Participants were asked to vote on the issues and six issues, which were later defined as themes, were selected, for prioritization. See **Annex 3** for the final results of the prioritization exercise.

The following six topics were chosen: The following 6 topics were identified to be of the highest priority. In three breakout groups, participants were then asked to develop a basic action plan for each topics with each group tackling two topics.

1. Building technical capacity and ensuring quality design
2. What a CVA for health package would look like
3. Context specific response analysis for CVA for health
4. Working with stakeholders
5. Overcoming the lack of coordination between CVA and Health stakeholders.
6. Lack of funding to pilot CVA for health - funding and donor engagement more generally

Groups were then asked to develop a basic action plan for each them, that included action steps, who is responsible for this, a timeframe and how. Given that the groups only have 45 minutes to complete, some

[2] The tool is still a draft – and this workshop was used as an opportunity to seek feedback on its relevance and effectiveness

[3] Annex

aspects of the action plan were not completed. The following is the output of the action planning exercise. This was refined during Day 3.

Topic	Action steps	Who?	When?	How?
Capacity				
1. Building technical capacity and ensuring quality design	• Map out what the technical needs are • Map out within the region what the capacity needs are as they relate to CVA and health • Operationalizing of the mapping/developing capacity building plan • Tailor the training materials to the region • Identify funding/other resources to roll out these trainings/capacity building activities • Develop additional case studies/evidence on the use of CVA and health • Dissemination of case studies and learnings	Country specific CWG's/HC in coordination with the RCWG		• Design a tool to gather the technical needs/capacity needs/analysis/report. • Develop a capacity building plan • Speak to stakeholders to ensure the training materials are context specific. • Develop a portfolio of case studies of CVA for health outcomes project addressing diverse problems /barriers in different contexts
2. What a CVA for health package can look like	• Develop a checklist for the design of a CVA for health project, including what do you need to do? How to analyze the needs? What assessments to undertake? Who you need to talk to etc. • <u>The checklist should also include:</u> - Barrier analysis and demand side perspective is taken into consideration in assessments - Focus on patient perspective to make sure services are available and accessible - Behavioral aspect in the response analysis	CaLP to lead in collaboration with RCWG and possibly health clusters noting that we don't have a regional health cluster	6 months-1 year	CaLP to start a toolbox collaborating with other stakeholders
3. Context specific response analysis for CVA for health	• The Global Health Cluster (GHC) already developed a response analysis framework, however this tool has to be tailored for country specific contexts. • More long-time monitoring to feed into contextualizing- long term impact pilot?	Led by GHC and the RCWG		Facilitate workshops in different countries Develop assessment templates
Coordination				
4.Working with stakeholders	• Assign a task team from the HC and CWG to be the focal points for CVA and health • Map the stakeholders - to understand who they are and what they are doing and how to engage with the above activities			Task team for CVA and health per country in the region to be the focal point for engaging stakeholders and working with the regional focal points on the regional WP – time bound task team.

				One HC person and one CWG person
5. Overcoming the lack of coordination between CVA and Health stakeholders.	• Bring health stakeholders into the cash working groups – for them to understand CVA. • Educate health actors on CVA programming – what it has to offer and what the value of CWG is, what our offer is. • Understand health cluster objectives to be able to better link them with the CWG's. • Data and indicators – are hard for outsiders to understand the highly specialized technical language health indicators • HRP process – what are the sets of markers – CVA marker as a grading criteria for proposals for health programming - where is cash useful? Donors and OCHA need to understand this. • Cf countries where funds not pooled (HRP process) and must look for funding elsewhere – where do we find funding for CVA for health			
6. Lack of funding to pilot CVA for health - funding and donor engagement more generally	• Having CVA embedded in HRP processes would help to highlight and have a more deliberate approach – needs to be there for donors to consider. • Health cluster – have to engage with HRP to say what they want. • Everything starts with needs assessment – understanding from OCHA how this is done – if the needs assessment offers opportunities to build in CVA usage in health. Understand from PDMs what is being spent on health e.g. ECHO's recent insights. Harness some of the data regarding health expenditure to show how CVA can contribute to effectiveness of health service provision. We have that data. • Difficulty is getting the right people around the table. Push for MPCA has marginalized the cash plus programming that dominates CVA for health outcomes. • Work with the lead agencies on coordinating with donors.	• Multi stakeholder – consult CWG leads, OCHA, ICCG, donor working group – WHO can share along with health cluster • Health cluster (but after the linking and coordination) • CWG and OCHA (possibly with Health actors) • Activities – dependent on coordination, advocacy • As above.		This would partly result from the tasks above - the better coordination and mutual education described above would contribute to having the indicators built. After the 'why bother' piece The stakeholder mapping, using ECHO guidance recently produced, ensure donors are aware of this, push to sector provision. Cluster lead agency Note CVP training – see range donor guidelines – look more carefully at this as good source of information to identify entry points and tap in existing resources.

During plenary discussion participants of the workshop prioritized the following actions. However, this is only a starting point as the Cash for Health Workstream of the CWG will further develop a worplan on the basis of the above action plan. The immediate actions included:

1. **Map and engage with current stakeholders when it comes to CVA and health**
    a. It is important to map out who the stakeholders are when it comes to CVA and health, including actors implementing CVA and health – agencies, private actions and governments. This is not limited to cash actors, but also includes health actors – including country Health Clusters.
    b. Engage with the CVA and health stakeholders, including donors and health clusters
2. **Develop and make available tools and guidelines related to the design and implementation of CVA and health, including training materials**
    a. Capacity building was an issue that came up frequently, including how to design a CVA and health project, including response option analysis, and how to include health in the MEB. Similarly, health actors also require capacity building on CVA programs and what role CVA can play in health outcomes
3. **Share case studies from the region on CVA and health**
    a. There is a lack of evidence on the effectiveness of CVA for health outcomes, specifically for the East Africa region. This does not mean that there are no projects but rather it may not be documented or shared with a larger audience. Therefore, there should be a more systemic sharing of case studies on CVA and health within the region and to different stakeholders.

Day 2 concluded with these actions. The Cash & Health Workstream will expand on these actions to develop an action/work plan for the Working Group.

Conclusion

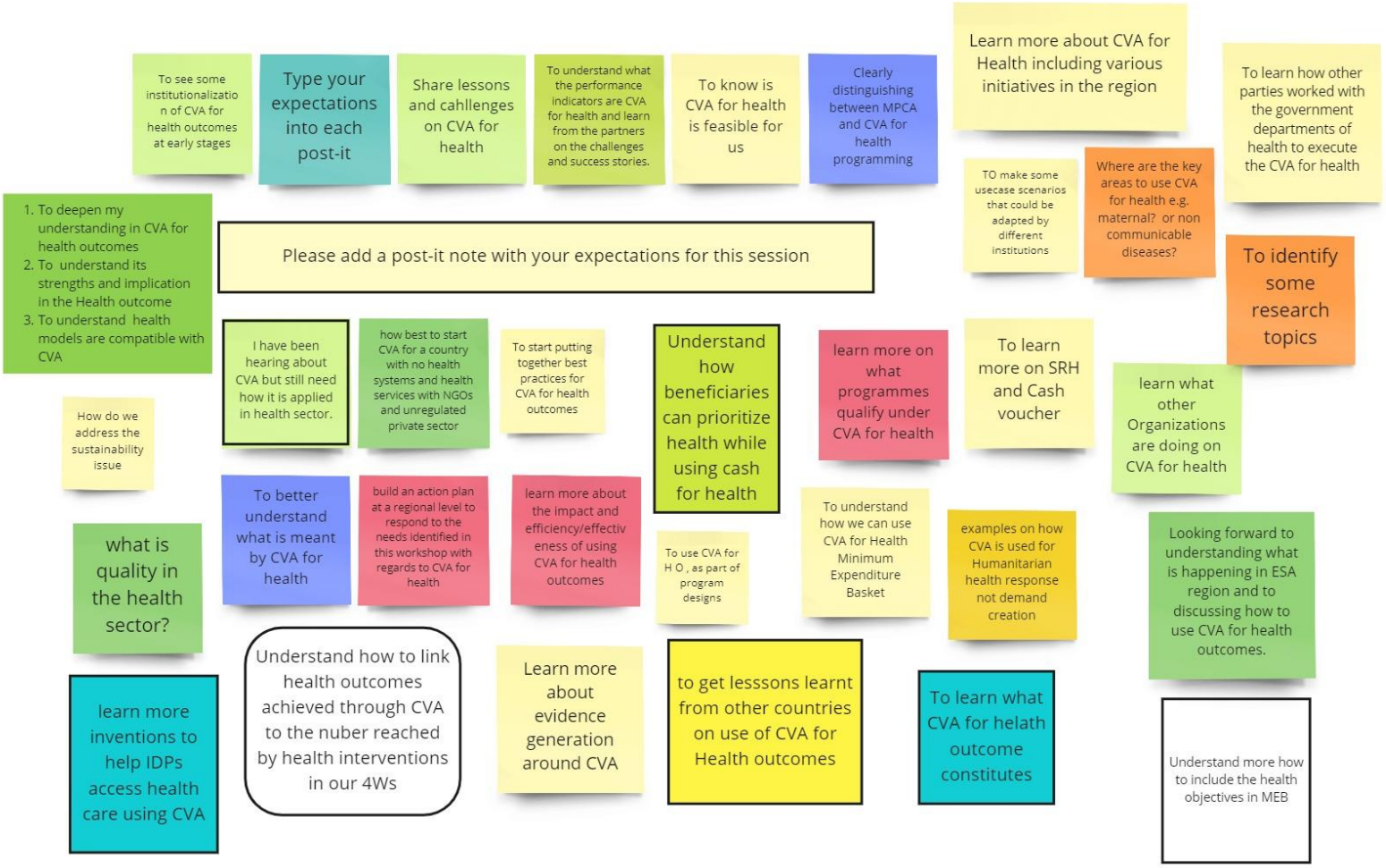
The workshop was a huge step towards building a joint action plan on how the Regional CWG can support and coordinate CVA and health practitioners in the design and implement cash and health projects. In summary:

- Using CVA for health outcome has great potential in the region- the health and CVA practitioners need to be engaged and the discussions that happened in the RCWG need to be cascaded to the National Cash Working Groups.
- Although there was diverse representation of organization in the 2 days' workshop, there is need to involve and reach out to key stakeholder that are implementing health programs/projects.
- Developing the capacity of the staff and undertaking timely response option analysis are priority. The Regional CWG needs the support of the Global Health cluster cash task team to undertake these pieces.
- Beyond the action planning further discussions need to take place to look at the whole health system, the national insurances and work with Governments more closely.
- Joint Advocacy and fundraising on CVA for health outcome will be the panacea in achieving the priority actions identified.

Annexes

Annex 1 – Participant Expectations
Annex 2 – Mapping of CVA and Health Activities in Eastern Africa
Annex 3 – Prioritization Exercise Miro Board
Annex 4 – Final Action Plan
Annex 5 – Participant List

Annex 1: Participant Expectations



Annex 2: Mapping of CVA and Health Activities in Eastern Africa

Analysis Report

May 2021

The Regional Cash Working Group conducted a mapping survey ahead of the Regional CVA and Health workshop. There were 29 responses to the survey. The breakdown of the findings per question is outlined below.

Because the survey is focused on mapping CVA activities related to health outcomes, the report only focuses on responses that had a health component. Responses related to other CVA interventions (those who responded "No" to Q2) were excluded.

Q1: Organization Name

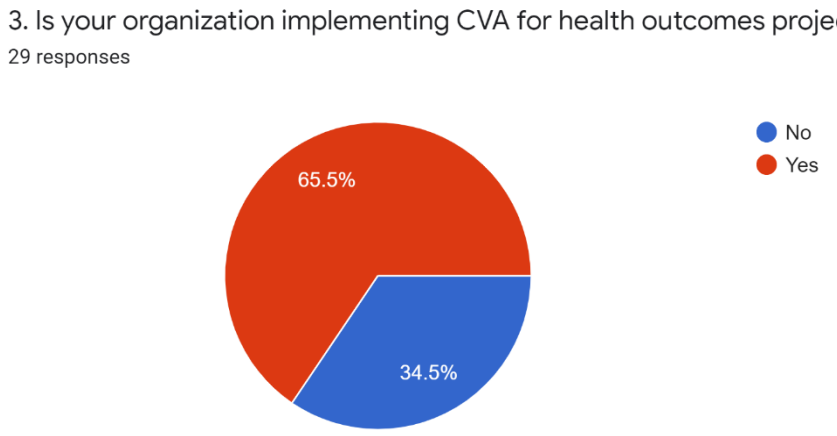
There were 29 responses to the survey. However, there was duplication of organizations, so the actual no. of organizations that responded was 26. The following organizations responded to the survey:-

No.	Organization
1	Danish Refugee Council
2	WFP
3	Norwegian Refugee Council
4	Kenya Red Cross Society
5	Catholic Relief Services
6	Affey Mohamed Olow
7	Mandhere Relief and Development Organization (MARDO)
8	CARE International
9	MIDNIMO Relief and Development Organization (MRDO)
10	Alnor charitable organization
11	Humanitarian Translation for Somalia [H.T.S]
12	Concern Worldwide
13	ZOA
14	HEKS/EPER
15	IOM
16	World Vision International
17	Wadani Relief Organisation (WARO)
18	SADCO
19	Association pour la défense, le rétablissement et le développement des droits humains en abrégé ADRDH
20	Omaria Comunity Development Organization (OCDO)
21	SEDO
22	Association pour la défense, le rétablissement et le développement des droits humains en abrégé ADRDH
23	British Red Cross and Kenya Red Cross
24	ECHO
25	ICRC
26	USAID KEA

The countries that were included in the responses were primarily Kenya, Somalia. There was also Burundi, South, South Sudan, Cameroon, Ethiopia, and Republic of Central Africa

Q2: N/A

Q3 & 4- Is your organization implementing CVA for health outcomes projects/programs AND country:



19 (65.5%) of the 29 respondents reported "Yes" to this question. However only **5** had actual CVA for health projects. Below is the breakdown of the types of cash intervention for those who answered "Yes" to the question. Also included are those who may have accidently answered "No" to the question but then responded to Q4 and detailed their health project.

Organization	Country	Intervention
Health		
Kenya Red Cross Society	Kenya	Cash for antenatal and post-natal care
Affey Mohamed OLOW	Somalia	Vouchers for pregnant women
CARE International	Somalia	Cash for Reproductive health
Humanitarian Translation for Somalia	Somalia	Cash for medicine
ICRC	N/A	Cash for medical care/needs including wounded persons
British Red Cross	Kenya	Cash for pregnant women
Nutrition		
Catholic Relief Services	Sudan	Voucher for nutrition
Concern Worldwide	Somalia	CASH for Improved Nutrition in Somalia – cash for health outcomes
HEKS/EPER	Ethiopia	Cash for health outcomes (part of multi-purpose cash grant)
SEDO	Somalia	Voucher following nutrition training
Danish Refugee Council	Cameroon	Voucher for nutrition

Other types of CVA interventions Reported		
Mandhere Relief and Development Organization (MARDO)	Somalia	Safety net
MIDNIMO Relief and Development Organization (MRDO)	Somalia	Cash in response to the drought in Somalia
Alnor charitable organization	Somalia	Cash for IDPs
Wadani Relief Organization (WARO)	Somalia	Mobile voucher for vulnerable persons
SADCO	Somalia	Cash (unclear for what)
ADRDH	République Centrafricaine RCA	Virement inconditionnel ou conditionnel
NRC	South Sudan	Cash for families impacted by Covid-19
NRC	Somalia	Cash for hygiene promoters (WASH)

There was a duplication for two organizations so while there are 19 responses, there were only 17 with accurate information

Q5: What modalities are you using?

The majority of the responses on CVA and health are using cash as a modality, however there are some using vouchers. On the health and nutrition interventions (listed above) **7** organizations are using direct cash, while **4** are using vouchers (including mobile money, mainly in Kenya)

Q6: Describe your CVA and health intervention:

Response is listed in the chart for Q3 & Q4

Q6: To what extent did your project/program involve the Health Cluster and other stakeholders such as private sector and governments on the design and response analysis? If yes, how?

Only **6** organizations responded to this question accurately. Of those 6 are, Kenya Red Cross, Humanitarian Translation for Somalia, HEKS/EPER, SEDO, NRC, and CARE International. Kenya Red Cross, CARE International, HEKS/EPER and NRC coordinated both with the government, including the Ministry of Health, and other coordinating bodies including Health, Nutrition, Food Security and Health clusters. Humanitarian Translation for Somalia only coordinated with clusters.

Q7: Lessons learnt responses

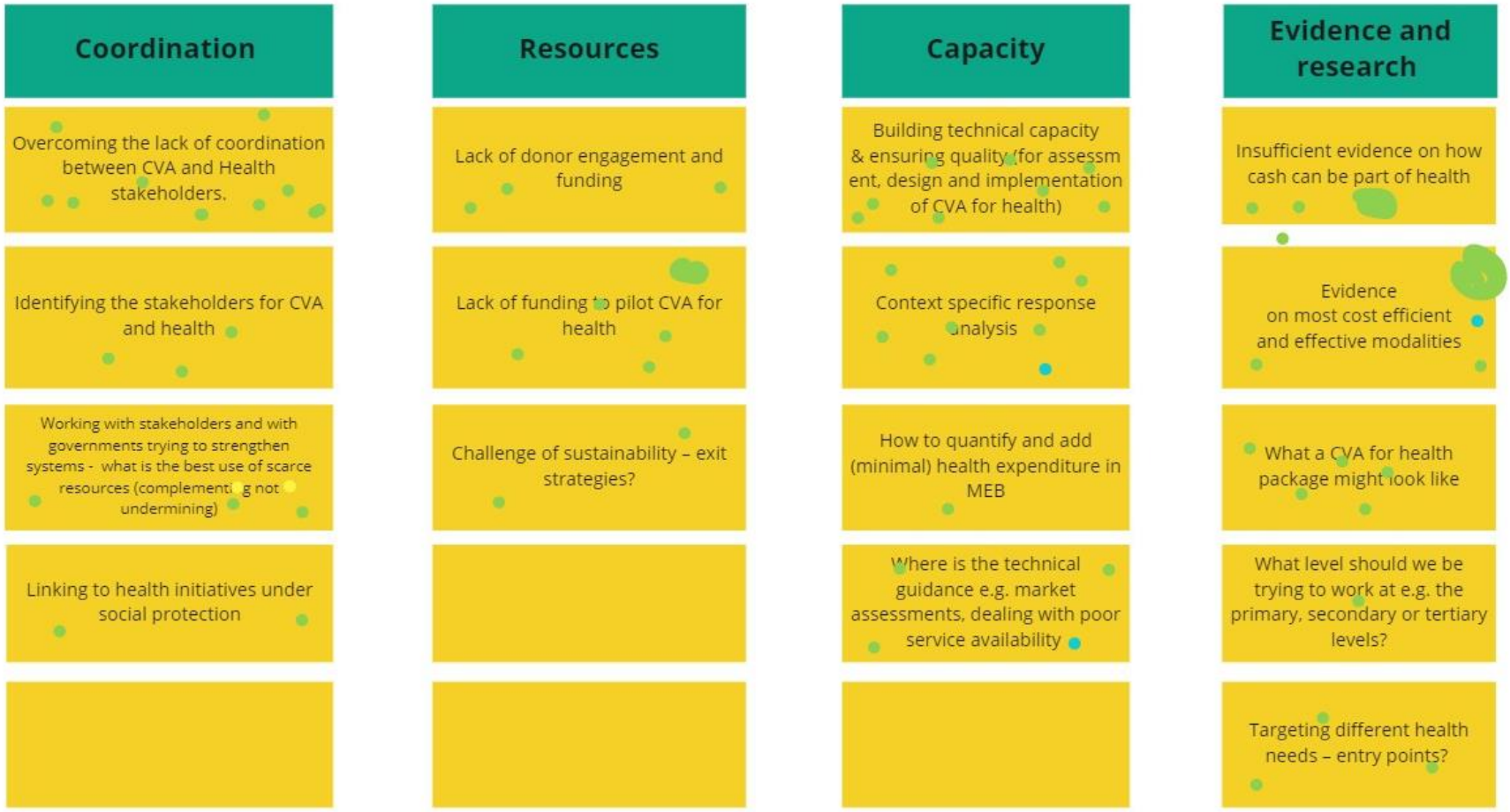
- Kenya Red Cross produced a video sharing lessons learnt of their project related to Reproductive Health. However, the link for the video was not posted
- CARE International reported the following lessons from their CVA for Reproductive Health:
    - CVA aids in the delivery of essential health care for women and children
    - CVA Improves couple decision making
    - Improves uptake of contraceptive use.

- Humanitarian Translation for Somalia noted:
    - We need to enhance cash programming and giving opportunities to organizations who can implement it. On the other hand, it is flexible in that poor people can buy according to their specific needs with the cash of which they would not be able to buy if given foods and NFIs. If you give us as organizations and humanitarian professionals to serve the beneficiaries in time, we will be able to deliver, and that is better than producing only studies and reports after reports without the actual action of the disbursement of the needed cash on the ground.
- Concern Worldwide reported the following lessons learnt from their nutrition for CVA intervention
    - As per the initial results, CCT seemed to have a positive impact especially on immunizations while health seemed not to have an impact though this is expected as behavior change usually takes time for any effects to be realized.
- ECHO – despite not having direct interventions but is a donor funding intervention noted the following:
    - PDMs from MPC transfers continue to prove that beneficiaries are spending the cash transfers on health needs whether payment for direct or indirect costs related to health, and or debt repayments in relation to health expenditures. Therefore, there is need to find ways to ensure a health component is included in the Minimum Expenditure Basket that is typically used to determine the cash transfer value in many humanitarian settings or more define recommendations for when cash for health outcome is to be implemented.

Overall observations:

- From the survey, there seems to be a misunderstanding of what CVA for health outcomes means and what qualifies as CVA for health. For this reason, it is important to outline during the workshop what we mean by CVA for health outcomes (including the different types of projects and interventions).
- Respondents seemed to mix CVA for health with CVA for nutrition – which can be related but they are not necessarily the same thing.
- There seems to also be a good number of Africa based local NGO's who responded to the survey.

Annex 3 – Prioritisation Exercise Miro Board



Additional comment by participant: I would add research on how people use MPC for health: to which extent do they buy services from non-qualified providers, buy medicines on the market, or traditional healers

Annex 4: Final Action Plan

Towards a Regional Action Plan- Eastern Africa Regional Cash Working Group Workshop on CVA for Health Outcomes. 2021-2022			
Action steps	**Who to implement**	**Time frame**	**How**
Technical Support and Capacity building			
Mapping out of the technical and capacity needs.	National CWG and Country Health Cluster	August- September 2021	• Design a tool to gather the technical needs/capacity needs/analysis/and report. • From the report you develop a capacity building plan speaking to stakeholders to ensure the training materials are context specific • Provide guidelines on how to pitch to donors CVA and health?
Tailor and develop training materials	Global Health Cluster Cash task team (GHC, CTT) and UNICEF (to confirm)	October 2021	
Basic training on CVA for health for the National/Country Cash working	East Africa CWG with the support of the Global Health Cluster teams.	August- December 2021	
Comprehensive Training on Health for CVA-Response Analysis	East Africa CWG and CaLP with support of the GHC	2022	
Context specific response analysis	National Health Clusters and CWG with technical support of the GHC CTT	September 2021-April2022	• The National Health clusters and partners go through context analysis already done • Systematically define a framework to go through these assessments. • More long time monitoring to feed into contextualizing- long term impact pilot? Through these assessments enrich country level responses with what is unique to each context
Develop Indicators that are relevant for CVA for health outcome. Adding questions to the PDMS- and use it as an advocacy tool to	Jointly by the different stakeholders at global level	To be determined	

donors that health costs more. (What needs were you able to use the money for?)			
Knowledge Management			
Develop a synthesis document or a Checklist. If you want to do CVA for health, what do you need to do? What are the needs? What assessments should you undertake? Who do you need to talk to?	CaLP	September -June 2022	Consult the CO and technical advisors on how the checklist will look like Develop a Template that the partners can complete
Enhance learnings: disseminate the global studies to the region	CaLP and the GHC CTT	July-June 2022	
Disseminate the materials on MEB and engage with CWG leads.	CaLP and GHC CTT	January- June 2022	Organize webinars on MEB and Health.
Coordination			
Assign a task team from the HC and CWG to be the focal points for CVA and Health. Overcoming the lack of coordination between CVA and Health stakeholders.	Health Clusters and Cash working groups	July- December 2021	• Identifying champions at the country level – (HC/CWG) • Reaching out to key stakeholders IRC, WV, Save, UNICEF.
Strengthening linkages overcoming the lack of coordination between CVA and Health stakeholders-	National CWG and country level Health Clusters	Continuous for long-term	• Bring health stakeholders into the cash working groups – for them to understand CVA. • Educate health actors on CVA programming – what it has to offer and what the value of CWG. • In HRP process – sets of markers – CVA marker as a grading criteria for proposals for health

			programming - to find out where is cash useful? • Discuss with Donors and OCHA • Cf countries where funds not pooled and must look for funding elsewhere – CVA without pooled funding, it is harder to propose funding or find funding for health.
• Funding and donor engagement more generally	• Multi stakeholder – consult CWG leads, OCHA, ICCG, donor working group – WHO can share along with health cluster	• 2021-2022	• Having CVA embedded in HRP processes would help to highlight and have a more deliberate approach – needs to be there for donors to consider. • Health cluster – have to engage with HRP to say what they want. • Everything starts with needs assessment – understanding from OCHA how this is done – if the needs assessment offers opportunities to build in CVA usage in health. Understand from PDMs what is being spent on health e.g. ECHO's recent insights. Harness some of the data regarding health expenditure to show how CVA can contribute to effectiveness of health service

			provision. Push for MPCA has marginalised the cash plus programming that dominates CVA for health outcomes. • Work with the lead agencies to ask them to work with the donors.

Annex 5: Participants List

Name	Organization	Role
Orla Kilroy		
Sapenzie Ojiambo	CaLP	Regional representative (Eastern Africa)
Sahara Ibrahim	CARE	Cash & Markets Advisor
Yassmin Moor	Cashcap - GHC	Cash Advisor
Hiba Abou Swaid	WFP	Regional Cash and markets Advisor
Lili Mohiddin	NRC	Regional Cash and Markets Advisor
Yu Tsukioka	UNICEF	Social Protection and Universal Health Coverage Specialist
Jeniffer Wasianga	USAID	Program Management Specialist - Orphans and Vulnerable Children
Julie Lawson-McDowall	CaLP	CaLP Technical Advisor
Abdulkadir Dayib Ahmed	UNFPA	Lead Somalia Health Cluster
Andre Griekspoor	WHO	Health advisor
Joy Maingi	OCHA-ROSEA	Humanitarian Affairs Officer
Danièle Wyss	ICRC	CVA Programme officer - RCRC CVA for Health TWG co-chair
Daniel Wanyoike	British Red cross	Program Manager
Abdi Osman	Social Enlightened Development Organization (SEDO)-Somalia	Monitoring & Evaluation Specialist
Musdafa (Musdfa	World Vision	Health and Nutrition Manager
Ali Mansoor	Cashcap	CWG South Sudan Cash Advisor
Ahmed Aweis	UNFPA	Sexual and Reproductive Health
Vyuka Sylvain	World Vision	
Florence Obura	World Vision Somalia	Technical Specialist; Health and Nutrition
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