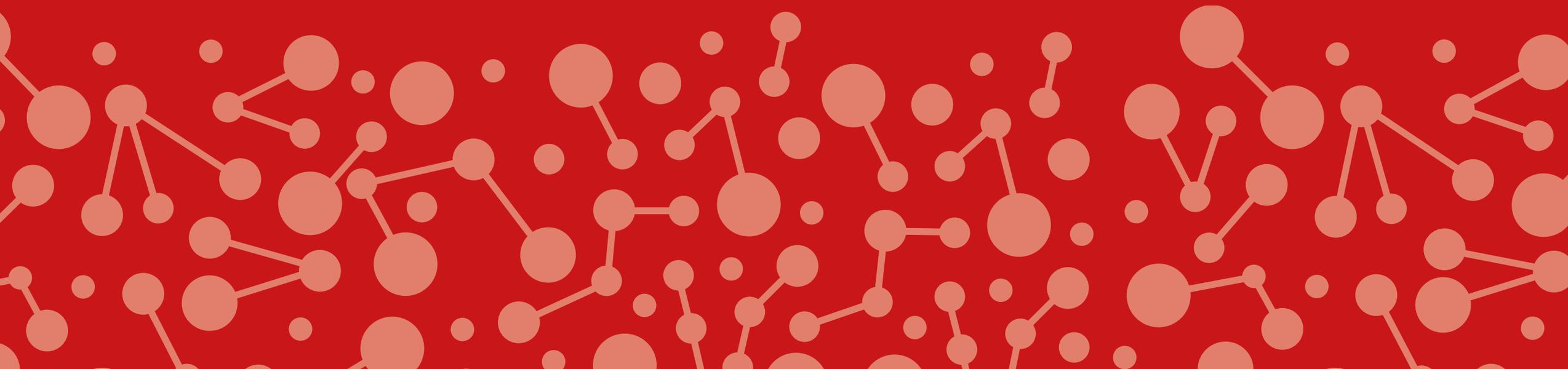


A 'Stocktake' of CVA for Health Outcomes in the Mena Region:

Moving from Evidence to Practice

Webinar 2 June 2021

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Structure of the presentation

- Methodology, definitions and introduction to the study (slides 3 - 8)
- Conceptual framework (slides 9 - 11)
- CVA for health modalities explained (slides 12 – 22)
- Findings from the study (slides 23 – 29)
- Conclusions and recommendations (slides 30 - 35)

Methodology

Timeline: February – April 2021

Geographical focus: MENA region - Iraq, Jordan, Lebanon, Occupied Palestinian Territories (OPT), Syria, Turkey and Yemen) in Tier I and Egypt in Tier II

Additional country examples: Afghanistan, Burkina Faso, Chad, Greece, Iran, Somalia and Ukraine

Method: a 'snowball' approach – i.e., identifying new projects, interventions and contacts as from existing documents and contacts. Systematic data collection and analysis using excel.

Document review included institutional frameworks, technical working papers and case studies and, where available, project-specific information such as Standard Operating Procedures (SOPs), presentations and data from monitoring systems.

A total of 28 KIIs were conducted with more than 45

Defining CVA for health with 3 questions

In order to select those CVA modalities which are predominantly used to ensure that POC can access and make effective use of healthcare, we asked the following three questions:

- Does the CVA approach address barriers which are constraining the use of health services for specific groups of persons of concern?
- Are the benefits 'tied' to the beneficiary and provided on a 'per beneficiary' basis; i.e., can they be seen to act predominantly on the demand-side (no beneficiaries = no funds)?
- Is the identification of the beneficiary or target group linked to their actual health needs?

Leading to a possible definition...

CVA within the health sector:

“is linked to a particular beneficiary or beneficiaries in need of specific healthcare by a qualified provider, and which addresses the barriers which s/he encounters when accessing that care, while incentivising use or adherence”

Why use CVA for health?

1. Healthcare costs cannot be averaged across households and can range from very low to extremely high (catastrophic costs which can push families into poverty)
2. Healthcare costs are often unpredictable
3. Information asymmetries between patient and health care provider - can lead to misuse of power (i.e., over- or under-treatment)
4. No set market price for health services
5. High costs and low availability of health services in crisis contexts

The CVA for health outcomes: a continuum

Multi-use cash delivered within a case management framework (i.e. targeted at POC with specific health)

Cash transfers provided in advance for specific health needs

Conditional cash transfers (i.e. cash provided after taking an action)

Vouchers for specific healthcare (i.e. obstetric care)

Value vouchers (i.e. vouchers with a financial ceiling)

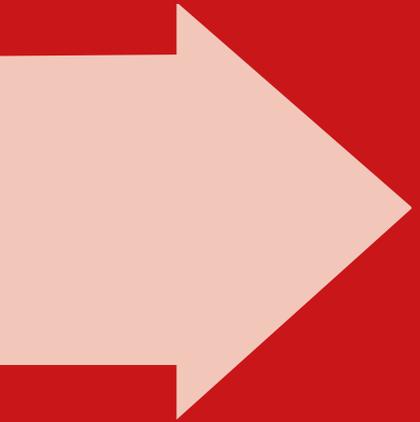
Reimbursement of specific healthcare costs for targeted beneficiaries

Summary of CVA for health interventions

A large range of CVA for health modalities:

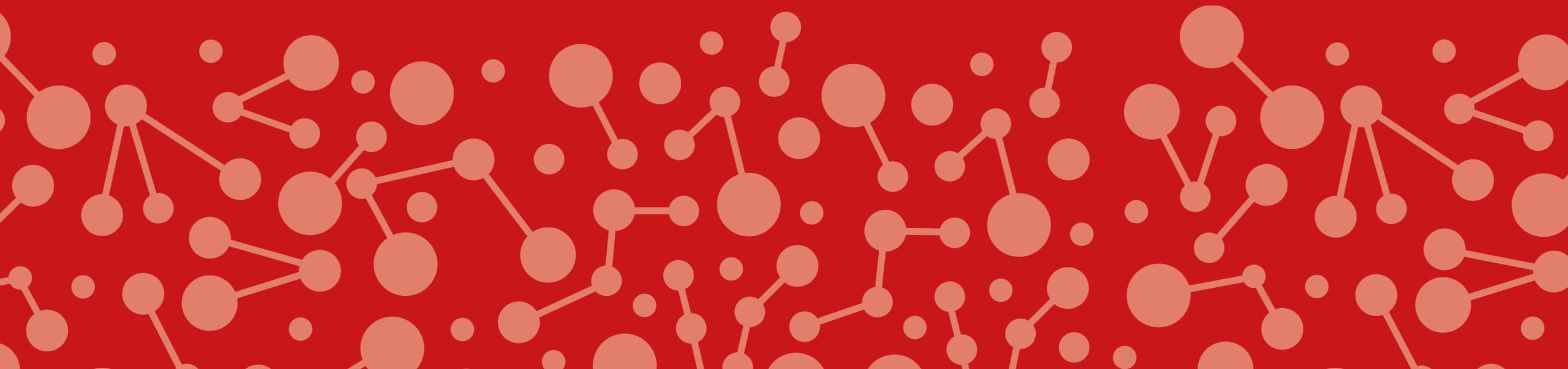
- From short pilots to multi-year, multi-donor interventions
- Many different (often hybrid) approaches to using cash, vouchers and reimbursement mechanisms

CVA for health	MENA region	Selected countries	Total
Was or is being implemented	13	7	20
In the pipeline	5	1	6
Total	18	8	26

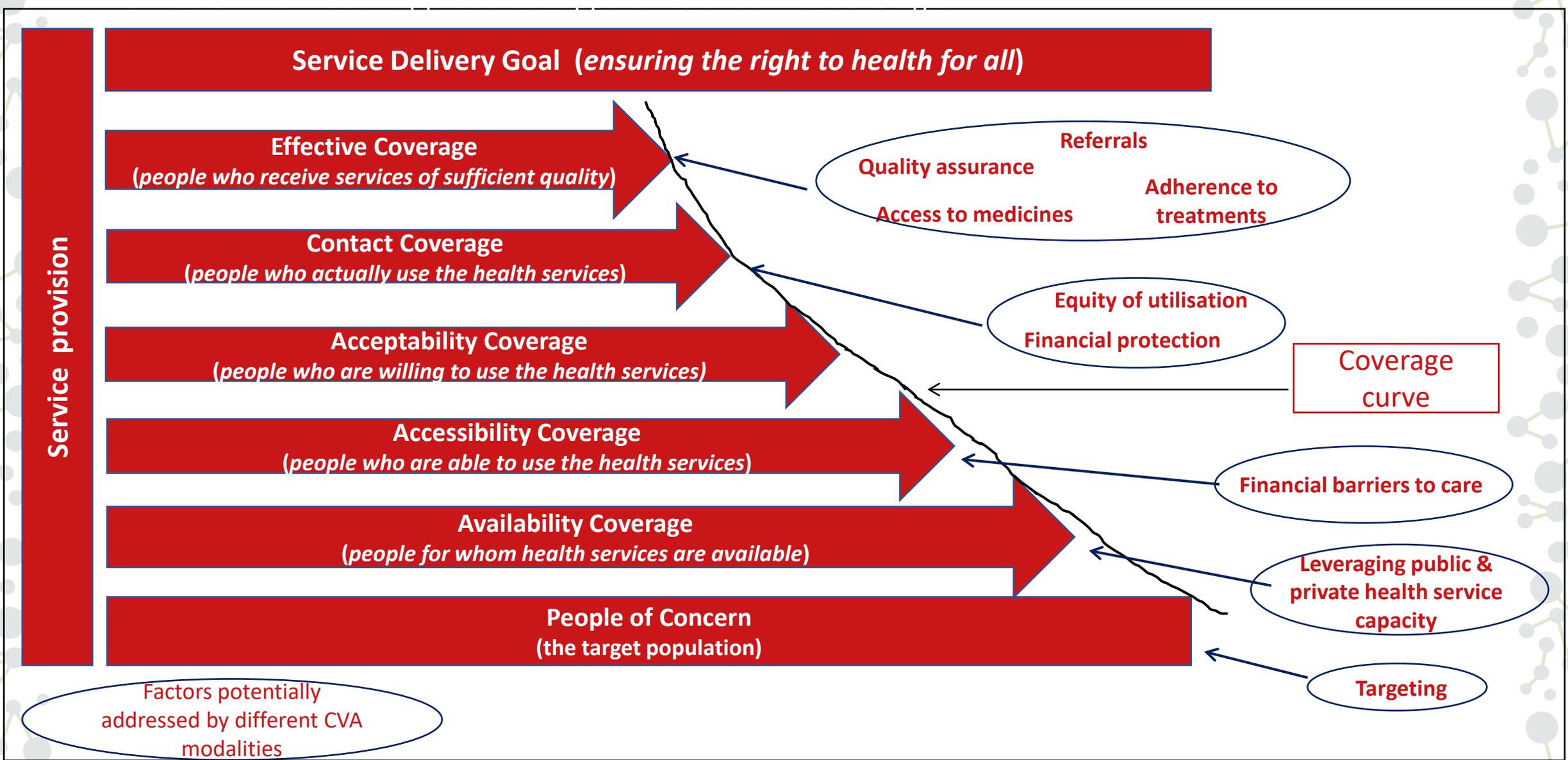
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The Conceptual Framework

Adapting the 'Tanahashi Barriers' framework

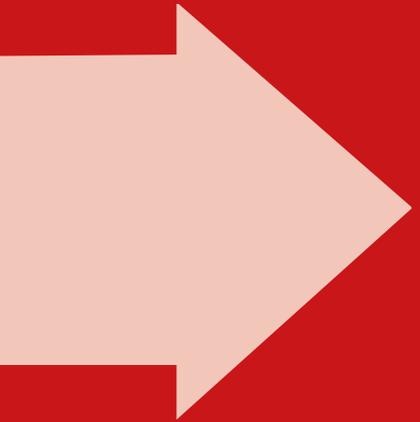
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How do CVA for health approaches support health service coverage? - Using Tanahashi framework

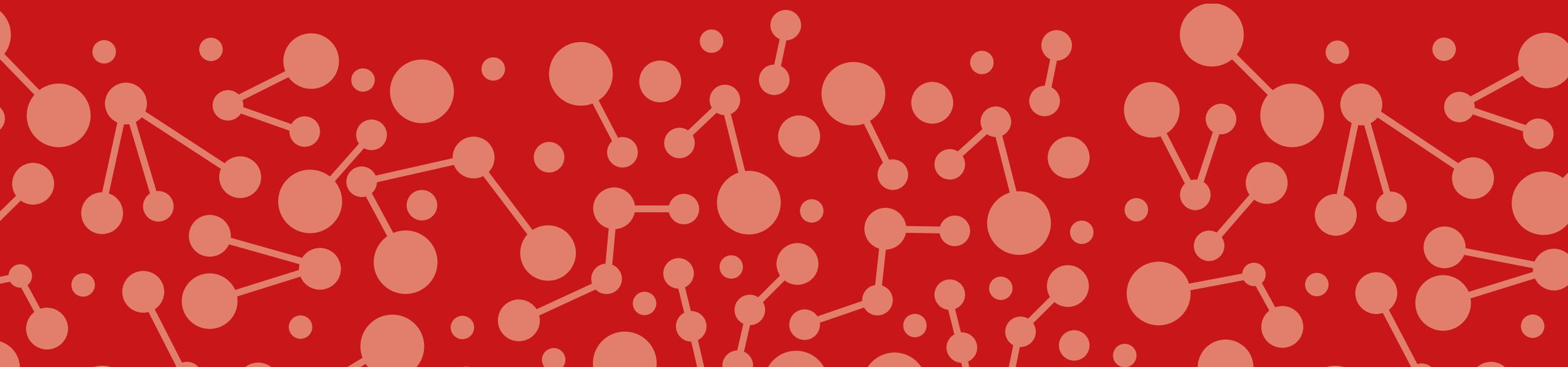


How do CVA modalities impact on barriers to health coverage

Direct & indirect costs	Potential modality	Tanahashi barriers addressed
Cost of transport and/or accommodation	Include in MPC or MPC top-up	Contact and Accessibility coverage
	Cash for transport etc. given in advance	
	Conditional Cash transfers (CCT)	
	Voucher	
Food / other indirect small costs	Include in MPC or MPC top-up	Contact and Accessibility coverage
User fees for Primary Health Care, including specific services such as SRH and GBV care and for Secondary and Tertiary care, including obstetric care	Include in MPC or MPC top-up	Effective, Contact, and Accessibility coverage
	Cash given in advance of service	Effective, Contact, and Accessibility coverage
	Conditional Cash Transfer (CCT)	Effective, Contact, and Accessibility coverage
	Payment provided after use (to POC or facility)	Effective, Contact, and Accessibility coverage
	Voucher for package of PHC services or other specific services	Effective, Contact, Acceptability, Accessibility, and Availability coverage
	Value-voucher	Effective, Contact, Acceptability, and Accessibility coverage
	Health Equity Fund	Effective, Contact, Acceptability, and Accessibility coverage
Costs of medicines; tests; other diagnostics; insecticide treated bed nets; kits for surgery; or kits for delivery etc.	Include in MPC or MPC top-up	Accessibility, and Contact coverage
	Cash given in advance	Accessibility, and Contact coverage
	Cash given after obtaining the goods	Accessibility, and Contact coverage
	Voucher for goods/services	Effective, Contact, Acceptability, Accessibility, and Availability coverage
	Value-voucher	Effective, Contact, Acceptability, Accessibility, and Availability coverage



CVA for health modalities explained

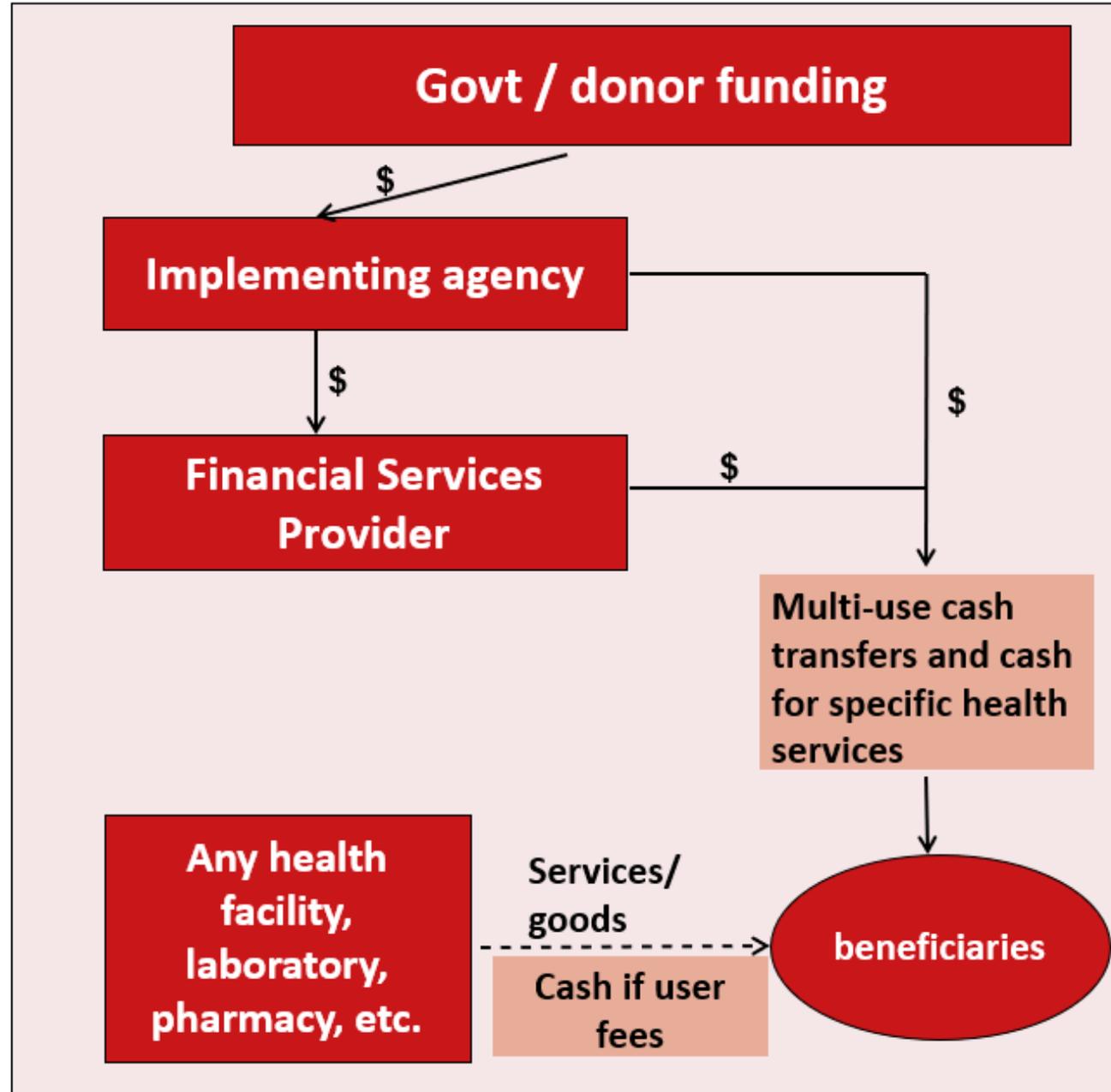


Unconditional cash transfers

Study identified two types:

- multi-use cash targeted at persons with specific health needs i.e. to ensure full recovery after major surgery (cash facilitates rest, transport for follow up care etc.)
- cash for specific health services (i.e. obstetric care or a life-saving treatment)

Figure 3: Unconditional cash transfers



Example of multi-use cash in North-East Syria



- The pilot is implemented by Humanity & Inclusion and Mercy Corps
- The cash is given to persons in need of rehabilitation services:
 - to pay for costs related to rehabilitation care
 - this helps people to complete the care they need, to take the required rest, and can prevent permanent or more severe disability
 - the multi-use cash may also be used for other costs such as food or debt repayment

Example of cash in advance for specific health needs

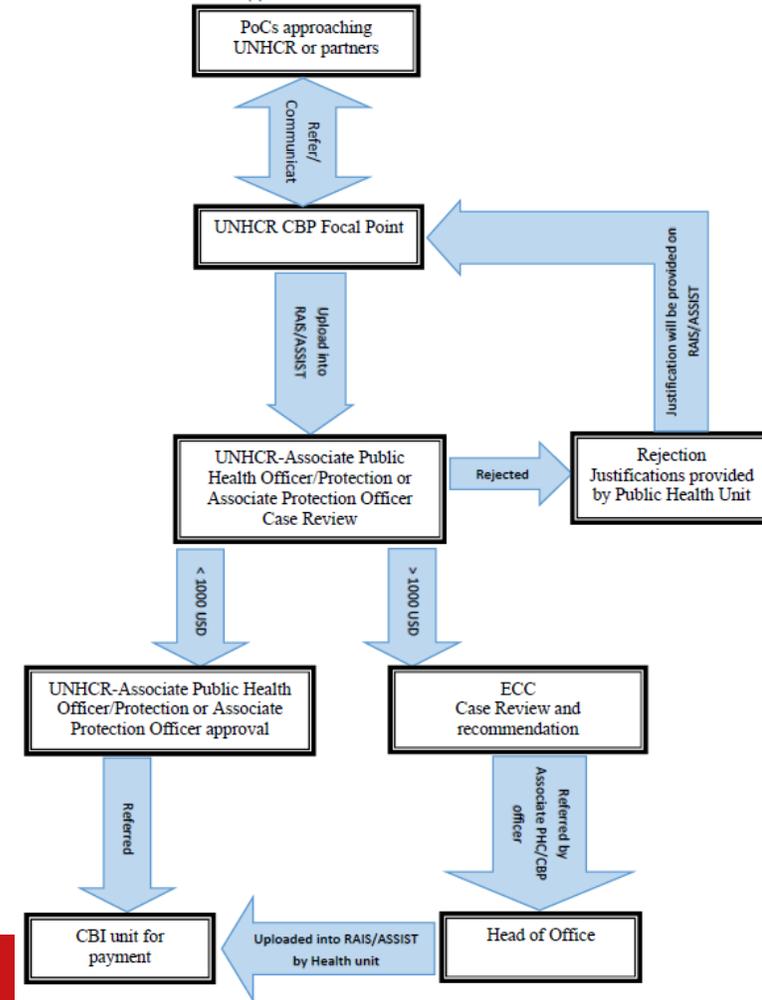
- The project Emergency Medical Cash Assistance (EMCA) in Irak is a good example where cash is provided in advance
- Even though persons of concern in Irak have free access to public health services, there can be costs
- This is because some treatments / interventions are not available in the public system, but can be obtained in the semi-private or private facilities at a certain fee
- In case of need for a life-saving treatment (i.e. blood transfusion, appendectomy) the project covers the fees of these health facilities.
- The project has developed SOPs which also ensure referral to health facilities of sufficient quality of care



Standard Operating Procedures

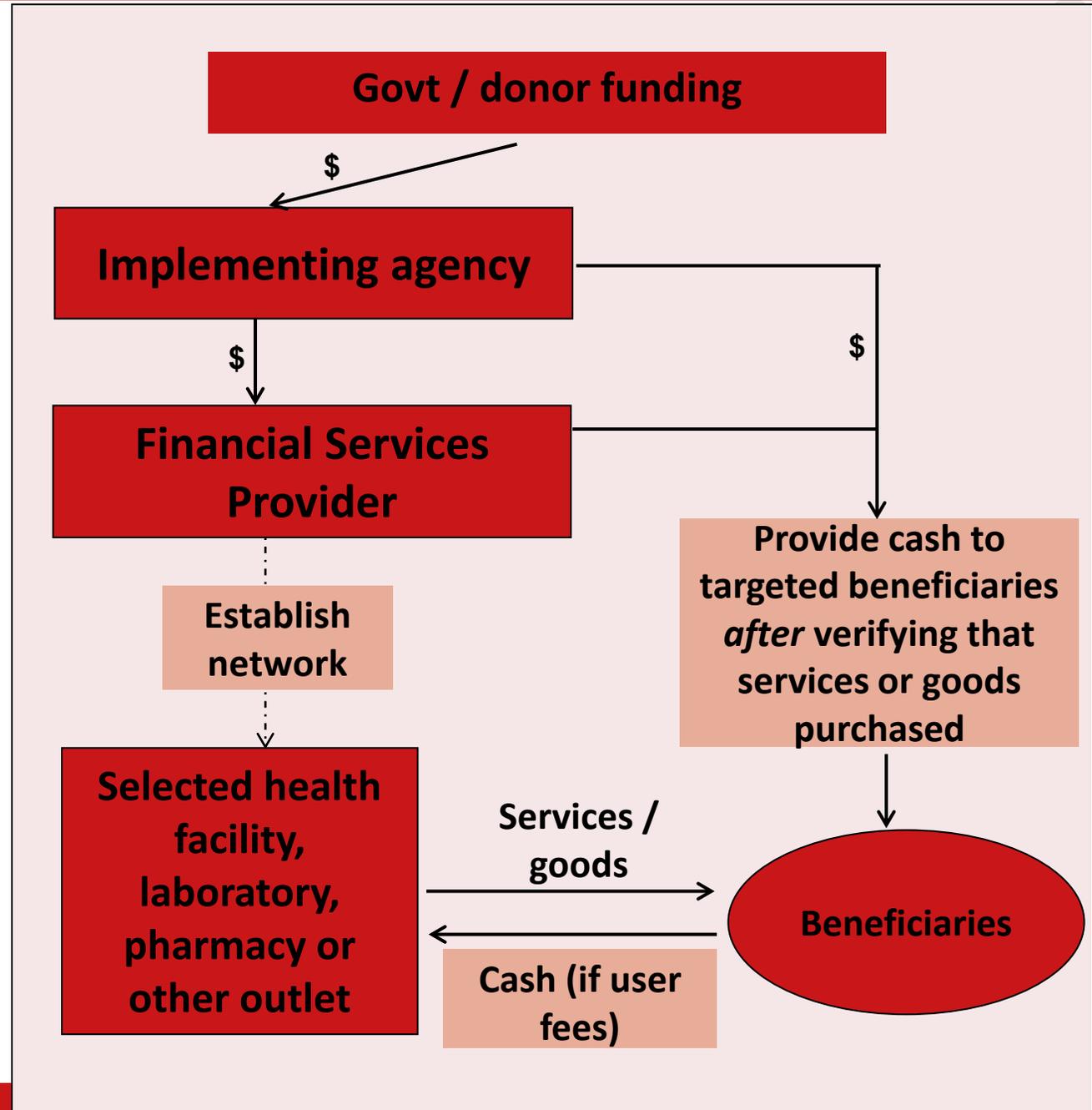
Emergency Medical Cash Assistance (EMCA) for Persons of Concern to UNHCR in Iraq

ANNEX A: Flow Chart Case Approval:



Conditional Cash Transfers

- Cash paid to a beneficiary after a certain action is taken
- Often linked with services that are provided for free
- Incentivises positive behaviour change (i.e. antenatal care visits, immunisation)
- The beneficiary needs to pay upfront which can be challenging for poor
- CCTs are relatively simple to set up, and can be combined with existing systems for MPC



Example of CCTs for Syrian refugees with diabetes in Jordan

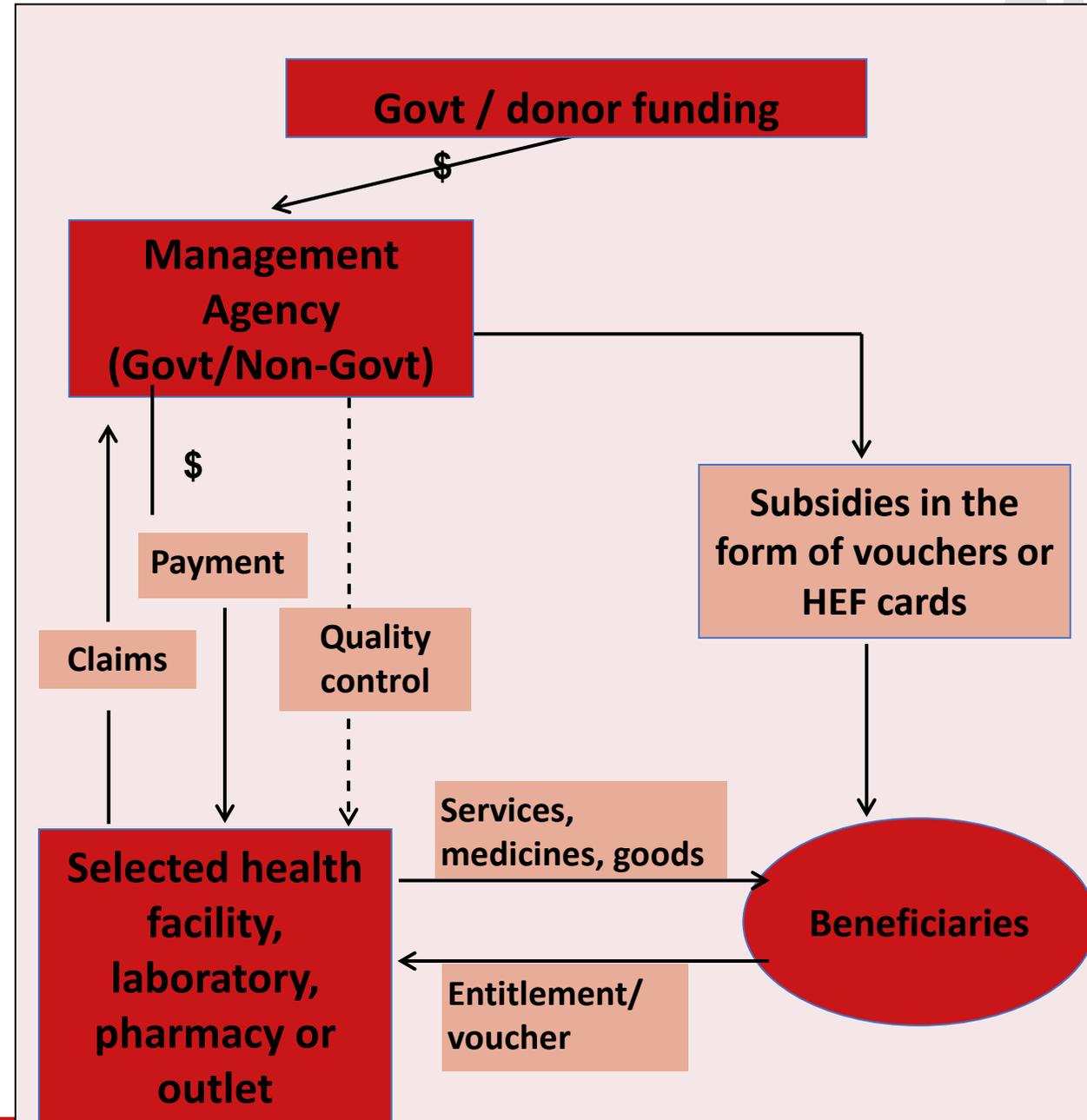


A Syrian refugee shows medications routinely taken for chronic diseases during a home visit.

- Since 2014 the costs of user fees for health care has been increasing for refugees in Jordan – this also resulted in lower use of diabetes care
- A pilot study in 2019/2020 investigated if CCTs were able to motivate refugees to access diabetes care. Three groups were formed: CCT alone; CCT and education; MPC.
- Results show that CCTs did improve the use of diabetes care, especially when combined with health education and the result was much better than when MPC was given.

Vouchers, value-vouchers and health equity funds (HEF)

- These modalities also strengthen the supply of services:
 - Quality and readiness to serve
- Vouchers can be used for:
 - A specific service
 - Package of services
 - Goods such as medicines
 - Indirect costs such as transport
- Value vouchers have in general a larger package, but value is capped
- HEF are basically like a large voucher, targeting is slightly different



Vouchers for safe motherhood and family planning in Yemen

- The vouchers address high maternal mortality due to low awareness and costs (transport and cost of services)
- Developed before onset of conflict – continued with some interruptions
- Authorities consider the vouchers useful as they ‘bring money where the services are provided’
- Currently it is planned to expand to six governorates, targeting IDPs, and poor populations



Voucher for drugs/consumables in Ukraine

- Drugs/consumables are free in public health facilities but often these are not available
- Vouchers developed to buy these drugs and consumables at private pharmacies
- Different packages:
 - Medicines for pregnant women; for lactating women; and for children <5;
 - Kits for normal delivery; for CS, for surgery trauma adults; for surgery trauma for children
 - Maximum costs were capped
- Scheme has been active since 2015



Value vouchers used in Chad



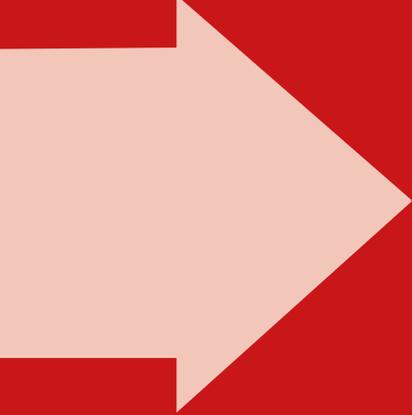
- Data showed that 15% of HIV patients in the POC did not complete their treatment
- Reason was lack of money to pay for costs
- Wallet 1: cash for transport (cash from hawala agents available when arriving at health centre);
- Wallet 2: value-based voucher to pay for services not free at the health facility (some medicines, tests and consultations)
- One-year pilot worked well, plans to continue and scale if funding is available



Example of a Health Equity Fund (HEF) in Lebanon

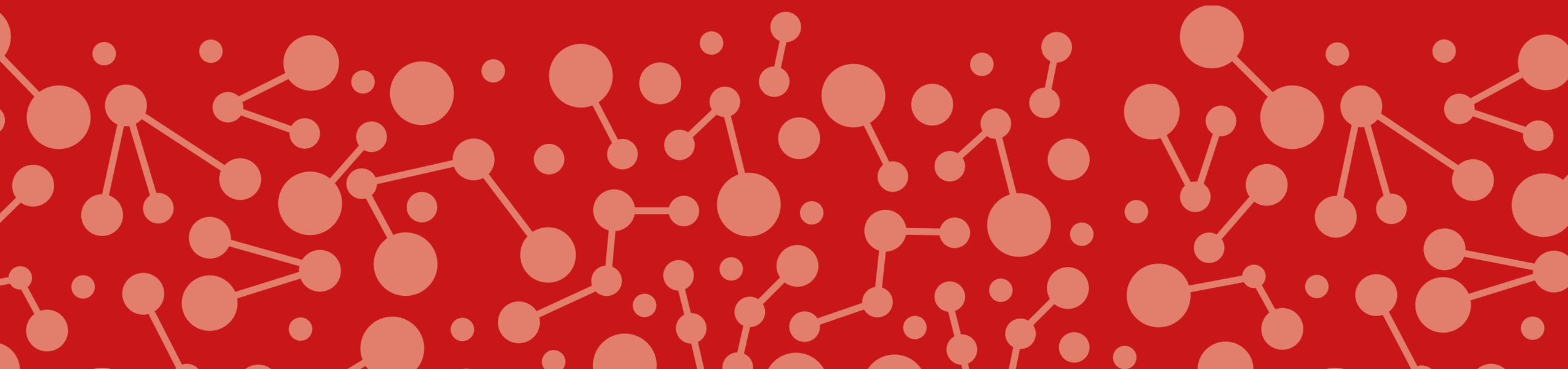
- In 2016 the MOH requested to support the MOH network with NGO/private clinics
- Relief International decided to support 8 primary healthcare facilities by subsidizing a package of health care on a case-by-case basis for everybody living in the catchment area
- RI choose for this modality as they felt that paying for performance would produce better results.
- When necessary, RI also supports the facility with supplies and staff to ensure quality of care.





Findings from the study

A summary of key findings





What we found – cash for health (1)

Most often used to pay for small expenditure items (half of the countries in the study), often as part of a wider package of CVA for health support (i.e., Jordan, Lebanon and Yemen)

Also used to pay for health services at secondary and tertiary care facilities (i.e., for Syrian refugees in Jordan)

Sometimes used to enhance effectiveness of care through enabling access to out of stock medicines and tests, or where these are only available in the private sector (i.e., Ukraine)

Hybrid approaches were found where cash is used to cover both direct and indirect costs of accessing healthcare (i.e., Jordan, Lebanon)

Cash is most often provided *before* the health service, sometimes afterwards (i.e., Jordan), and sometimes both before and afterwards (i.e., Egypt)

Cash may be paid in instalments as treatment progresses (i.e. ANC and delivery)



What we found – cash for health (2)

Multiple MPC top-ups are a feasible modality where costs for transport and accommodation are predictable, regular and low

One-off MPC top-ups can be used to channel cash for life-saving healthcare (i.e., Iran).

Targeting may be more challenging because individuals with specific health needs may live in households not in receipt of MPC

Cash for higher-cost health services (i.e., hospital level) requires a case management approach - logistically more complex

Ensuring that POC use health facilities of sufficient quality requires strong linkages with health sector programmes

This directs them to health services supported as part of the humanitarian effort or are known to deliver high-quality of care.



What we found – vouchers for health (1)

- Are less common in the humanitarian sector (6 voucher interventions identified - Burkina Faso, Chad, Ukraine and Yemen)
- Are more suitable for protracted emergency situations (unless already operating on the ground and can be adapted to the emerging crisis)
- Can have an important impact on health-seeking behaviour, helping to increase effective use of essential services (i.e., SRH services or preventive health services)
- Also work well to link internally displaced persons to hospital care for clearly defined services (i.e. Syria)
- Are better-suited to higher-value services

What we found – vouchers for health (2)

Experience from development contexts shows that voucher programmes can build health sector capacities in health financing and health insurance developing expertise in:

- Targeting
- Contracting
- Purchasing of services
- Payments and reimbursements,
- Quality and fraud control
- Monitoring and evaluation



Coordination: different perspectives have been an important barrier to better coordination in the past

Differences between MPC and CVA for health

CVA for health	Multi-purpose cash
Focus on the individual case	Focus on the household
Specific case-based costs	Average costs
Unpredictable costs which may be high and risk catastrophic expenditure	Predictable, standardised transfers with emphasis on speed and scale of delivery
Beneficiaries are directed to good enough quality healthcare services	Recipients have choices over what to buy and where to buy from, based on market mechanisms
Health actors worry that cash promotes a culture of user fees, does not direct POC to services of sufficient quality and does not prevent catastrophic healthcare costs	Humanitarian cash actors worry that CVA for health is not sufficiently integrated and multisectoral, and does not respect the dignity and rights of the individual



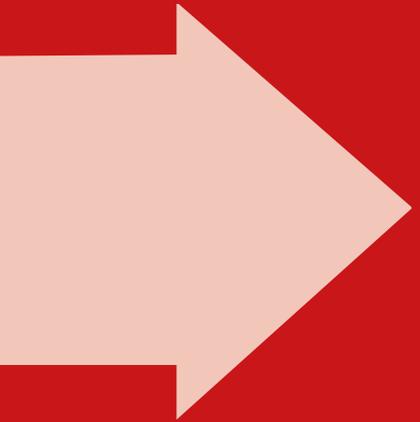
Coordination

Opportunities

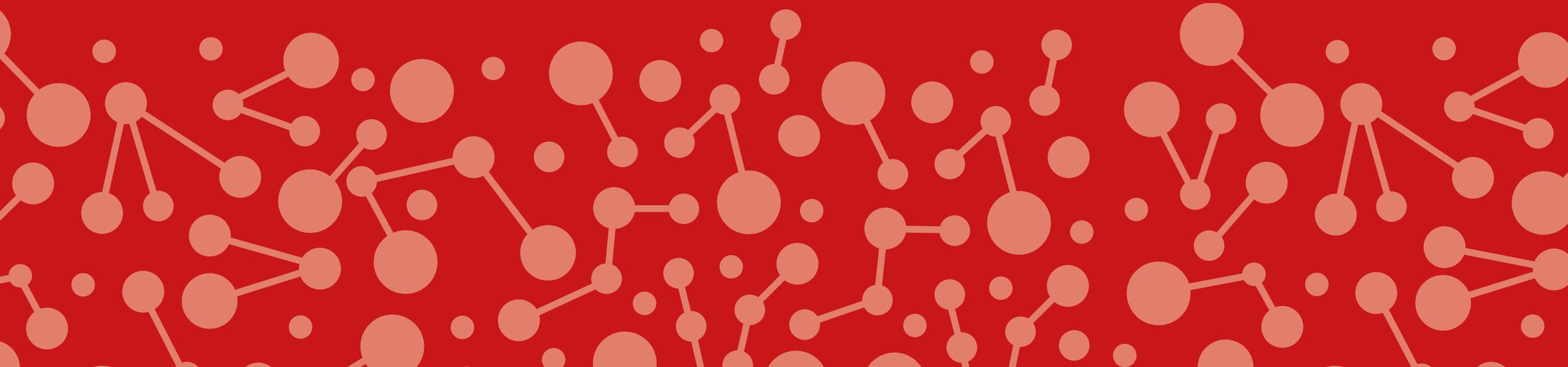
- Widespread agreement on the need for strengthened coordination between health and other clusters (particularly cash and social protection)
- Recognition that CVA for health is important (i.e. data from PDM surveys)
- Some good examples of cross-cluster coordination – but it's not the norm
- Technical assistance (TA), training and orientation could foster better coordination

Challenges

- Good mechanisms for coordination at global level but lack of functioning coordination platforms at national/country level (role of the CWGs)
- Lack of technical knowledge about CVA for health among cash practitioners and lack of knowledge of cash and MPC among health practitioners

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Conclusions and recommendations



Conclusions (1)

CVA for health is taking off in the MENA region and in other humanitarian contexts

- The pipeline is growing and evidence of a willingness to innovate
- Too early to identify best practices but successful interventions are already being scaled up to new services and geographies

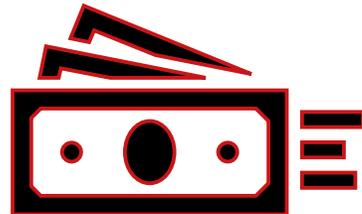
No single default CVA for health modality for addressing specific health needs and financial barriers

- Choice of modality is highly dependent on context:
 - Health system characteristics and health financing policies
 - Barriers to healthcare found in each specific context
- A need to reconsider and adjust modalities over time - the choice of the modality may need to evolve as characteristics evolve

Conclusions (2)

But - the study finds that some CVA modalities are better suited to specific humanitarian contexts than others

Cash transfers...



- Are generally easier to set up (systems may already be established)
- Are logistically easy and simply to control
- But where cash is provided *before* services, additional programmatic interventions required to mitigate potential risks:
 - Support appropriate health-seeking behaviour
 - ensure treatments provided according to agreed standards of care

Vouchers...

A voucher form for a health service. The form is titled 'الخدمة المقدمة: ولادة طبيعية' (Service provided: Natural birth) and 'الخدمة المقدمة: ولادة طبيعية في المنزل' (Service provided: Natural birth at home). It includes fields for 'رقم البطاقة:' (Card number), 'اسم المستفيد:' (Beneficiary name), 'اسم المرفق:' (Clinic name), 'المحافظة:' (Governorate), 'المديرية:' (District), 'اسم وتوقيع مقدم الخدمة:' (Name and signature of service provider), 'تاريخ الحصول على الخدمة:' (Date of service), and 'توقيع أو بصمة المستفيد:' (Signature or fingerprint of beneficiary). There are two QR codes and the number '10-10-1005' on the form. The text at the bottom reads: 'كل ولادة معزضة لحدوث مخاطر لهذا يفضل ولادة المرأة في المرفق الصحي لتجنب أية مخاطر قد تحدث لها أثناء الولادة.' (Every assisted birth carries risks, therefore it is preferred for the woman to give birth in the health facility to avoid any risks that may occur during childbirth.)

Take time to establish and set up. Once established, they can:

- be scaled to other health conditions and to other geographical areas
- provide a conduit for channelling additional benefits to POC (i.e. cash)
- continue to channel health-related benefits to POC during - and after - transitions from humanitarian to development contexts and vice versa

Conclusions (3)

Widespread agreement that CVA for health 'adds value' to supply-side health interventions

This has been achieved through:

- strengthening and making use of existing adequate referral systems
- the conditionality of the CVA which directs POC to selected health facilities, other health outlets, or specific transporters
- accompanying the CVA with intensive health promotion activities and IEC at the community level to explain the importance of accessing care
- strong linkages between the POC and the health services (i.e. selecting facilities that are already well known to the POC)
- Verification and monitoring systems to deter fraud



Recommendations (1)

Recommendations are divided into three broad categories:

I. Technical assistance, training, orientation

- Develop training materials
- Review and strengthen decision tools
- Provide on-site/country level hands-on training in CVA for health
- Develop group of technical specialists in CVA for health and deploy to regions/countries

Recommendations (2)

II. Funding

- Provide orientation to donors on (successful) CVA for health outcomes
- Support country teams to access funding for developed concepts

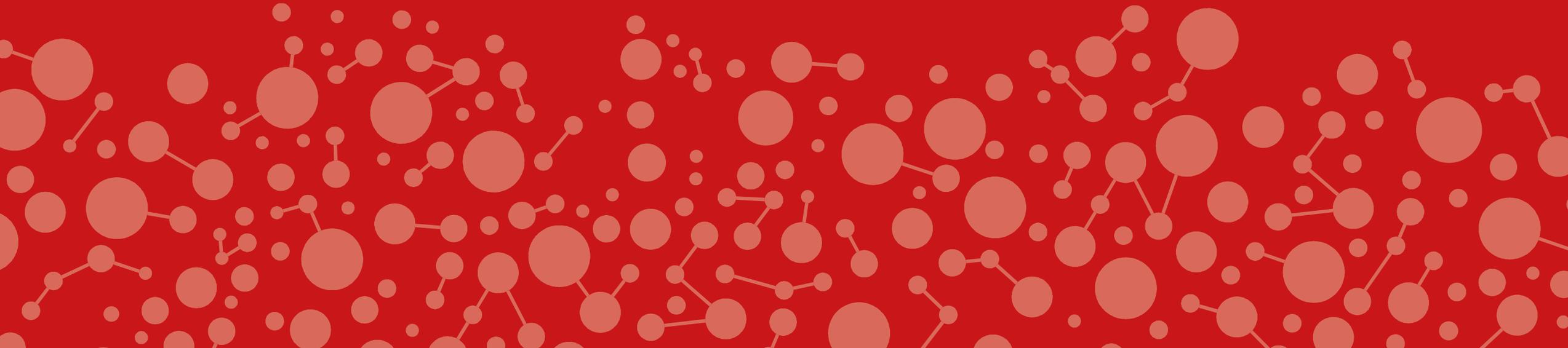
III. Coordination

- Develop more effective coordination platforms at country level
- Leverage the skills and knowledge of CWG members
- Improve mechanisms (make more systematic) for identifying POC with health needs

www.calpnetwork.org

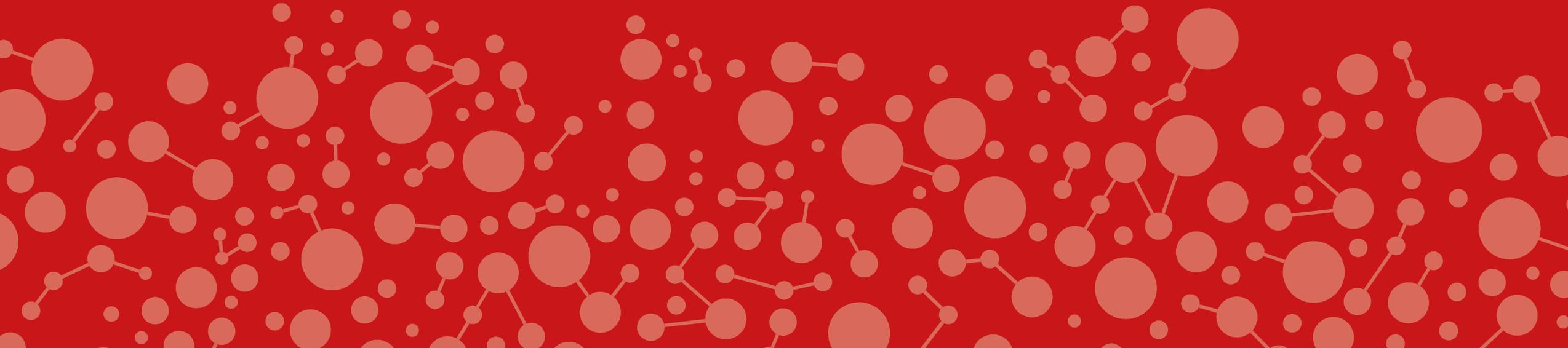


THANK YOU



ANY QUESTIONS?

Questions and Answers



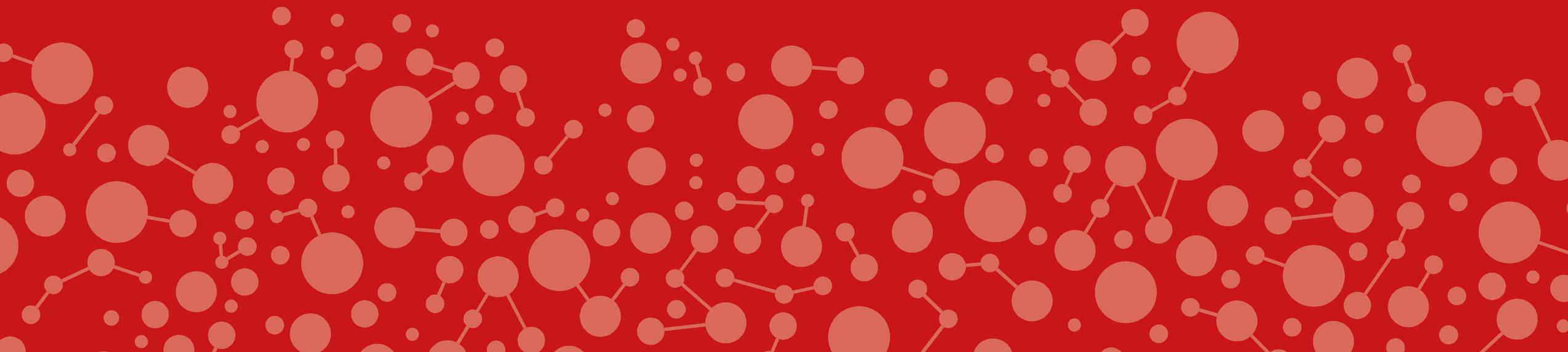
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