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A 'Stocktake' of CVA for Health Outcomes in the MENA Region

Moving from Evidence to Practice

CaLP
The Cash Learning Partnership

Auswärtiges Amt

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[1] Cash Research and Learning Network in Lebanon.

Cover photo: A mother in Yemen who has participated in the Yemen Safe Motherhood Voucher Scheme implemented by Yamaan Foundation in Lahj Governorate in Yemen. Taken by Mohammed al Hamid, 2018.

CVA for Health Outcomes in the MENA Region

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Table of abbreviations

ANC	Antenatal care
CaLP	Cash Learning Partnership
CCT	Conditional cash transfer
CEmONC	Comprehensive emergency obstetric and neonatal care
CHW	Community health worker
CVA	Cash and Voucher Assistance
CWG	Cash Working Group
FP	Family planning
GBV	Gender-based violence
GHC	Global Health Cluster
HEF	Health equity fund
HI	Humanity & Inclusion
ICRC	International Committee of the Red Cross
IEC	Information, education and communication
KII	Key informant interview
MCH	Maternal child health
MENA	Middle East and North Africa
MHPSS	Mental health and psychosocial support
MPC	Multipurpose cash
NCD	Non-communicable disease
OPT	Occupied Palestinian Territories
PNC	Postnatal care
POC	Persons of concern
RH	Reproductive health
SGBV	Survivors of gender-based violence
SOP	Standard operating procedure
SRH	Sexual and reproductive health
SRHiE	Sexual and reproductive health in emergencies
TA	Technical assistance
UCT	Unconditional cash transfer
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

Health is inherently complex, and health needs are unpredictable and can lead to high levels of expenditure. Without support, information asymmetries make it difficult for vulnerable people in humanitarian contexts to access the quality healthcare they need. It is increasingly clear from the results of post-distribution monitoring and other surveys that people in receipt of multipurpose cash (MPC) repeatedly spend a proportion of the cash on accessing healthcare, in proportions which vary greatly between contexts, but which may be as high as 60 percent of the transfer.

With effective targeting, Cash and Voucher Assistance (CVA) for health interventions can reach persons of concern (POC) in humanitarian contexts and protect them from catastrophic healthcare costs, reduce financial barriers and enable access to healthcare of sufficient quality.

It is clear that interest in CVA for health is growing, both in the Middle East and North Africa (MENA) region and beyond. This report, commissioned by the Cash Learning Partnership (CaLP) with funding from the German Federal Foreign Office (GFFO), sets out the findings from a 'stocktake' (rapid operational research study) of CVA for health outcomes in the MENA region,[2] and is part of a broader process of documenting and disseminating learning on CVA programming for health.

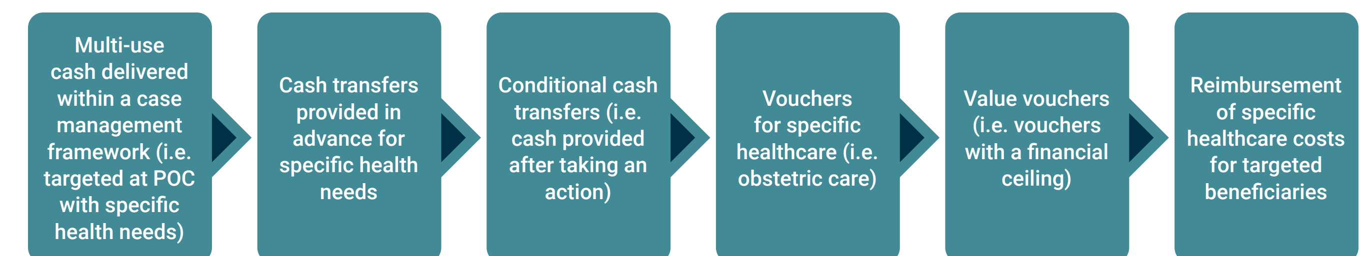
What is CVA for health? The study identified 20 CVA for health interventions, including 13 from the MENA region and 7 in fragile and conflict-affected settings in non-MENA countries judged to be highly relevant to the analysis.[3] Six projects which are still at the design or concept stage were also included, giving a total sample size of 26 interventions.

Three questions were used to identify the CVA modalities that can be considered 'CVA for health':

- 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?

A potential definition for CVA for health, for discussion by CVA stakeholders, would be 'CVA that is linked to a particular beneficiary or beneficiaries in need of specific healthcare, and which addresses the barriers which they encounter when accessing that care, while incentivising service use and adherence to treatment'.

Figure 1: The CVA for health outcomes continuum



[2] Examples are drawn from Egypt, Iraq, Jordan, Lebanon, Syria and Yemen.
[3] These examples are drawn from Afghanistan, Burkina Faso, Chad, Iran, Somalia and Ukraine.

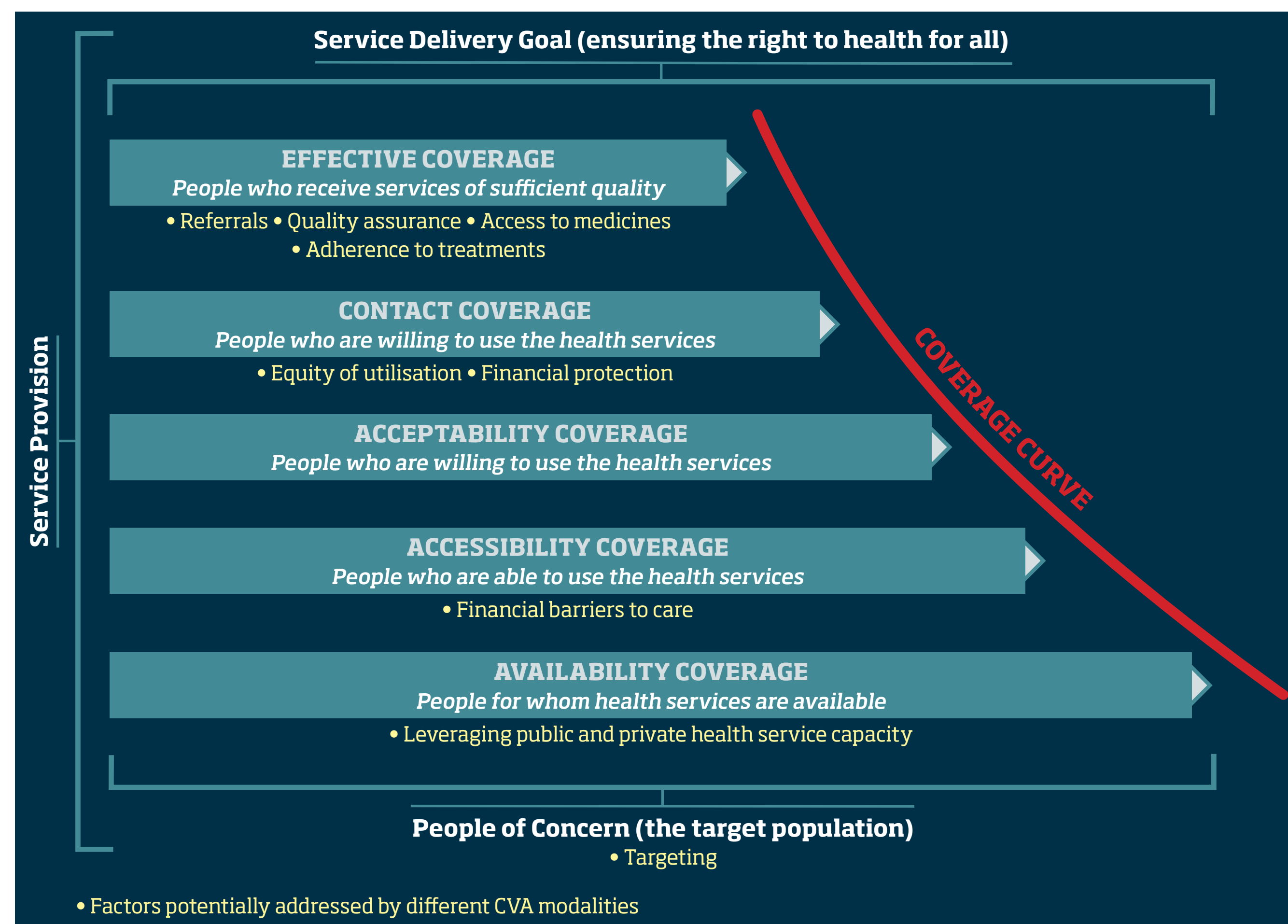
The CVA modalities identified can be situated along a 'continuum' of CVA for health interventions (Figure 1), with unconditional (multi-use) cash assistance at one end of the spectrum targeting those with defined health needs, and direct reimbursements to pre-selected health facilities for health services used by a defined target group at the other end. In the middle of this continuum lie the conditional cash and voucher programmes that directly link services used by individual patients to payments. As the continuum moves from the left-hand side, approaches generally become more resource intensive and complex in their design and implementation. Balanced against rising operational complexity and resource needs, the approaches on the right-hand side are particularly well suited to reaching specific groups of vulnerable POC and enabling them to address barriers to accessing needed health services.

It is worth noting that many CVA for health interventions are hybrid approaches (i.e. cash transfers with vouchers) and many do not fall into clear 'modality categories' because their design is purposefully flexible to enable them to respond to the (often changing) context.

Framework of Analysis: The sample was analysed using an adapted Tanahashi framework (Figure 2) which looks specifically at the ways in which the different modalities address barriers to accessing health services. Table 4 in the main report includes a summary of this analysis, while Table 5 in Annex 1 provides a more detailed analysis.

Findings and recommendations: The report describes each of the different CVA modalities: unconditional and conditional cash transfers, vouchers for health services, value-vouchers and health equity funds

Figure 2: How do CVA for health approaches support health service coverage?



(Section 3). Using the adapted framework, the report presents an analysis of how the CVA for health interventions in the study impact on barriers to effective health service coverage, highlighting the strengths and challenges of each modality (Section 4). It is important to note that there is no single 'default' CVA modality for addressing health needs and financial barriers in a specific type of humanitarian situation; the choice of the modality depends on the health system characteristics and barriers found in that context.

The report looks at the extent of coordination between the health and cash clusters at country level (Section 5), mediated through the perspectives of each group, and notes a growing willingness to coordinate across sectors, as well as a clear need for technical assistance, both to strengthen collaboration and to help nascent CVA for health interventions get off the ground.

An important finding relates to the 'value-added' of CVA for health to supply-side health interventions. The analysis clearly shows that CVA for health can help to overcome market failures which prevent vulnerable people from accessing the healthcare they need, enabling them to access services of sufficient quality. In nearly all examples, the risk of the cash not being used for the intended health-related objectives was found to be negligible. Further, verification and monitoring systems deter health facilities from introducing informal 'user fees' for services that should be free at the point of delivery.

Recommendations are divided into those which relate to the **need for additional technical assistance, training and orientation** (i.e. the need to develop training materials, to improve existing decision tools for use in the design of new interventions and to provide hands-on technical assistance at the country level), **the need for funding** (i.e. to orient donors on CVA for health and to support country teams to access funding) and **the need to strengthen coordination mechanisms at country and regional levels**.

01. Introduction

This report sets out the findings from a 'stocktake' or rapid operational research study of Cash and Voucher Assistance (CVA) for health outcomes in the Middle East and North Africa (MENA) region. Countries in this study are drawn from Cash Learning Partnership's (CaLP) Tier 1 group of countries (Iraq, Jordan, Lebanon, Occupied Palestinian Territories (OPT), Syria, Turkey and Yemen) together with Egypt, given its role in hosting refugee populations in the MENA region, which is classified by CaLP as a Tier 2 country.[4] A small number of interventions were also drawn from countries outside the MENA region where these provide interesting examples. The study is part of a broader process of documenting and disseminating learning on CVA programming for health and was commissioned by the CaLP with funding from the German Federal Foreign Office (GFFO), in collaboration with UNICEF, UNHCR, WHO and the Norwegian Red Cross. The results presented here will be used as part of efforts to foster more consistent consideration of CVA for health in Humanitarian Response Plans (HRPs) as a means of reducing financial and other barriers to accessing essential health services.

1.1 Background

A Regional Expert Meeting on Cash & Voucher Assistance in Health Emergencies was held in Beirut in September 2019, which led to a formal collaboration between CaLP and the Global Health Cluster (GHC) to map, document and disseminate current practices of using CVA in the health sector, and to work out how to better support humanitarian actors in using CVA to address barriers to accessing health services. This work is guided by a joint Action Plan developed at the Beirut meeting and, to date, the collaboration has generated a number of country case studies which look at the use of CVA for health outcomes in Bangladesh, Jordan and Burkina Faso.[5] However, while these case studies make an important contribution to the evidence base, considerable gaps persist in the documentation of CVA interventions for health (i.e. World Bank 2016; Doocy & Tappis 2017).[6]

The current study was commissioned to assess the application of CVA for health outcomes on the ground in the MENA region. This region is of particular relevance because many countries either require high levels of humanitarian assistance due to escalating and long-term conflicts or are hosting large numbers of refugees, and the region has seen particularly high levels of cash programming as part of the humanitarian response.[7]

1.2 Study objectives

The overall objective of the study is to develop a light-touch stocktake and analytical synthesis of enabling factors and principal challenges for implementation that are encountered in cash for health outcomes programming for the MENA region. This objective is aligned with CaLP's expected outcome for the period 2018–2021 to strengthen the enabling environment for CVA assistance in the MENA region. The findings will be used by the regional health cluster coordination mechanisms, and by national health clusters and Cash Working Groups (CWG) to inform collaboration between them and to facilitate the integration of appropriate CVA for health outcomes in the health sector strategies of the Humanitarian Response Plans.

The study takes as its starting point the need to enable access to health services of sufficient quality for vulnerable people caught up in humanitarian situations and emergencies, often referred to as persons of concern (POC). Consequently, the study aimed to identify the different approaches that are currently being implemented or planned in the MENA region to enable access to health services for this group. Available examples were examined in terms of their added value to the provision of comprehensive healthcare and their contribution to the humanitarian response (see Section 2).

[4] CaLP's funding from the German Federal Foreign Office (GFFO), as stated in the GFFO Proposal 2018 – 2020, divides countries into Tier 1, which are focus countries due to the high level of cash programming taking place, and Tier 2 countries (Egypt, Libya, Tunisia, Ukraine and Greece), which were selected based on the diversity of contexts and the current gaps in learning from the response types.

[5] These case studies can be found on the CaLP website at: www.calpnetwork.org/cva-and-health-case-studies-from-jordan-burkina-faso-and-bangladesh/.

[6] In their systematic review, Doocy and Tappis looked at 108 research studies, only one of which had a primary focus on health, four on nutrition and two on WASH, with the majority focused on livelihoods and food security.

[7] It is anticipated that this study will feed into a longer-term project around cash for health outcomes that is being developed by the Norwegian Red Cross.

1.3 Methodology

Data collection and analysis took place between February and April 2021. The methodology comprised a review of documentation and a wide range of key informant interviews (KIIs), relying predominantly on the 'snowball' approach to identify new documents and new informants. Documents 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 technical advisers in humanitarian agencies at global, regional and country levels in the seven MENA study countries. KIIs were also conducted to gather information on a small number of highly relevant CVA for health in non-MENA countries that can provide learning for the MENA region.

The mapping exercise uncovered a wide range of different modalities in use, tailored to specific humanitarian and local contexts. 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[8] 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?

These three questions were therefore used to identify the CVA modalities which can be considered CVA for health. A potential definition, for discussion by stakeholders, would be 'CVA that is linked to a particular beneficiary or beneficiaries in need of specific healthcare, and which addresses the barriers which they encounter when accessing that care, while incentivising service use and adherence to treatment'.

Below we present an overview of the CVA for health interventions identified through the mapping exercise (Section 2), the framework of analysis used in the study and a brief explanation of the different CVA for health modalities (Section 3). Results of the analysis are presented in Section 4 and recommendations and conclusions in Section 5.

[8] While CaLP usually refers to the person in receipt of benefits as the 'recipient', the term 'beneficiary' will be used here and when discussing CVA for health to emphasise that persons using the health benefits are considered active stakeholders as opposed to being passive recipients of healthcare.

02. Mapping of CVA for health modalities

The mapping exercise of CVA for health modalities in the MENA region uncovered a total of 13 CVA interventions which met the above criteria for CVA for health across the seven countries. Table 1 presents an overview of these interventions, while more detailed information can be found in the accompanying spreadsheet.[9]

The mapping exercise was restricted by the time available for the study, the level of detail in responses from key informants and by the methodology itself, which used key informant interviews to identify further key informants and to provide additional project-related documentation such as SOPs. The list of CVA for health interventions provided in Table 1 may therefore not be an exhaustive one.

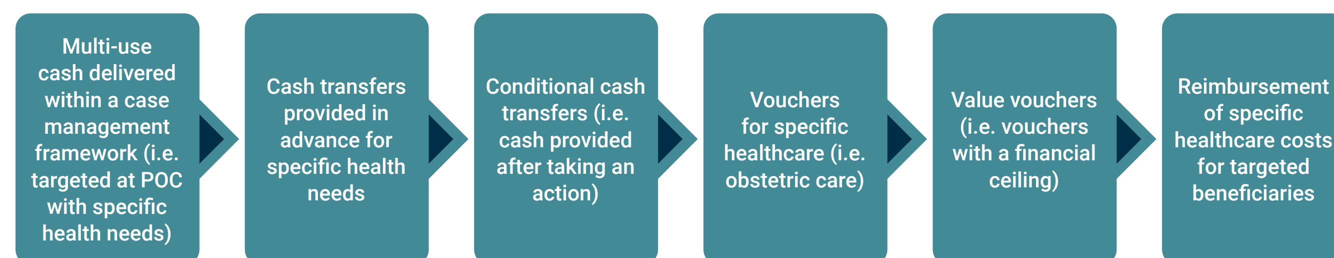
Table 1: Overview of CVA interventions for health in the MENA region

Country	Modality	Objective	Period	Organisation
Egypt	Cash for obstetric care (30 percent before and 70 percent after the service) (*Cash for Obstetric Care*)	To overcome barriers to obstetric care for POC and direct refugees to public or NGO-managed health facilities for delivery (rather than the private sector)	2017 ongoing	Caritas, in partnership with UNHCR
Iraq	Cash transfers in advance of treatment to POC (*EMCA - Emergency Medical Cash Assistance*)	To cover user fees for life-saving treatment at secondary and/or tertiary health facilities after referral. Services are quality assured.	Oct 2020-present	UNHCR
Jordan	Conditional cash transfer (CCT) to POC (pilot) (Research for *Health in Humanitarian Crises - r2hc*)	To motivate POC to access Non-Communicable Diseases (NCD) care and facilitate payment of direct and indirect costs (part of CVA research)	Late 2018-Jan 2020	MEDAIR and Research Inst.
Jordan	Cash transfers in advance of treatment to POC (in special cases to facility after service use)	To enable free access to quality assured secondary and tertiary services (incl. life-saving services) after referral. Cash is for user fees for essential care (i.e. obstetric care, high morbidity NCDs, conditions leading to disability or death).	Nov 2015-present	MEDAIR
Jordan	Cash transfers: i) in advance of treatment if costs are known (i.e. predefined); ii) after service for emergency care if costs are unknown before.	To enable free access for POC to life-saving secondary and tertiary care (quality assured). Cash pays for user fees for essential care such as obstetric care, elective cold cases, life-saving surgery, thalassemia, blood transfusion.	Nov 2015-present	UNHCR
Lebanon	Payments to hospitals for POC after treatment, unless costs predefined (<5 percent) where cash given to POC, in addition to several rounds of MPC (*ESCAPE*)	To cover the cost of treatment for POC that is not covered by UNHCR, which pays 75 percent of costs of life-saving treatment. Caritas pays 25 percent of user fees as direct reimbursement to facilities. POC receive three rounds of MPC to support recovery and complete treatment.	July 2018-June 2020	Caritas Lebanon
Lebanon	CCT in instalments for ANC, delivery, PNC and FP provided after first ANC paid for by ICRC (pilot)	To address high maternal mortality and morbidity through increasing access to SRH services. CCT designed to motivate women and cover indirect and direct costs.	End 2019 for 1 year	ICRC
Lebanon	Cash transfers in advance of the service to POC (pilot)	To gain experience with using CVA to pay for direct and indirect costs of accessing SRH services. Women could choose if and where to use SRH services. However, before receiving cash women received information, education and communication (IEC).	Sept-Dec 2020	CARE
Lebanon	HEF linked to 8 PHC facilities belonging to network set up by MOH and RI support facilities to ensure quality.	To provide free PHC services to all people living in catchment of PHC facility. RI pays services directly to facility for each beneficiary who made use of PHC (based on outputs).	2016-present	Relief International (RI)
Syria	Vouchers for maternal health services. Vouchers for hygiene items complementary to WFP food vouchers, and as an additional entry point for SRH and GBV service information.	To increase the use of maternal health services which was low due to costs, cultural/social issues, and security. Public and private hospitals were quality assured. Voucher credited with helping to maintain health system and sustain demand.	2012-present	UNFPA
Syria (NES)	Multi-use cash for those in need of disability treatment services (pilot) (*Inclusive MPC - formerly called Cash for Health*)	To support POC financially so they can complete disability treatment, ensuring effectiveness and preventing permanent or more severe disability. The cash may be used for indirect costs of disability care. Services provided by Humanity Inclusion (HI).	2018-present	Humanity & Inclusion; Mercy Corps
Yemen	Vouchers for safe motherhood and family planning - (*Reproductive Health (RH) vouchers*)	To reduce mortality due to lack of awareness about the relevance of SRH services, compounded by the costs of accessing these services (transport and cost of services).	2012-present	Yamaan (Marie Stopes)
Yemen	Vouchers for transport to CEmONC, plus cash to POC after referral for i) indirect costs of fistula care; and ii) direct/indirect costs of accessing GBV services.	To enhance access to SRHiE services, including GBV services. Cost of transport is an important barrier, especially to access specialised care. Cash can pay for GBV services in areas where UNFPA has no GBV services established.	2019-present	UNFPA

Notes: i) where the intervention is identified by a specific project name, this is included under 'modality' in italics; ii) No examples of CVA for health outcomes were identified in either Turkey or OPT, either in the literature or through KIIs in both countries (cash and health coordinators). All abbreviations can be found in the table of abbreviations.

[9] Please see this link for a copy of the Excel datasheet. www.calpnetwork.org/publication/cva-for-health-examples-2021

Figure 1: The CVA for health outcomes continuum



2.1 A continuum of CVA for health outcomes

These interventions can be seen as sitting on a continuum from multi-use cash assistance targeted specifically to those with a defined health need at one end of the spectrum, to reimbursements for health services directly to the health facilities on behalf of the target group at the other end (see Figure 1).[10] For example, on the far left of the continuum, a project in North-East Syria identifies vulnerable people with disabilities attending a health facility, who are then listed to receive cash transfers, which they urgently need to be able to access their follow-up care. Without this cash, it is highly likely that the POC would not be able to access the care they need for the management of their disability (i.e. rehabilitative treatment, medicines, transport to/from a facility, and so on), leading to less effective care and risking more permanent disability. Hence, this type of cash transfer is directed at people with specific health needs, who otherwise would not be able to adhere to, or finalise, their medical treatment, but it may also be used to address other needs (i.e. debt repayments or food).

In the middle of the continuum lie the cash or voucher programmes that are specific to the health sector, linked to the expenditures of individual patients when they use a service. Cash and vouchers (service vouchers or value-vouchers)[11] are distributed to beneficiaries to pay for or exchange for the indirect costs related to accessing healthcare or for the direct costs of healthcare. Note that cash transfers can be provided in advance of the action or after it has been accomplished (i.e. a taxi journey to a health facility or paying for medicines at a facility or pharmacy). When cash is distributed in advance and is targeted to enable POC to access the healthcare they need (i.e. giving birth at a health facility), beneficiaries have the freedom to use this cash according to their own priorities. However, most projects implement activities which closely link the beneficiary to the health services, monitor or verify that these services were actually used, and may adapt the design where the cash is not being used for the intended purpose (i.e. to access a health service) (see Sections 3 and 4).

At the far right of the continuum presented in Figure 1 are those interventions which effectively purchase specific health services on behalf of the POC by reimbursing the health facility for each health service utilised by a beneficiary. Provided the targeting is effective, these are equitable and non-regressive approaches for financing health services in support of Universal Health Coverage. Health facilities are only paid when a pre-identified beneficiary uses the defined health services from preselected qualified providers at an agreed price. For example, in Lebanon, selected primary healthcare facilities are reimbursed for the fees related to health services taken up by a POC belonging to a defined catchment population. This is done in addition to strengthening the quality of service delivery. In summary, this CVA for health addresses barriers to health service use (the service fees), is specifically tied to the beneficiary, and is linked to the actual healthcare needs of this beneficiary.

[10] We use the term 'multi-use cash' as these types of transfer can take different forms: a top-up to an existing MPC or new unconditional cash transfer to POC in need of defined care (i.e. NCD treatment). See also Figure 3

[11] See Section 2.3 for a description of the different CVA approaches.

2.2 CVA for health in selected non-MENA countries

The study also encompassed a small number of highly relevant CVA for health interventions in fragile and conflict-affected settings in both MENA and non-MENA countries, including Afghanistan, Burkina Faso, Chad, Iran, Somalia and Ukraine. These interventions, in countries that were not part of the original study, were chosen to provide rich examples of different CVA for health modalities which demonstrate feasible and interesting approaches. This includes interesting hybrid interventions combining more than one CVA modality.

For example, the 'dual wallet' modality in Chad[12] (see Box 4) provides a multipurpose cash transfer and a dual wallet on a smart card; this dual approach provides both cash for transport and a value-based voucher that pays for medical consultations, tests and medicines at designated health facilities. In Burkina Faso, the target group receives cash for food and a voucher for emergency medical care that is not included in the government's policy of free health services (the *gratuité*). In Ukraine, vouchers provide access to medication at a network of quality assured private pharmacies for pregnant and lactating women, children under five years of age, and people in need of urgent hospital care for medicines and consumables for surgery not available in the public sector.

Table 2: Overview of CVA interventions for health in selected non-MENA countries

Country	Modality	Objective	Period	Agency
Ukraine	Vouchers for medicines and consumables used during surgery	To enable access to medicines and consumables for MCH care and emergency surgery at private pharmacies that are not available at public health facilities	2015-present	Premiere Urgence Intl (PUI)
Afghanistan	One-off CCT after institutional delivery	To increase demand for institutional deliveries (and improve maternal and neonatal health outcomes by reducing financial barriers)	2016-2017 1-yr pilot	UNICEF
Afghanistan	CCTs for i) institutional delivery; ii) services at therapeutic feeding centre; iii) MHPSS	To facilitate access to MCH and mental health and psychosocial support (MHPSS) services, and motivate POC to access priority, under-utilised health services	2018-2021	PUI
Burkina Faso	Vouchers for life-saving healthcare services, together with vouchers for food	To enable access for vulnerable POC to life-saving care not included in the package of free services provided by government, i.e. severe malaria, emergency surgery, GBVR services.	45 days in Nov/Dec 2019	WHO IEDA Relief
Chad	Value-vouchers for HIV treatment and cash for indirect costs (transport & food)	To ensure HIV patients complete treatment by providing cash for indirect costs (i.e. transport and food), and vouchers for those services that are not free at the health centre.	April 2019 to March 2020	IRC
Iran	One-off Cash for Specific Needs (CSN)	To enhance protection of vulnerable Afghans in urban areas using CVA. Cash for emergency or life-saving treatment is part of CSN which also provides cash for other specific needs.	2017-2019	Danish Refugee Council
Somalia	Cash in advance to POC for maternal services (pilot)	To increase the use of maternal services, ANC, delivery care, and PNC. Cash used for transport to the facilities and to pay direct costs (i.e. lab tests, ultrasound) and nutritious food.	Sept-Dec 2020	CARE

[12] The term 'dual wallet' is used here to refer to an electronic or smart card which provides two separate amounts of cash that are to be used for different purposes (see Box 4).

2.3 Summary analysis of CVA for health

In total, the study investigated 26 separate CVA for health activities and projects, 20 of which are being implemented or have been implemented in recent years, and 6 that are at design stage.[13] Table 3 provides a summary of all activities.

The most common CVA for health modality in the MENA region (either currently being used or used in the past) is cash paid to POC in advance of using a service (six interventions), including a project in Yemen which uses two modalities (cash in advance for indirect costs and a voucher for RH services) and one in Egypt which provides cash both before and after care. Three programmes in the MENA sample use(d) vouchers (one in Syria and two in Yemen), and two conditional cash transfer (CCT) pilot interventions were implemented (in Lebanon and Jordan). In Lebanon, where more than 85 percent of the hospital beds are in the private sector and less than half of the population has health insurance, two examples reimburse(d) costs of specific health services directly to the facility. Finally, one project in North-East Syria identifies vulnerable individuals with disabilities and provides them with multi-use cash to support care and recovery.

However, it is important to note that many interventions in both the MENA and wider sample do not fall into clear 'modality categories', and their design is purposefully flexible to enable them to respond to the (often changing) context. For example, in Egypt cash is paid to women in instalments, both before delivery and after the birth of the child, and this cash is also in some ways conditional since the second instalment is only paid to those women seeking care at a public or selected NGO facility. In Jordan, one project uses a combination of monthly cash transfers in advance for chronic health conditions and one-off payments for delivery, as well as reimbursements to private facilities.

At least seven of the examples are also pilot interventions, signalling that country teams are willing to try out new CVA for health approaches when they are able to access the funding, as can be seen with the innovative approaches employed in Burkina Faso and Chad.

Table 3: Summary of CVA for health interventions

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**

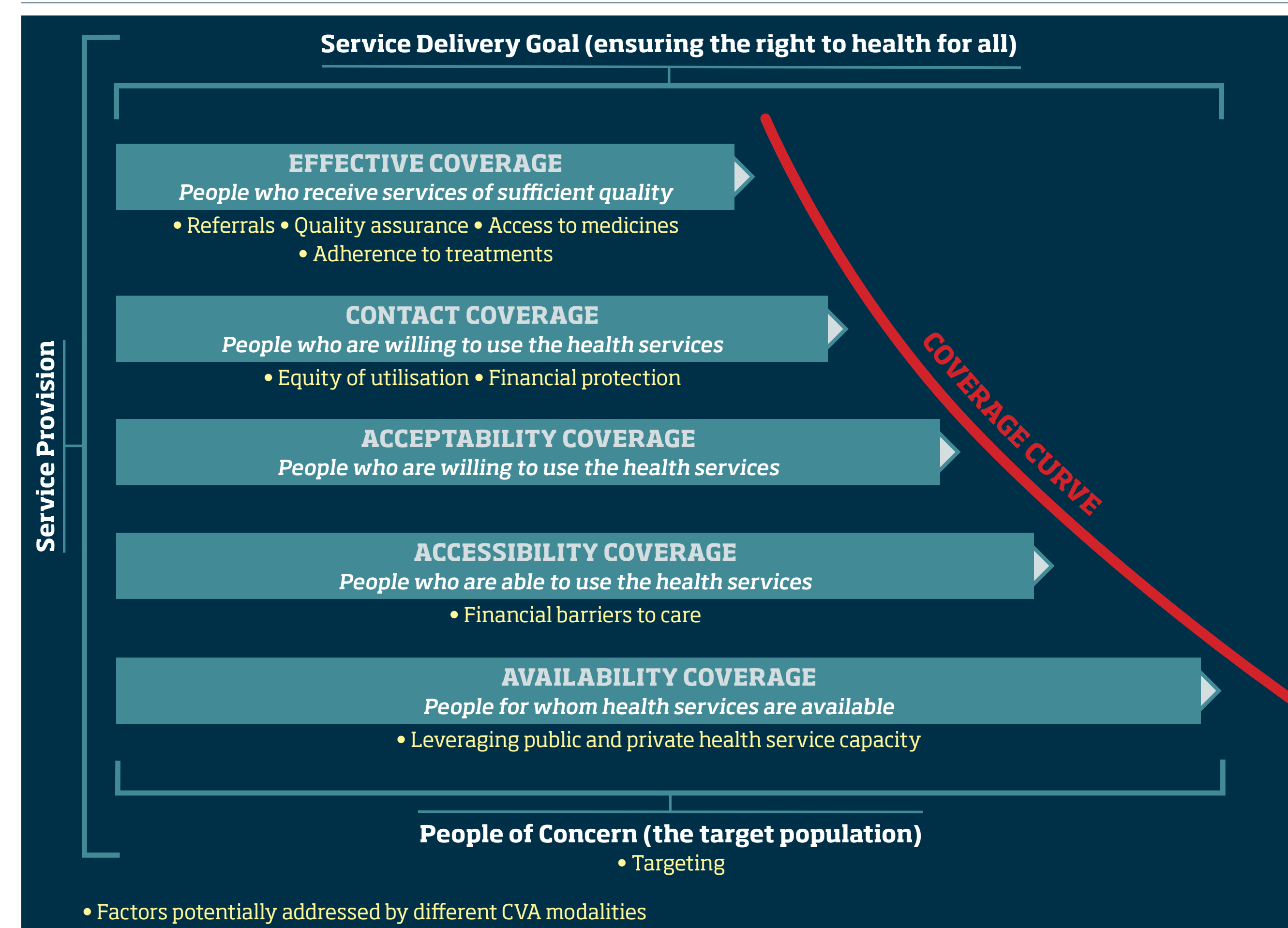
[13] See Section 4 for a detailed analysis of how the different CVA modalities address barriers to healthcare and the accompanying Excel sheet for additional details on each of the CVA for health interventions, and further analysis of the modalities in use.

03. Framework of analysis for addressing barriers to healthcare

Enabling access to healthcare of sufficient quality, particularly for very vulnerable people, and addressing barriers to universal coverage, bring multiple benefits, including: reducing health inequities; improving financial protection; enhancing health system responsiveness to client needs; and of course ensuring the right to health for all and leaving no one behind. Meeting these important objectives strengthens health system performance. Using an adapted Tanahashi framework (Figure 2) demonstrates how CVA for health supports health service coverage.[14]

CVA for health programming essentially addresses financial barriers to accessing care (so-called demand-side barriers). However, some CVA approaches also introduce broader advantages. For example, voucher distribution provides a conduit for distributing information to communities about the reasons why a service is important, and where and when it can be accessed; these are conceptualised as an 'invitation' which acts as an incentive to take up a service. Vouchers can also direct beneficiaries to services above a minimum quality. As vouchers also require contracts with preselected providers, they provide an entry point for negotiating and monitoring the quality of the services to be provided. Income from voucher services can be used by the facility to cover facility operating costs and to pay staff incentives.

Figure 2: How do CVA for health approaches support health service coverage?



[14] Adapted by the authors from presentation by T.S. Koller. *The Tanahashi framework for effective coverage*, World Health Organisation, December 2020.

With effective targeting, CVA for health interventions can reach POC in humanitarian contexts and protect them from catastrophic healthcare costs, reducing financial barriers, while enabling access to healthcare of sufficient quality. This may include individuals and households not currently in receipt of multipurpose or other types of cash, but with recurrent, high and/or unexpected health-related expenditures that threaten to push them further into poverty. Table 5 in Annex 1 provides a detailed analysis of the barriers to accessing healthcare which each modality addresses, based on this adapted Tanahashi framework.

Figures 3, 4 and 5 below demonstrate how the three principal CVA for health modalities operate.

Figure 3 illustrates two types of unconditional cash identified by the study: multi-use cash targeted at POC with specific health needs; and cash for specific health services. In the first, beneficiaries are targeted through the health, protection or other clusters and identified as requiring assistance to access needed health services. They may then be assessed against vulnerability criteria, and provided with unconditional cash transfers (UCTs). In North-East Syria, people with disabilities are identified at a hospital and referred for vulnerability assessment by an NGO, which provides six monthly cash transfers to help them complete their treatment and support recovery. This cash enables households to prioritise treatment for family members with disabilities and to prevent what may be a temporary disability from becoming permanent. This approach will particularly impact on health outcomes where beneficiaries are able to meet their other basic needs (i.e. for shelter, food security, debt repayments and so on).

Figure 3 also presents a second modality, whereby cash is provided in advance to POC for specific (usually high-cost) health services. Information about the health services and how to access them is provided to cash recipients, and links with the health sector are strengthened. There is usually also a 'pre-commitment' to seek services from recommended health facilities where the quality of services and/or medicines meet national standards. In the case of life-saving treatments (i.e. caesarean section, appendectomy, open fractures, acute poly-trauma, etc.), and where there are strong referral systems in place, such as in Jordan and Iraq, it has been observed that POC use the money as intended.

Figure 4 presents conditional cash transfers (CCTs) which are paid to a beneficiary *after* a certain action is taken, and often linked with services that are themselves provided for free. They incentivise positive behaviour change, based on the evidence for what works to improve health outcomes (i.e. antenatal attendance and institutional delivery, child vaccination, or adherence to chronic care regimens, such as for NCD, HIV or TB). The beneficiary must find funds upfront, which may be challenging for very poor households until the scheme becomes well enough known in the community that people will assist and loan the cash. In comparison with vouchers, cash transfers are quicker to set up, and simpler to implement and to combine with other forms of cash, although the conditionality adds a layer of complexity (the setting and monitoring of conditions requires technical knowledge and expertise). Unless conditionality is extended to the selection of outlets

Figure 3: Unconditional cash transfers

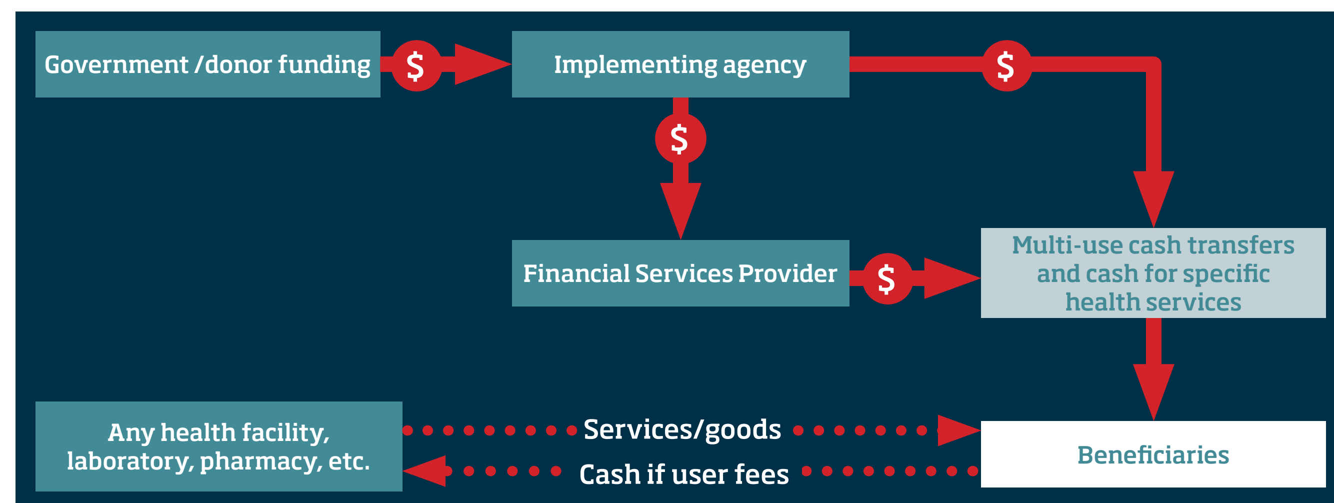
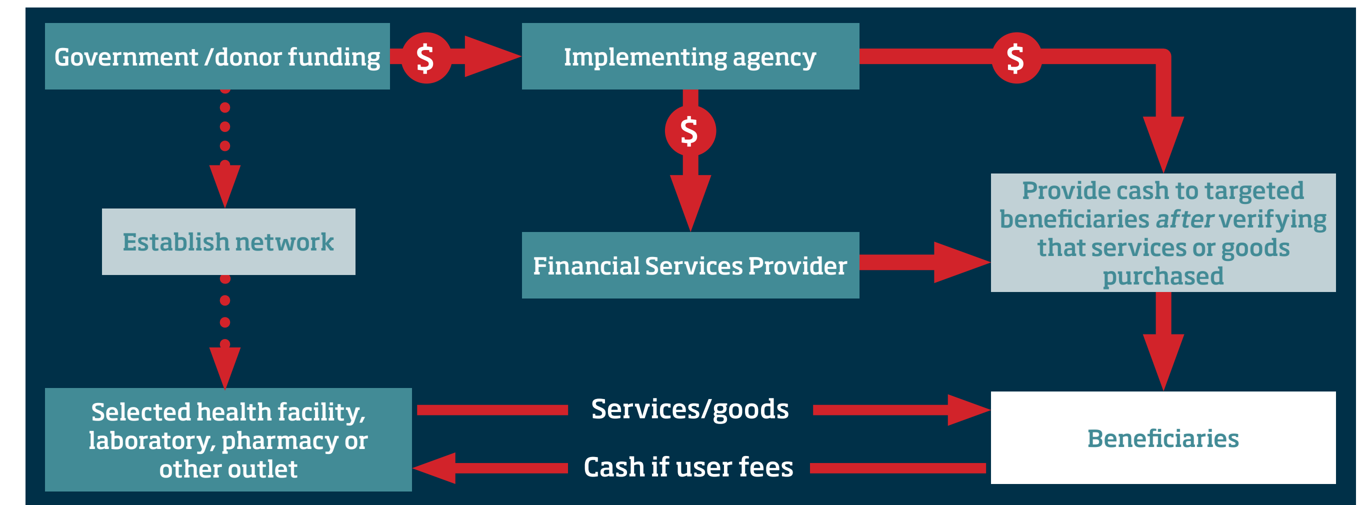


Figure 4: Conditional cash transfers



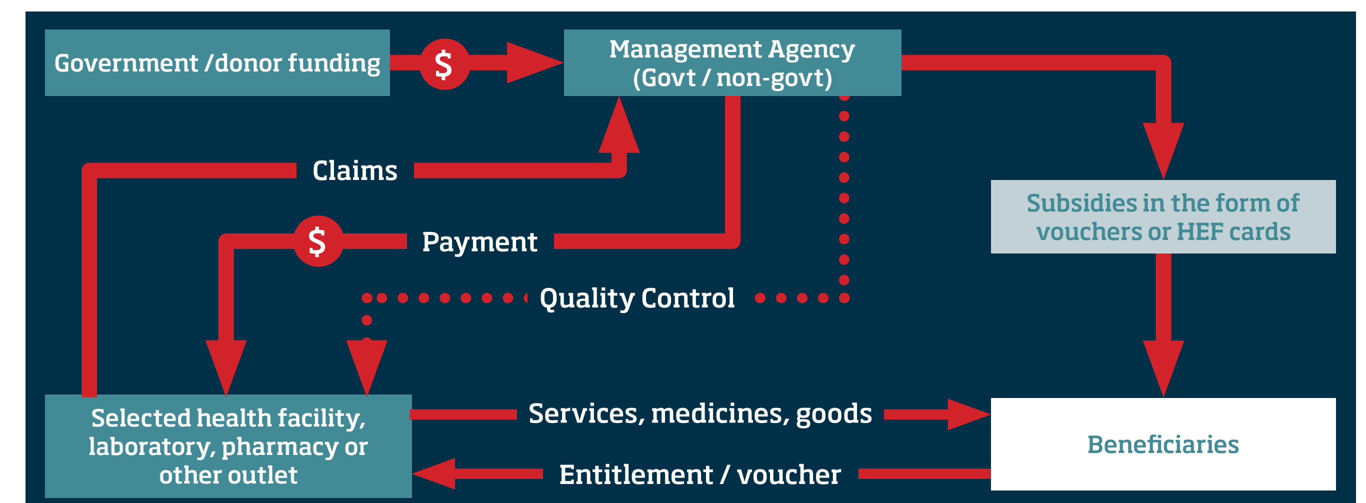
where POC are expected to access the services or goods, ensuring quality of care may remain a challenge.

Examples from the MENA region include conditional cash provided in Lebanon to pregnant women attending their first antenatal care (ANC) appointment to cover the costs of subsequent ANC visits, delivery, postnatal care (PNC) and family planning (FP). The CCT was designed to address persistently high maternal and neonatal mortality. In Jordan, CCTs are provided every three months to cover the costs of care-seeking and medications for vulnerable POC with NCDs. Community health volunteers visited the households and provided information, education and communication (IEC) around the need to adhere to treatment regimes.

As shown in Figure 5, some CVA modalities, such as vouchers for services, value-vouchers and health equity funds, strengthen the supply of services by channelling funds to contracted health facilities to cover user fees and control the quality of care provided to targeted beneficiaries, either through the selection process or through regular quality checks. Vouchers may be used in exchange for either a specific service (i.e. institutional delivery or a journey in the case of transport) or a package of services (i.e. sexual and reproductive healthcare), or they may represent a value (a value-voucher) for services, up to a fixed ceiling (i.e. for a package of essential services).

Vouchers can increase uptake of underutilised services and provide a conduit to deliver information to beneficiaries on the specific services (why, where,

Figure 5: Vouchers and health equity funds



when, etc.). Vouchers and health equity funds (HEF) can also act strongly to increase demand: satisfied clients will bring the subsidy encapsulated in the voucher to a particular health outlet or transport provider of their choice, and this also drives quality and responsiveness to the needs of POC.

Additional incentives may be built on to voucher schemes to support the functioning of the health system, as in the case of Yemen, where the Reproductive Health (RH) voucher programme provides a percentage of funds to the Governorate Health Office to strengthen supervision and quality control of participating health facilities. In Syria, it was found that vouchers facilitate targeting and reduce administration costs, since payments are made after services have been rendered and the costs can be managed as an aggregate reimbursement to the hospital, as opposed to a series of individual transfers to women to enable them to pay for healthcare directly.[15]

In all the above-described modalities, the cash is linked to the beneficiary (no beneficiary = no funds), in contrast to the majority of supply-side approaches, in which support is provided regardless of the level of utilisation by beneficiaries.

[15] Kokoevi Sossouvi, Independent consultant UNFPA, information obtained in interview on 20 October 2015 with Omar Ballan, assistant representative and humanitarian focal point for UNFPA, Damascus, Syria.

04. How do CVA modalities impact on barriers to health coverage?

Using the adapted Tanahashi framework (see Figure 2), we conducted analysis of how the different CVA modalities impact on the barriers to accessing healthcare of sufficient quality in the MENA region.

Table 4 provides a summary of this analysis.

Table 4: Summary of findings: how CVA for health impacts on barriers to accessing healthcare

Direct & Indirect costs	Potential modality	Tanahashi barriers	Country examples
Cost of transport and/or accommodation	Include in MPC or MPC top-up	Contact coverage, Accessibility coverage	North-East Syria
	Cash for transport etc. given in advance		Lebanon
	Conditional Cash transfers (CCT)		Yemen
	Voucher		Yemen
Food and other indirect small costs	Include in MPC or MPC top-up		In most countries
User fees for primary healthcare (PHC), including specific services such as SRH and GBV care	Include in MPC or MPC top-up		Post-distribution monitoring (PDM) surveys show POC use MPC for user fees
	Cash given in advance of service		Lebanon, Somalia
	Conditional Cash Transfer (CCT)	Effective coverage, Contact coverage, Accessibility coverage	Jordan, Lebanon, Greece, Afghanistan
	Voucher for package of PHC services	Effective coverage, Contact coverage, Acceptability coverage, Accessibility coverage, Availability coverage	No example
	Value-voucher		Chad
	Vouchers for specific services (i.e. SRH, GBV)		Yemen, Syria
	Health Equity Fund	Effective coverage, Contact overage, Acceptability coverage, Accessibility coverage	Lebanon
User fees for secondary and tertiary care, including obstetric care	Include in MPC or MPC-top-up	Contact coverage, Accessibility coverage	North-East Syria, Iran
	Cash given in advance		Iraq, Jordan, Somalia
	Payment provided after use (to POC or facility)	Effective coverage, Contact coverage, Accessibility coverage	Lebanon (to hospital), Egypt, Afghanistan
	Voucher for specific services	Effective coverage, Contact coverage, Acceptability coverage, Accessibility coverage, Availability coverage	Syria
	Value-voucher		No example
	Health Equity Fund	Effective coverage, Contact overage, Acceptability coverage, Accessibility coverage	Lebanon
Costs of medicines, tests and other diagnostics, consumables such as kits for surgery and delivery etc.	Include in MPC or MPC top-up	Effective coverage, Accessibility coverage, Contact coverage	PDMs show POC use MPC to pay
	Cash given in advance		Lebanon
	Cash given after obtaining the goods		Jordan, Greece
	Voucher for goods/services	Effective coverage, Contact coverage, Acceptability coverage, Accessibility coverage, Availability coverage	Ukraine
	Value-voucher		Chad

Over half of the CVA for health activities identified in the MENA region (7 of 13) address insufficient use of essential health services, such as maternal or other sexual and reproductive health services, or NCD treatment. A total of four address catastrophic healthcare costs. A more detailed table looking at how the different CVA for health modalities impact on the barriers to health services is included as Annex 1.

4.1 CVA for health is beginning to take off in the MENA region

The study also uncovered a number of CVA for health interventions currently at the conceptual stage or being considered (see Box 1), and this, together with the many requests for information about the different CVA modalities by key informants, demonstrates that CVA for health is a topic of significant and growing interest.

Health is inherently complex and health needs are unpredictable and can lead to high levels of expenditure. Without support, information asymmetries make it difficult for vulnerable people in humanitarian contexts to access the quality healthcare they need.

Box 1: Pipeline of CVA for health in the MENA region

Country	CVA for health	Stage
Iraq (Health Cluster)	Cash for transport, vouchers and prescription for NCD medicines for returning refugees.	Partial concept
Greece (Hellenic Red Cross)	CCT for vulnerable people with underlying chronic diseases to supplement medical and pharmaceutical expenses in times of Corona.	Full concept
Lebanon (UNFPA with various partners)	CVA within GBV case management including cash assistance for emergency medical treatment as part of GBV response.	Starting pilot in 2021
Lebanon (IRC)	Value-voucher: expanding existing protection intervention to cover cash for mental health, RH and SGBV.	Initial concept
Lebanon (PUI)	CCT for deliveries, severe acute malnutrition, and mental health (was successfully applied in Afghanistan).	Initial concept
Yemen (UNICEF)	Healthy Start vouchers: transport coupons for pregnant and lactating women to reach hospital for safe delivery and enable access to EmONC for complications, and treatment for malnutrition.	Full concept

Health sector support in humanitarian situations has necessarily focused, where possible, on supporting existing government processes and systems, strengthening the infrastructure and boosting available human resources, and improving the quality of care, while advocating for a policy of free services to overcome financial barriers to access.

From post-distribution monitoring and other surveys, it is increasingly clear that people in receipt of multipurpose cash repeatedly spend a proportion of this cash on accessing healthcare, in proportions which vary greatly between contexts (from as little as 5 percent to over 60 percent of the transfer) (Grasset and Khattak 2020; Hall 2019; Harvey and Pavanello 2018; Khan and Clingain 2020; and REACH[16]). Healthcare costs can be very high, and while this only usually applies to a small number of cases, it is mostly unpredictable. High health-related costs often lead to negative coping strategies and foregone care.

There is a growing body of evidence that targeted CVA to overcome financial barriers to accessing health services is effective. With this in mind, the WHO and Global Health Cluster partners, with support from the Norwegian Refugee Council's CashCap programme, have been developing guidance on using CVA for health

[16] REACH Afghanistan (2019). *REACH's activities in Afghanistan: Health and Cash Monitoring*, PowerPoint Presentation, November 2019, Afghanistan.

outcomes in humanitarian settings,[17] and provides some technical assistance to country teams to design CVA for health interventions. In the wake of the 2019 Beirut meeting, CaLP has supported both the publication of case studies and organised webinars to share knowledge and lessons on CVA for health programming. International NGOs have written or are writing strategy documents on how CVA can best be used in health, including summaries of CVA examples that are currently being implemented.[18]

All these efforts are building interest in CVA for health, and it is likely that the next few years will see increasing requests for hands-on technical guidance. However, a number of challenges remain, not least the need to convince health sector donors that these are viable modalities for improving access to quality healthcare, and to further orient and train cash advisers on the complexities of healthcare in humanitarian settings.

4.2 Cash for health

As a modality, cash is often used to pay for indirect costs of accessing healthcare, such as transport, which is known to be an important barrier in both humanitarian and development contexts, as well as other indirect costs such as accommodation, food and replacing income from work lost. In fact, cash is the most obvious choice for small expenditure items that can be purchased easily. In around half of the countries in the study, one or more programmes address these costs, often as part of a wider package of CVA for health support (i.e. in Jordan, Lebanon and Yemen).

Cash is also used to pay for health services at secondary and tertiary care facilities, and to enhance the effectiveness of care through enabling access to medicines and tests that are frequently out of stock in public health facilities or only available in the private sector. However, the unpredictable nature and frequency of some high-cost health services makes this modality more challenging to implement, particularly for life-saving and emergency care at secondary and tertiary levels. Furthermore, unless addressed in the programme approach, cash would not ensure that services and medicines are obtained from qualified and licensed service providers at a reasonable price. To address some of these challenges, UNHCR has developed global guidance which can be adapted to local contexts for the smooth implementation of cash programming in the health sector, including criteria for decisions around what can and cannot be paid for, and how to ensure a transparent process.[19]

Examples of programmes which use cash to address both indirect and direct financial barriers to healthcare in the MENA region include unconditional cash provided in Lebanon in late 2020 in the wake of the port explosion to cover costs of both transport and fees for sexual and reproductive health (SRH) services, and a programme in Jordan which uses cash to cover transport to life-saving health services as part of a wider package of care for urban refugees.

Payment is usually made before the costs are incurred, rather than after because vulnerable POC may have difficulty in accessing funds. In Jordan, Syrian refugees receive an SMS and go to the bank to collect cash, which they then use to cover the cost of facility-based delivery and other specific health treatments (i.e. life-saving surgery, thalassemia, blood transfusion), while unexpected complications of delivery are reimbursed after the event. Because the cash is designed to cover the costs of specific, much-needed health interventions, recipients use the cash for its intended purpose.[20]

However, some cash for health that is paid before costs are incurred may not be used for the intended purpose. To counteract this risk, the *Cash for Obstetric Care* project in Egypt provides a third of funds upfront to cover ANC appointments and then provides the rest of the cash after delivery. This is done to ensure that the cash is used only for public sector services. Strong links to activities at the community level help to ensure people are informed about the availability of health services and the need for preventive healthcare. In Lebanon, cash is provided upfront to women identified with high-risk pregnancies in three instalments: for ANC 2 and 3; for delivery; and for PNC and FP, and they are encouraged to attend the health facility through strong community outreach work. This was considered to be a CCT, since non-attendance put further instalments in question.

[17] See, for instance, two technical notes: WHO & Global Health Cluster 2018; and WHO & Global Health Cluster 2020.
[18] Examples include guidance documents by UNFPA, CARE and ICRC, as well as case studies by UNFPA, CARE and other agencies.
[19] UNHCR (2020). *The Role of Cash Assistance in Financing Access to Health Care in Refugee Settings and for other People of Concern to UNHCR*. www.unhcr.org/5fc0b3fb4.pdf
[20] Verification is carried out by a third party, which investigates how the cash was spent among a sample of 20 percent of cash recipients.

In general, unconditional cash has the advantage of being straightforward to implement (logistically easy and simply to control), particularly in humanitarian settings where systems may be well established (i.e. in many countries in the MENA region) and monitoring systems can be adapted. Multiple MPC top-ups are a feasible modality where costs for transport and accommodation are predictable, regular and low (i.e. transport to pick up NCD prescriptions, attend antenatal appointments or child vaccinations). One-off MPC top-ups can also be used to channel cash for life-saving healthcare, as was the case in Iran. However, targeting may be more challenging because individuals with specific health needs may live in households that are not currently receiving multipurpose cash transfers.

Provision of cash transfers for higher-cost health services, mostly at the hospital level, requires a case management approach, which is logistically more complex. Individuals need to be identified through health or other sectoral cluster programmes such as the protection cluster.[21] Ensuring that POC use health facilities of sufficient quality requires strong links with health sector programmes to direct people to health services that are being supported as part of the humanitarian effort or are known to deliver high-quality of care.

When cash is paid *after* costs are incurred, this becomes conditional upon the desired action and is a CCT, such as in the aforementioned project in Afghanistan which paid cash after delivery in a health facility. When such schemes become well known in the community, people may be able to access cash on the understanding that cash can be repaid once the transfer is provided. The administration of cash payments at the health facility itself may be administratively challenging, as the facilities must predict cash flows and ensure sufficient liquidity to provide the payments. Implementing agencies or financial service providers may support these activities.

4.3 Vouchers for health

While vouchers for health have been used in the development sector for many years,[22] this approach is less familiar to the humanitarian sector. A total of six voucher interventions were identified in the study. In Yemen, the reproductive health (RH) voucher programme started in 2012 and continues to provide access to a package of safe delivery and family planning (FP) services, while a more recent programme uses vouchers for transport to emergency obstetric care, as part of a broader package of support. In Ukraine, vouchers provide health consumables and medications (see Box 2) and in Burkina Faso and Chad, vouchers are used to enable access to secondary and tertiary health services (see Section 4.5). The health cluster in Iraq is also planning an intervention for returning refugees to enable them to access good quality care by providing cash for transport and vouchers with prescriptions for medications (see Box 1).

Box 2: Vouchers in Ukraine

In Ukraine, vouchers were introduced in 2015 to support vulnerable individuals to access good quality healthcare in response to the conflict that began in 2014. Persons of concern are identified at public health facilities and receive a voucher and a prescription for medicines and consumables. Pregnant and lactating women, children under five years of age and adults in need of emergency surgery are all eligible. Consumables include delivery kits and surgery trauma kits for children and adults. Over 12,000 persons had been assisted by 2018.

Electronic vouchers replaced paper vouchers in 2017 and can be exchanged at a network of accredited private pharmacies. The vouchers have an upper fixed ceiling which supports budgeting and ensures that more people can access the services. The programme connected private and public health providers, building their capacity and serving as a base for more sustainable long-term partnerships. Further benefits include the prevention of illegal and uncontrolled use of medicines. Challenges included the fixed value of the voucher, which declined over time with the devaluation of the currency.

[21] In fact, the study found that the need for CVA support to address barriers to accessing health services is frequently highlighted through work done by protection clusters, while individuals are usually identified through interaction with the health sector (i.e. at facilities or through CHWs).

[22] See for example, B. Bellows et al., (2016). *Family Planning Vouchers in Low and Middle Income Countries: A Systematic Review. Studies in Family Planning*, 47(4), 357–70; C. Grainger et al. (2014). *Lessons from Sexual and Reproductive Health Voucher Program Design and Function: A Comprehensive Review*. *Studies in Family Planning*, International Journal for Equity in Health, 13, 33.

Voucher programmes take time to set up and establish, and are logistically more complex than UCTs or CCTs. This makes them more suitable for protracted emergency situations, unless a voucher programme is already operating on the ground and can be adapted to the emerging crisis. For example, agreements must be signed with selected, quality assured health facilities, pharmacies or other outlets, vouchers must be printed and distributed, or e-voucher information systems developed, and health facilities must claim reimbursements, similarly to an insurance scheme. Budgeting and cash flow planning may be challenging, particularly until experience is gained and/or data is available with which to predict client flows and costs. Where vouchers are restricted to a limited geographical area or specific beneficiary group, they tend to 'leak' to other areas and groups.

However, it is interesting to note the RH voucher programme in Yemen was set up in 2012, prior to the current conflict which started in 2015. Despite the worsening situation in the country, which has severely damaged the health infrastructure and resulted in large numbers of internally displaced, highly vulnerable people, the programme continues to function and to channel vital funds to health facilities. These funds can then be used to purchase essential medicines and supplies and support the rebuilding of damaged structures, and other activities to ensure functionality. While the Ministry of Health was at first hesitant regarding the use of vouchers, they have recently recognised that the approach does work well in the particular context of Yemen because it channels funding to sites where services are actually being provided (i.e. where the outputs are being produced).[23]

Vouchers can have an important impact on health-seeking behaviour, and are well suited for situations where the objective is to increase effective use of essential services, such as SRH services and preventive health services (i.e. immunisation, NCDs). Vouchers also work well to link internally displaced persons (IDPs) to hospital care for clearly defined services, as was demonstrated in the case of Syria, where the UNFPA used vouchers to enable access to obstetric care.

Where voucher programmes are operational over a period of years, they can build health sector capacities in health financing and health insurance through developing expertise in targeting, contracting, purchasing of services, payments and reimbursements, quality and fraud control, monitoring and evaluation. In a development context, a large RH voucher programme in Kenya financed by the German development bank KfW was instrumental in developing capacities for health insurance, and was eventually overtaken by the insurance scheme.

Vouchers can be used for indirect costs of accessing healthcare, such as transport, but the logistical complexity and management costs will be high in comparison to the value of the vouchers unless an existing voucher programme is in place for other higher-value services. However, even when this is the case, it may be more appropriate to use cash for indirect costs alongside vouchers. For the vouchers for transport to work, there must be sufficient safe transport options available, and transporters must be willing to take vouchers and exchange them for cash.

Vouchers for health services can leverage capacity of public, private and NGO providers, particularly in rural areas where public providers may be sparsely situated, for example by including private midwives, as in the case of Yemen. In general, vouchers are not advisable for a large package of essential primary healthcare (PHC) services as this requires different vouchers for many different services with different prices requiring large voucher books. In most countries in the study, PHC was available for free to vulnerable host and refugee populations.

4.4 Value-vouchers and health equity funds

Where PHC services are not provided free of charge, value-vouchers or HEF may provide useful modalities. Value-vouchers can accommodate a large package of PHC services and, where needed, relevant hospital services. Beneficiaries can access healthcare up to a fixed financial ceiling. One value-voucher can serve all members of a household, in contrast to vouchers for services which usually target one member of a household (i.e. a pregnant women or a child).

[23] For information on the operational modalities of the Yemen RH voucher programme, see the case study produced by KIT and the Global Health Cluster (*Case Studies: Afghanistan & Yemen – Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian emergencies*), as well as publications by L. Boddam-Whetham et al. (2016). Vouchers in Fragile States: Reducing Barriers to Long-Acting Reversible Contraception in Yemen and Pakistan. Global Health: Science and Practice, 4(Suppl 2), S94–S108; and C. Grainger et al., (2017). *Providing safe motherhood services to underserved and neglected populations in Yemen: the case for vouchers*, Int J Humanitarian Action, 2(6).

Box 3: Health equity funds in Lebanon for primary care

In Lebanon, the Ministry of Health requested all health partners to provide support in a more aligned and harmonised manner. Humanitarian health partners work to strengthen access to good quality primary care under a standardised scheme that accredits those primary health care centres (PHCC) which meet government standards.

While most partners directly support the PHCCs with resources (i.e. equipment, infrastructure up-grades, staff salaries, supplies and so on), one international NGO supports 8 primary health care centres of the network through a HEF. All Lebanese living in the catchment areas of the selected PHC centres (who are all deemed to be vulnerable whether from the host or refugee communities) can use health services for a highly subsidised cost (occasionally for free for very vulnerable POC) and the PHCCs are reimbursed through the implementing agency. Consultation fees are one of the greatest barriers to access in Lebanon and this project design was expected to guarantee better outputs, and has indeed proven to work well, reaching up to 1,000 or more beneficiaries per clinic per month.

The budget for a value-voucher for PHC is defined according to the expected needs of the target population and the available budget. People usually spend a certain proportion of this cap. For safe motherhood vouchers, calculations exist to estimate the proportion of complicated deliveries and therefore the costs, based on the number of women coming for institutional delivery in a particular context. In both these approaches, budgeting becomes more predictable over time, although demand for services will also change, according to context.

A recent CaLP/WHO case study describes three pilots with value-vouchers used to provide access to an essential package of health services for extremely poor people living in urban settings in Bangladesh. Each identified household receives a voucher card which they can use at contracted quality assured private hospitals to access essential PHC services and a small package of inpatient care. The voucher cards in the three pilots have financial ceilings of €50–100 for outpatient care, and €150–500 for inpatient care for a period of one year for one household.[24] HEF function in a similar way to value-vouchers, but there is no voucher as such and in general they do not apply a financial cap. Value-vouchers and HEF can be seen as a step along the pathway towards the introduction of insurance and more strategic purchasing of health services.

A risk with vouchers – particularly value-vouchers – is that providers may add unnecessary interventions so they can maximise their benefits, unless controlled by the managing agency. Other risks include the potential for fraud, such as reporting inaccurate data or collusion, such as between providers and voucher distributors to earn additional funds.

In both modalities, selected health facilities report the services provided with the names of the head of the household and the beneficiary, and are usually reimbursed on a monthly basis by a managing agency. However, with electronic technology, as in the case of the Chad dual wallet (see Box 4), the funds are debited from the amount available on the smart card, and at the end of the month, the project transfers the total sum to the health facility. In future, the reimbursement to the facility can easily be automated. If a higher amount of cash is needed, this can then be arranged (through case management and by putting extra value on the voucher). In comparison with HEFs, selection of beneficiaries for value-vouchers may be slightly different, since value-vouchers target particularly vulnerable people and provide them with a physical voucher or other token of their entitlement, while HEF usually provide access for all vulnerable people living in the catchment area of a health facility.

Value-vouchers can also be used in the private sector, while HEF is most often implemented in facilities belonging to the public sector or to a health facility network (i.e. belonging to a charity) with oversight by the relevant health authority, as in the case of Lebanon, described in Box 3.

4.5 Hybrid approaches

Several programmes use more than one CVA modality and this is quite common since, as we set out above, the different CVA modalities are better suited to different health access barriers. Several of the CVA for health interventions both in MENA and non-MENA countries use more than one modality. For example, in Yemen, the safe motherhood vouchers pay for maternal health services at primary, secondary and tertiary care levels, and also entitle beneficiaries to cash for transport which they receive on arrival at the facility for delivery or when treated for complications at a hospital. Cash is also paid for the accommodation of a companion when a woman is hospitalised. An innovative approach in Chad uses a dual wallet to address both indirect and direct barriers to accessing healthcare (Box 4).

[24] See the CALP case study on Bangladesh: Health and Nutrition Vouchers for Marginalized Urban Extreme Poor in Bangladesh, March 2021.

Box 4: Using a dual wallet in Chad

In Chad, a year-long project used a dual wallet (separate wallets for health and cash) to cover both indirect costs associated with accessing healthcare (i.e. transport) and direct costs of health services for people living with HIV. A separate programme provided health system strengthening and multisectoral assistance to displaced women and girls to access nutritious food at designated vendors.

Using the first wallet, cash could be accessed via Hawala agents situated near to the health facilities in order to pay the transporter and buy food, while the second health wallet covered the costs of consultation fees, tests and medicines which are not provided for free. The health wallet was capped and acted as an electronic value-voucher which was 'debited' by the facility when health services were used.

The project piggybacked on an existing programme and used the same sQuid technology, placing mobile terminals at the designated facilities and the Hawala agents. This digital delivery of funds enabled the IRC to trace every dollar to the intended beneficiary - improving programme transparency and accountability.

In Syria, SOPs for GBV have been developed which specify different modalities according to the type and severity of the case: some cases can be supported by a one-off MPC or a few rounds of MPC, which is combined with a larger one-off transfer outside the standard MPC when necessary to cover the costs of specific needs, including transport to a facility and payment for medical care.

4.6 The role of Information technology

Information technology (IT) that is available to support CVA in humanitarian assistance is evolving fast, and a number of agencies provide specialist IT solutions. These include, but are not limited to: the possibility of collecting information offline and uploading it as soon as a connection with a web-based information system is established; web-based management information systems for the different CVA modalities; e-vouchers, smart cards and e-wallets, which are replacing paper vouchers and greatly improve information management systems; and payment through mobile money, including through the use of biometric technologies, such as iris-enabled ATMs as is the case in Jordan. Blockchain technology has also opened new and safer ways to deliver cash. These and other IT developments mean that CVA approaches are becoming easier to design and implement as paperwork is replaced by electronic forms and technology enables real-time monitoring. As the example of Chad demonstrates (Box 4), technology can also enable better harmonisation of systems.

Some of these IT solutions can be connected to electronic medical records with, for example, electronic processing of prescriptions to pharmacies. All IT solutions need to protect the confidentiality of patient-related health information.

05. Coordination between cash and health

The need to provide additional support to POC to enable them to access the healthcare they need is widely acknowledged among humanitarian actors and clearly demonstrated both in the data from post-distribution monitoring of multipurpose cash transfers and in the high number of cases identified as requiring such support in protection clusters. The pipeline of CVA for health interventions (see Box 1) demonstrates that CVA is now being widely considered as a potential modality.

Different perspectives: However, an important challenge for the design and implementation of CVA for health outcomes emerges from the different perspectives of the cash community on the one hand and health actors on the other. While cash for health interventions are generally case-based and focused on the needs of the individual, addressing specific and sometimes high healthcare-related costs, multipurpose cash interventions are usually targeted at the household level, addressing average needs, and humanitarian cash interventions necessarily prioritise scale and standardised systems, processes and transfers.

Based on a wide range of KIIs, it was seen that some forms of CVA are considered to be restrictive by the cash community (i.e. CCTs). Humanitarian cash actors value multisectoral and integrated responses, which support dignity and rights of self-determination by offering beneficiaries choices over what to buy and where to buy from, based on market mechanisms. It is felt that CVA for health approaches do not necessarily reinforce the dignity of vulnerable people or enable them to choose how to meet their needs and fulfil their rights.

From the perspective of the health community, cash may be seen as insufficiently targeted to those most in need of healthcare and as an approach that cannot direct people to services of sufficient quality. Healthcare actors worry that multipurpose cash which is intended to cover healthcare costs can promote a culture of user fees, does not prevent catastrophic healthcare costs, is regressive and not equitable. Furthermore, humanitarian health actors rightly prioritise the strengthening of government health systems and free healthcare policies. These different perspectives have constituted an important barrier to better coordination in the past.

Willingness and enthusiasm to coordinate across the sectors: During the KIIs, the study encountered a strong willingness to coordinate across the health and cash sectors. Both sectors recognise that CVA for health can have a 'value-added' effect, complementing supply-side support by the health sector and strengthening cash transfers for those households with members in need of high-cost healthcare. However, there appears to be a lack of effective coordination mechanisms at the country level, and a gap in knowledge and skills, as well as the necessary donor financing, in the health cluster.

Although they provide a forum for updating humanitarian actors on ongoing and planned activities, CWG meetings do not appear to be the best forum for improved coordination, since they are focused on other priorities (i.e. calculating minimum expenditure baskets and transfers). The KIIs found very few examples of health cluster representatives who regularly attend CWG meetings. This may be largely due to the lack of knowledge on the part of the sector clusters of the workings of the CWGs and survey data, including on health expenditure, at their disposal. In Iraq, the new concept for a cash and voucher project to support returning refugees and displaced people was presented to the CWG in March 2021, but it was felt that the concept was at too early a stage to warrant inputs by the cash cluster team.

Technical assistance (TA), training and orientation are needed to foster better coordination: However, with additional orientation and training in CVA for health, CWGs could provide the basis for reaching out to health clusters (using selected cash advisers trained to be CVA for health focal points perhaps) and for providing inputs to CVA for health intervention design and implementation. Without such training, cash advisors are often insufficiently aware of the pitfalls related to healthcare access, particularly for vulnerable groups: i) information asymmetries

between POC and health providers, with the attendant risk of over- or under-treatment; and, ii) unpredictability of acute and chronic illness and trauma and corresponding unpredictability of costs (including catastrophic costs), not only for POC in receipt of multipurpose cash, but for all POC. Health advisors will also need training on the different CVA modalities and to understand how these can add value to existing healthcare interventions (see Section 6.2 for recommendations).

The global guidance on CVA for health developed by UNHCR, WHO and other agencies is an important step in bridging the gap between the health and cash worlds. However, there are many different forms and types of CVA for health (see Section 2.1) and the most appropriate intervention is one that is highly context-specific and can flexibly respond to changes at country level. Key informants considered that hands-on technical assistance and training in CVA provided to health teams on the ground to help them design, implement and monitor CVA interventions would greatly support coordination efforts.

For example, in Burkina Faso, the CashCap representative from WHO headquarters, together with a colleague from the regional office, provided CVA training leading to the piloting of a voucher programme (see Table 2) which provided access to both cash for food and health services that fall outside the free healthcare policy (i.e. serious malaria cases, SGBV and emergency medical and surgical cases). CVA is now one of the principal intervention pillars for increasing access to health services in conflict-affected areas and humanitarian crises in Burkina Faso. In summary, appropriate training and practical support as a first step, followed by piloting a CVA for health, were instrumental at country level for recognising the added value of CVA for health.

Identifying an experienced and energetic focal point in-country for driving cash programming across the different clusters is also important. As one senior key informant in Chad noted,

> *My responsibility was integrating cash in all sectors. I worked with my colleagues in the health sector and they were really convinced by the cash approach and we agreed to do it together. They needed to know and understand how cash works. On our side as cash specialists we need to understand a little bit more about health and how we can adapt cash to health. This was really an area of great interest for me and I also did the same for GBV.*

06. Conclusions and recommendations

Below we present a summary of conclusions (6.1) and some initial recommendations (6.2) based on the above analysis.

6.1 Conclusions

CVA for health – a continuum of modalities: The study uncovered a number of interesting past and current examples of CVA for health in the MENA region, and also describes selected innovative CVA approaches in other countries experiencing humanitarian crises. These ranged from short pilots (i.e. the shortest lasted just 45 days) to multi-year, multi-donor interventions, and comprised many different (often hybrid) approaches to using cash and vouchers. We suggest above that it is useful to place these different CVA for health approaches along a continuum, with multipurpose cash to address specific health needs at one end, through to direct reimbursements to facilities for specific services for selected POC at the other (Section 2.1).

As the continuum represented in Figure 1 moves from the left-hand side (multi-use cash for specific health needs, cash in advance or after the action) to the right-hand side (service vouchers, value-vouchers, reimbursement of health services), approaches generally become more complex in terms of their design and implementation (i.e. budgeting and logistics, targeting of vulnerable POC, establishing systems for quality assurance and contracting) as is highlighted in Table 5 in Annex 1, which describes the advantages and disadvantages for implementing each of the different modalities. Similarly, moving to the right in Figure 1, more resources (time and money) may be required both to set up these CVA for health interventions, and to manage them (i.e. the need for a third-party managing agency and for quality assurance processes).

Balanced against the rising complexity and resource needs, the approaches on the right of the continuum in Figure 1 are particularly well suited to reaching specific groups of vulnerable POC and enabling them to access critical health services, which they would not otherwise have been able to access due to financial and other barriers. This is particularly relevant for preventive healthcare, life-saving healthcare, treatment of disabilities which may become permanent without treatment and specialised treatment for survivors of GBV.

Therefore, there is no single default CVA modality for addressing health needs and financial barriers. The choice of the modality depends on the health system characteristics and barriers found in a specific context. As these characteristics evolve, the choice of the modality may need to evolve accordingly.

CVA modalities according to context: These and other reasons mean that some CVA modalities are better suited to specific humanitarian contexts. For example, voucher programmes take time to establish and set up, although once established they can continue to function during crisis situations, as has been seen in Yemen, and provide a flexible conduit for channelling additional benefits (i.e. cash) to vulnerable POC. Once these programmes have been set up, vouchers (including value-vouchers) can easily be scaled to other health conditions and/or to other geographical areas. Furthermore, because of their unique ability to target specific groups of people with specific health services and overcome a range of barriers to access, voucher programmes can be seen as a longer-term approach which continue to channel health-related benefits to people in need during (and after) transitions from humanitarian to development contexts and vice versa, as in the case of Yemen.

Transferring cash is generally easier to set up (such as cash for transport), but as explained above, when cash is provided before services are accessed, this modality also requires additional programmatic interventions to mitigate possible risks, such as by supporting appropriate health-seeking behaviour, and ensuring that treatments are provided according to agreed standards of care.

While the typical multipurpose cash programmes cannot and should not replace health sector–specific CVA, multipurpose cash transfers may serve as a useful entry point for other more complex CVA for health modalities, not only for MPC top-ups to cover health-related costs but to identify vulnerable households with individuals in need of higher cost healthcare. For example, the Cash for Specific Needs (CSN) programme in Iran provided one-off cash transfers for POC, both as an MPC top-up for those already receiving MPC, and as a one-off payment in advance of treatment for those outside the MPC.

CVA for health outcomes adds value to supply-side health interventions: This has been an important finding and confirms that CVA for health outcomes is required to address the concerns that general MPC does not overcome financial barriers to accessing health services, does not protect households from catastrophic health expenditures, and may direct POC to facilities with inadequate quality of care. Market mechanisms do not mitigate these health sector–specific risks, given the asymmetries of information, the imbalance of power between health providers and patients, particularly very vulnerable POC, and the unpredictability of health needs.

Almost all schemes identified in the study are well linked to the supply-side of the health sector, and this is a condition when implementing CVA for health. 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; and strong links with the health services (i.e. selecting facilities that are already well known to the POC).

CVA for health is nearly always provided *in addition* to existing efforts to strengthening the delivery of services in the health sector, and brings an added value to such activities. An important finding relates to the concern among health professionals and others that some CVA for health modalities (particularly cash modalities) might direct POC to facilities which do not provide adequate quality of care. However, it is important to note that no evidence of this was found during the review, because specific programmatic components were built into the design to address these risks. The designs of the identified CVA for health interventions were all geared towards improving healthcare access for POC, enabling positive health-seeking behaviour and ensuring the supply of good enough quality of services.

Furthermore, in nearly all examples, the risk of the cash not being used for the intended health-related objectives was found to be either zero or close to zero. Only in one short pilot programme in Beirut was cash used by POC for other priorities, and this was because needs were very high after the port blast, and because linkages with health system were weak. Verification and monitoring systems are used to deter health facilities from introducing informal 'user fees' for services that should be free at the point of delivery.

The study found that almost all CVA modalities were implemented in a comprehensive manner, with clear targeting and eligibility criteria, dissemination of relevant information, practical payment systems and, where feasible, making use of existing systems developed for MPC or other cluster transfers (i.e. information and payment systems). Most interventions either established systems to check and control the quality of health services, used health facilities known to be quality assured, or provided additional supply-side inputs to improve the quality of care at public health facilities. Many of the interventions also had detailed and clear SOPs or were in the process of updating SOPs.

Innovation and issues of scale: Across the whole sample, at least seven interventions were designed as pilots to trial a new approach to addressing barriers to accessing specific types of healthcare. This, together with the pipeline of new concepts and interventions,[25] demonstrates considerable interest in CVA for health, as well as the need to find new and innovative solutions to long-experienced problems of accessing healthcare in humanitarian crises. The production of additional case studies of CVA for health like those already developed by CaLP, UNFPA, KIT, CARE and other organisations, together with further opportunities to share data and findings from these interventions, will support the community of health actors keen to use CVA, as will better monitoring and data systems for the pilots.

The study also found several examples (i.e. in Chad, Burkina Faso, Afghanistan and Yemen) where the health teams which successfully implemented CVA for health then transferred (or are planning to transfer) this experience to other contexts, health conditions and even other countries. The Chad dual wallet pilot was thought to work so well that the team are planning to extend the approach to people

[25] Many of the key informants mentioned plans to replicate CVA for health, but where these were not actual concepts, they were not included in the pipeline in Box 1.

living with disabilities to enable them to access and complete their treatment. A CCT programme in Afghanistan to enable access to safe delivery, severe acute malnutrition, and mental health services is being replicated in Lebanon. The momentum is slowly building.

6.2 Recommendations

Some recommendations have emerged from the analysis, which can also be applied outside the MENA context. These points should be discussed and prioritised among a wider group of humanitarian health cluster partners and cash actors, ideally with in-country involvement of ministries of health.

The existing formal collaboration between CaLP and the Global Health Cluster to map and document CVA for health outcomes could possibly be extended to support (some of) the recommendations set out below, as well as to prioritise the recommendations and to identify the most suitable actors for taking these forward. This may include other members of the Reference Group which may be interested to sponsor specific activities, in line with their own strategies and plans.

Technical assistance, training, orientation:

- **Develop training materials** that are tailored to the principal audiences (i.e. cash advisors, health advisors and possibly protection officers) which include the pitfalls of designing CVA for health and a typology of the principal CVA for health approaches, together with short case studies (max. two pages) for each typology, to include the most common hybrid or combined approaches (i.e. that use cash and vouchers); [26]
- **Review and strengthen the decision tool developed by WHO**, and adapted by UNHCR, in the light of the findings of this study and develop simple guidance indicating when CVA for health would add value to supply-side interventions, and which modality or modalities would be suitable:
  - A good starting point would be to use frameworks that help to identify the most relevant barriers to the effective use of healthcare by POC most in need of care (e.g. the Tanahashi framework of barriers to accessing health services – but other similar frameworks would also work). PDM and other survey data will be helpful in identifying these barriers;
  - There should be a range of response options which are well understood (i.e. linked to the descriptions of CVA for health modalities mentioned above) and which address different barriers to accessing healthcare, depending on the context in a specific country;
  - The tool should emphasise that the different CVA for health modalities work alongside and add value to existing health sector and cash interventions, rather than serving as an alternative, which the current decision tool suggests. Changes to this decision tool would benefit from further discussion and agreement among interested cash and health actors;[27]
- **Provide on-site/country level hands-on training in CVA for health**: in particular, provide on-site or virtual country-specific training and technical assistance to interested health and cash teams, prioritising those with developed concepts for CVA for health interventions to help them progress these into pilot projects. At first, this support could be provided jointly by cash and health advisors from global and/or regional levels, but over time this TA should ideally be provided by country-level stakeholders (i.e. by CWGs and health cluster actors) with support from global/regional level where necessary;
- **Develop group of technical specialists in CVA for health**: in relation to the above point, start to develop a technical group of CVA for health specialists which can provide hands-on TA and orientation at central/regional level, and in particular, at country level (in person or remotely) and seek funding for this activity.

[26] Based on the KIIs, separate training for cash and health teams would be most useful as these sessions would need to focus on different aspects of CVA for health and be tailored to groups with different technical expertise.

[27] For example, the interagency CWG for North West Syria and the GBV sub-cluster for the whole of Syria (Turkey hub) have recently developed *Standard Operating Procedures for Cash and Voucher Assistance (CVA) and Gender Based Violence (GBV)*. This clear and concise document provides a nice example of a framework within which future CVA interventions can be designed. www.humanitarianresponse.info/en/operations/stima/document/cash-and-voucher-assistance-and-gender-based-violence-standart-operating

Funding:

- **Orientation to donors**: Provide orientation (and/or documentation) on successful CVA for health outcomes to the major donors and other funding organisations across the clusters (including multipurpose cash, protection, nutrition and so on) specifically at global level, and where relevant at country level;
- **Support country teams to access funding**: Support country teams with developed CVA for health concepts to access funding both to develop the concept into fully-fledged designs and to pilot the approach. Where training on CVA for health has been rolled out (or the knowledge and expertise already exists at the country level), this could be provided through existing channels, such as the CWGs, but is likely to require additional support from global/regional specialists, at least to begin with. This activity could also become part of the responsibilities of a new group of CVA for health specialists (e.g. provide advice on which funders to approach and how to advocate for funding and develop high-quality proposals and pitches).

Coordination:

- **Effective coordination forum**: conduct further consultations on the most effective forums and coordination mechanisms at country level for bringing cash and health teams together, without creating additional burdens for all concerned (i.e. building on existing coordination platforms rather than developing parallel structures). There is ample willingness to coordinate across the health and cash sectors, but an effective forum for discussing the development of CVA for health is still to be identified, as the current set-up (with health advisors participating in long meetings on the MEB etc.) does not seem to work well;
- **Leveraging the skills and knowledge of CWG members**: in parallel with the provision of training/orientation in CVA for health (see above), explore how CWGs (and other clusters as appropriate) can best contribute to the conceptualisation, design and implementation of CVA for health interventions which address specific, identified barriers to accessing health services for POC (e.g. CWGs may be the first to observe these barriers through the results of the PDM);
- **Identification of POC with health needs**: Given the challenge of identifying POC with health-related needs who are not using the health services they need due to financial barriers, find ways to strengthen coordination and collaboration between the cash, protection and health clusters. Support health cluster actors regularly to use data and tools such as PDM and small surveys to collect more nuanced information related to how people spend cash transfers on health, because early indication of the gaps in access to services can then be addressed by one of the CVA modalities identified in this study. Promote awareness among different clusters that POC who are not listed as vulnerable might need support due to their specific health needs and hence will need to be identified through separate mechanisms other than the PDMs, such as small surveys.

Annex 1: CVA for health modalities and barriers to accessing healthcare

Table 5: Barriers to accessing healthcare and CVA for health modalities

Direct & indirect costs	Potential modality	Advantages	Disadvantages	Tanahashi barriers	Country Examples
Indirect costs of accessing healthcare					
Cost of transport and/or accommodation	Include in MPC or MPC top-up	Straightforward to implement (systems established and can be adapted); feasible where costs for transport and accommodation are low	Unpredictable costs and frequency; expenditure may exceed allocation; targeting can be challenging – misses POC not receiving MPC	Contact coverage Accessibility coverage	North-East Syria
	Cash for transport etc. given in advance	Logistically easy and simple to control; being done in protection sector for GBV cases to enable access to services	Requires case management approach; cash may be used for competing priorities; when given upfront, can lead to misuse for other purposes than referral	Contact coverage Accessibility coverage	Lebanon
	Conditional Cash transfers (CCT)	Logistically easy; works best when the programme is understood in the community and cash is given on arrival at the health facility	Very vulnerable POC will not be able to advance the funds; health facilities may not have capacity to handle cash	Contact coverage Accessibility coverage	Yemen
	Vouchers	Transporters/other service providers can be quality assured and discounts negotiated; works best when added to voucher for other health services	Transporters must be willing to take vouchers and able to exchange for cash; overheads expensive compared to the value of underlying activities	Contact coverage Accessibility coverage	Yemen Yemen (pipeline)
Food, other indirect small costs	Include in MPC or MPC top-up	Cash is obvious choice for small costs; should be provided alongside support to enable access to services	May not be used for health-related expenditure	Contact coverage Accessibility coverage	According to PDMs used in most countries
Direct costs of using healthcare					
User fees for primary healthcare (PHC), including specific services such as SRH and GBV care	Include in MPC or MPC top-up	Relatively straightforward to implement: systems are already set up and monitoring can be adapted to incl. health indicators.	Unpredictable costs make this less feasible; Accurate targeting is a challenge (HHs with serious health needs may not receive MPC) Cannot ensure quality of care for POC	Contact coverage Accessibility coverage	Surveys/PDM show POC use MPC to pay direct costs of care
	Cash given in advance of service	Can be done on case-by-case basis for a small number of acutely vulnerable POC and for a short period of time	Logistics challenging: need for PHC is often frequent, requiring multiple transfers; Difficult to ensure quality of care for POC	Contact coverage Accessibility coverage	Lebanon Lebanon Somalia
	Conditional Cash Transfers (CCT)	Ensures cash is used for desired purpose; Once widely known in the community, POC may be able to borrow cash; Directs POC to quality assured facility; Incentivises use (i.e. immunisation, ANC)	Very vulnerable POC may not be able to access care; focal point needed at or near health facility to distribute cash to POC; conditionality adds design/implementation complexity	Effective coverage Contact coverage Accessibility coverage	Jordan Lebanon Greece Afghanistan
	Vouchers for package of PHC services	Channels funds to providers (i.e. when government systems break down); Quality can be assured; can limit benefit package to essential services; can leverage capacity of public and private providers	Not feasible for a large package of essential PHC services: requires large voucher book and complex management or multiple reimbursements; third-party management	Effective coverage Contact coverage Acceptability coverage Accessibility coverage	No examples
	Value-voucher	As above for package of PHC, plus: with experience, average expenses can be costed and cap set to control expenditure; can target all members of a household with one voucher card	Logistics very challenging (reimbursement, monitoring, verification to prevent fraud); budgeting difficult until experience gained; requires system for quality assurance among large number of providers	Effective coverage Contact coverage Acceptability coverage Accessibility coverage Availability coverage	Chad
	Vouchers for specific services (i.e. SRH, GBV)	As above, plus: increases uptake of underutilised services; can be used to deliver information on specific services (why, where, when etc.)	Requires third-party management (contract and financial management, quality assurance of services); requires costing study to establish prices; requires sufficient trained providers	Effective coverage Contact coverage Acceptability coverage Accessibility coverage Availability coverage	Yemen Syria
	Health Equity Fund	Works in the same way as value-voucher but without the need for a voucher; services are free at the point of service delivery; easier to cover a larger package of services than for vouchers	Requires targeting system such as ID cards; often no cap on value per beneficiary, so difficult to budget without modelling costs and utilisation; usually requires focal point at health service providers	Effective coverage Contact coverage Acceptability coverage Accessibility coverage	Lebanon

Direct & indirect costs	Potential modality	Advantages	Disadvantages	Tanahashi barriers	Country Examples
User fees for secondary and tertiary care, including obstetric care	Include in MPC or MPC-top-up	Can be used to bring POC suffering specific health-related shocks into the MPC (i.e. wounded, SGBV, disability treatment) for multiple rounds of cash or as top-up for predefined costs of life-saving services	For all types of cash: Health-related costs unpredictable and can be very high; accurate targeting can be challenging (incidence of illness difficult to predict); can drive POC into poverty and negative coping if transfers too low; Case management approach needed; Needs development of SOPs together with IEC activities with POC group and strong referral system to encourage POC to use the service as desired; more challenging to assure quality; potential for fraud	Contact coverage Accessibility coverage	North-East Syria Iran
	Cash given in advance	Logistically easy and simple to control especially when accompanied by SOPs and a strong referral system			Iraq Jordan Somalia
	Payment provided after use (to POC or facility)	Becomes conditional on use of the quality assured hospital; payment (usually by third party) can be to patient or directly to hospital (when paid to hospital directly, this is equivalent to a HEF)		Effective coverage Contact coverage Accessibility coverage	Lebanon (to hospital) Egypt Afghanistan
	Voucher for specific services	Best suited to regular, predictable health issues (e.g. institutional delivery); can be distributed at PHC level or in the community; can be used to distribute information (why, where, when, etc.); can strengthen the referral system; can strengthen up-take for specific under-utilised services; can leverage capacity of public and private providers; directs POC to quality assured hospital	Requires third-party management agency (contract and financial management, quality assurance of services); requires costing study to establish prices; requires sufficient trained providers; takes time to establish voucher schemes which means they may not always be best option in crisis situations	Effective coverage Contact coverage Acceptability coverage Accessibility coverage Availability coverage	Yemen Syria Burkina Faso
	Value-voucher	Functions as cash given after use; Client has proof in hand when visiting hospital that services will be paid; value is capped; more flexible than a service voucher because it can be used for different services and target all members of a household.	As above for service vouchers, but for a larger basket of services. Requires clearly defined basket of services, that is clearly explained to POC. Costing of a larger package of services can be challenging	Effective coverage Contact coverage Acceptability coverage Accessibility coverage Availability coverage	No example in this study Bangladesh value-voucher for extreme poor in urban settings
	Health Equity Fund	Functions as value-voucher, but usually with additional services and no cap; works well with existing social protection targeting systems (i.e. ID poor cards)	Costing challenging at first; logistics can be complicated: often requires focal point at the health facility to manage targeting, verification and payments; indirect costs (i.e. transport) may remain a barrier	Effective coverage Contact coverage Acceptability coverage Accessibility coverage	Lebanon
Costs of medicines, tests and other diagnostics, and goods such as kits for surgery or delivery	Include in MPC or MPC top-up	Straightforward as MPC top-up; best suited to recurrent, highly predictable health needs (i.e. medication for chronic disease, ultrasound during pregnancy)	Cost of specific medicines may be high and difficult to predict (with the exception of NCD medication); may not be used for desired purpose; very vulnerable POC may not follow treatment protocols	Effective coverage Contact coverage Accessibility coverage	Surveys and PDMs show POC use MPC to pay direct costs of care
	Cash given in advance	Straightforward, particularly if payments system already set up; better suited to recurrent or predictable costs as above	Similar disadvantages as for secondary and tertiary care (i.e. quality assurance not possible, costs largely unpredictable, POC may not access care, etc.)	Effective coverage Contact coverage Accessibility coverage	Lebanon
	Cash given after obtaining the goods	Straightforward; can be made conditional on use of a quality assured pharmacy, laboratory or other outlet	Vulnerable POC may not have cash to access services/goods; requires monitoring to prevent fraud	Effective coverage Contact coverage Accessibility coverage	Jordan Greece
	Voucher for goods/ services	Best suited to frequent, recurrent health needs (e.g. malaria, NCD, child illness); can be linked to essential care; vouchers can be distributed by health workers according to protocols (strengthens quality of e.g. prescriptions); health facility, pharmacies and other outlets can be quality assured	Management requirements and overheads of setting up a voucher programme; takes time to establish and set up contractual relationships so less appropriate for an emergency or crisis situation	Effective coverage Contact coverage Accessibility coverage Acceptability coverage Availability coverage	Ukraine
	Value-voucher	Same as voucher for service, but enables wider coverage of goods (i.e. medicines); can be capped up to a certain amount to cover specific needs and for cost control	Requires explicit monitoring and control of adherence to protocols when prescribing the medicines, providing tests etc. (to prevent over-treatment)	Effective coverage Contact coverage Accessibility coverage Acceptability coverage Availability coverage	Chad

Note: different modalities can be used and are often combined; e.g. cash for transport with a voucher for services. The same modality can also be used for different levels of the health system (i.e. safe motherhood vouchers in Yemen can be used at primary, secondary and tertiary level), and a single modality can also pay for costs of different services and goods, such as costs of PHC services and costs of tests and medicines (i.e. value-vouchers as part of the dual wallet in Chad), or pay for both indirect and direct costs.

Annex 2: List of key informant interviews

Name	Job title	Agency	Country
Global & headquarters key informants (global and regional)			
Holly Radice	Global Cash and Markets Technical Advisor	Care	global
Daniele Wyss	Cash and Voucher Assistance Officer	ICRC	global
Jo Burton	Cash Transfers & Markets Specialist	ICRC	global
Khaldoun al Amir	Regional Health Adviser	IRC	MENA
Alison Wittcoff	Primary Healthcare Technical Advisor	IRC	global
Gabrielle Fox	Co-Chair, Cash Consortium for Iraq (CCI) and Cash Working Group, Iraq	Mercy Corps	global & Iraq
Ansa Jørgensen	Cash and Health Coordinator	Norwegian Red Cross	Global
Vigdis GOSSET	Cash Interventions Technical Advisor	Premiere Urgence Internationale (PUI)	Global
Joanna Friedman	Cash and Voucher Assistance Specialist, Geneva	UNFPA	Global
Catrin Schulte-Hillen	SRHiE Specialist	UNFPA	Global
Primo Madra	Reproductive Health Coordinator	UNFPA	global
Giuseppe Simeon	Senior Programme CBI Officer, MENA	UNHCR	MENA
Sandra Harlass	Senior Public Health officer	UNHCR	global
Fatima Zehra Rizvi	Consultant (Social protection in humanitarian contexts)	UNICEF	global
Andre Griekspoor	Senior Humanitarian Policy Adviser	WHO	global
Yassmin Moor	Supports Global Cash team of GHC	WHO (CashCap/ NorCap)	MENA
Elodie Ho	Infodemic Country Support Lead	WHO (formerly CashCap/NorCap)	MENA
Thomas Byrnes	Consultant (CaLP)	Independent consultant	MENA
Country Specialists			
Zinia Sultana	Public health officer	UNHCR	Egypt
Nesrine Bascales	Senior Public Health Associate	UNHCR	Egypt
Mireia Serra	Economic Recovery Coordinator	Danish Refugee Council (currently CashCap/Norcap)	Iraq
Dr. Kamal Sunil Olleri	Health Cluster Coordinator	WHO	Iraq
Dr Demis A. Lega	Health Cluster Co-Coordinator, Erbil, Iraq	Médecins du Monde (MdM)	Iraq
Loreto Palmera	Cash-based Intervention (CBI) officer	UNHCR	Iraq
Mohammed Marzoog	Associated public health officer	UNHCR	Iraq
Elsy Ghanameh	Deputy Chief of Party at Caritas Schweiz	CARITAS Switzerland	Lebanon and Syria
Sarah Omrane	Programme Manager	CARITAS Switzerland	Lebanon and Syria
Elizabeth Hendry	Consortium Manager CAMEALEON	Cash research and learning network in Lebanon	Lebanon
Sandra Nakhle	Country Director	Relief International	Lebanon
Loubna Al Batlouni	Health Cluster Coordinator	WHO	Lebanon
Ms Chipo Takawira	Health Cluster Coordinator	WHO	Palestinian Occupied Territory
Luca Sangalli	CVA Expert, Gaza	Action Against Hunger	Palestinian Occupied Territory
Oliver Westerman	Cash Transfer Adviser, Gaza	Mercy Corps	Palestinian Occupied Territory
Fe Kagahastian	Cash & Markets Advisor, Whole of Syria Response Coordinator	CashCap	Whole of Syria
Manon Dumortier	Emergency Response Programs Manager	Mercy Corps	NE Syria
Ahmed Tawil	NES Cash Working Group Coordinator		NE Syria
Benedetta di Cintio	Head of Programmes	Humanity & Inclusion	NE Syria
Orwa Al-Abdullah	Health Program Manager	WHO	NW Syria
Eman Al Kubati	MNH Specialist	UNICEF	Yemen
Rabeea Ahmed	Senior Cash Advisor (Inter-Agency) Deployed to UN OCHA	OCHA	Yemen
Ahmed Malah	Humanitarian Coordinator	UNFPA	Yemen
Abdulsalam AL-AHSAB	RH Commodities Security Specialist	UNFPA	Yemen
Afrah Thabet	Reproductive Health Analyst	UNFPA	Yemen
Jerry-Jonas Mbasha	Health Cluster Coordinator	WHO	Burkina Faso
Mouhamadou Abdoulaye Diaw	Deputy Director of Programs	IRC	Chad

Agencies are listed in alphabetical order for global and regional contacts and then in country order with Tier 1 countries, followed by Tier 2 and Tier 3. Individuals whose names are in bold are part of the Reference Group. Many additional people sent documents which were also important to the review.

Anna Gorter and Corinne Grainger

May 2021

A ‘Stocktake’ of CVA for Health Outcomes in the MENA Region

Moving from Evidence to Practice