Use of Cash and Voucher Assistance for Health Services

Guidance note

Iraq, September 2021

This guidance has been prepared by the Health Cluster, the Cash Working Group, and the Protection Cluster with the technical support of CashCap

HEALTH CLUSTER IRAQ

CWG CASH WORKING GROUP

Global Protection Cluster
Protection Cluster Iraq

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Acronyms	
CLCI	Cash and Livelihoods for Iraq
CVA	Cash and Voucher Assistance
CWG	Cash Working Group
DoH	Directorate of Health
FSP	Financial Service Provider
HH	Household
KI	Key Informant
MoH	Ministry of Health
MPCA	Multi-Purpose Cash Assistance
NCD	Non-Communicable Diseases
PDS	Public Distribution System
PHC	Primary Health Care
SEVAT	Socio-Economic Vulnerability Assessment Tool
SHC	Secondary Health Care
SMEB	Survival Minimum Expenditure Basket
SOP	Standard Operational Procedures
THC	Tertiray Health Care

Introduction

The use of Cash and Voucher Assistance (CVA) as a modality for providing humanitarian assistance has expanded rapidly in recent years. Arguments for the use of CVA to address several needs and facilitate people's access to them include greater flexibility, cost-efficiency and dignity. There is extensive experience in the use of CVA for specific needs such as food, shelter or non-food items and evidence shows it can also be a relevant modality to improving access to and utilization of quality health services in humanitarian and recovery settings.
The availability and quality of health services is crucial to obtaining positive health outcomes. However, evidence shows that socio-economic barriers from the demand side (e.g. medical fees) are one of the key barriers for people to use a health service.

The use of CVA in the health sector has the potential to reduce direct and indirect financial barriers and support the utilization on the demand side. However, no single modality (CVA, services or in-kind) is sufficient to meet health objectives and achieve public health outcomes.[1] Therefore, CVA can be used as a complementary intervention when providing health assistance and should not replace the supply side interventions of providing health services.

In Iraq, health services are provided either by the government, private centers or humanitarian organizations. However, socio-economic vulnerable populations, primarily the displaced people and refugees, face financial barriers to accessing specific health services, while humanitarian organizations have a limited scope of support.

70% of MPCA beneficiaries reporting healthcare as top priority needs	16% of MPCA beneficiaries are using this assistance for health	14% of total distributed MPCA amount is used for health services

*Data provided by the Cash and Livelihoods Consortium for Iraq

Based on this data, health is a priority need for a large number of beneficiaries. However, the MPCA assistance is also used for other basic needs, although health is still one of the relevant expenses. It is important to highlight that the Survival Minimum Expenditure Basket (SMEB) in Iraq does not include a health component. Therefore, it is envisaged that CVA, as a modality of assistance, may be drawn upon to address this need and mitigate barriers by supporting direct and indirect costs for accessing health services.

The following table shows the different types of health providers in Iraq, the services offered and the related costs:

Table 1: Types of health providers in Iraq

Entity	Services	Cost
Government	Primary, secondary and tertiary healthcare	Primary Health Care (PHC): Nominal fee for consultations and investigations (around IQD 2,000) Secondary Health Care (SHC): Free Tertiary Health Care (THC): Free

[1] Working paper for considering Cash Transfer Programming for health in humanitarian contexts, Global Health Cluster and World Health Organization, Cash Task Team, March 2018

Private	Primary, secondary and tertiary healthcare	All types of services have to be paid
Humanitarian agencies	Essential Primary Healthcare and referrals to public hospitals	Free

The Cash Working Group (CWG), the Health Cluster and the Protection Cluster in Iraq are in close coordination to design the strategy for the use of CVA in the health sector. This document outlines the guidance to effectively incorporate the use of CVA by the health partners in Iraq.

Objective of CVA for Health

The aim of using CVA for health services is to support vulnerable population in reducing financial barriers to meet their health needs.
Based on the discussion between the Health Cluster and partners interested in piloting the CVA for health in Iraq, the main barriers that will be addressed are related to access, including financial and affordability:

- Cost of transportation to access health facilities.
- Cost of transportation to access medications at assigned hospitals.
- Cost of medicines for chronic illnesses among adults and children previously prescribed.

The CVA approach, therefore, is designed to support the cost of transportation to health facilities and the cost of the medicines and its related transportation.

Identification of needs

Traditionally, the support to the health sector that humanitarian organizations have been providing in Iraq is focused on the supply side with in-kind support with medical supplies or staff incentives and services such as quality or training to either existing Ministry of Health (MoH) Primary Health Care facilities and/or by establishing additional PHC facilities for IDPs, with referrals to MoH hospitals. However, an additional need to support displaced and returning population to increase their access to the health services has been identified.
Protection monitoring[2] done at the community level indicates that, in average across the country, 63% of key informants (KIs) report that some or most people face barriers to access essential services, with health being ranked as the 3rd most affected service by such barriers. Among KIs who report that their community members face barriers to access health services:

63% of Key Informants reported some or most people face barriers to access essential services – Health ranked as the 3rd one with more barriers

72% Lack of financial resources

64% lack of available services in their location or nearby

22% cost of transportation

[2] National Protection Cluster, Protection Monitoring System, February 2021. Data was collected through 2783 Key Informants Interviews between December 2020 and January 2021.

Furthermore, follow-up surveys conducted with households (HH) after they departed from camps due to camp closures indicate that 39% of households report having at least one member in need of medical assistance but unable to access it.[3]

Based on the context and needs analysis, the Iraq Health Cluster, in discussion with interested partners, including the Global Health Cluster, is considering providing support to the cost of transportation to health facilities and making available chronic medicines in pre-identified hospitals.

The response modality has been designed considering different areas related to feasibility and appropriateness:

Table 2: Feasibility and appropriateness of CVA for health outcomes in Iraq

Feasibility of CVA	
Availability of goods and services	Transportation is available widely in Iraq by taxis and the cost is reasonably cheap. The population is familiar with this type of transportation. Medicines are also available and can be provided on a regular basis.
Delivery of CVA	There are several delivery mechanisms existing and a Financial Service Provider (FSP) mapping is available. The CVA support for transportation is recommended to be delivered as cash in hand due to the small amounts of cash to be handled to beneficiaries and considering that this support should be quick. Providing cash is also more effective than providing a transportation service, because each beneficiary needs to access health at different times, days and locations. In this way, beneficiaries can use the cash when needed. The CVA support for medicines will be delivered in a commodity voucher that restricts the items to be purchased in order to ensure assistance is used for the intended purpose. The voucher is also easy to emit by the organizations and safe for beneficiaries.
Risk analysis	Please, refer to the next section for more details
Capacity of the humanitarian organizations	Humanitarian organizations are familiar with the design and implementation of CVA. Also, the CWG can provide technical support and it can be complemented with specific training when needed. Also, this intervention is coordinated with the protection partners to strengthen referral pathways with health actors. There are specific health partners with more capacity to start implementing this approach. The initial idea is to start as a pilot and, if the results are positive, expand it in the future depending on available funding.

[3] Camp Coordination and Camp Management (CCCM), National Protection Cluster (NPC) and Iraq Information Center (IIC), Camp Departure Follow-up Survey. A total of 2,815 HHs were interviewed during the period from October 2020 to January 2021.

Appropriateness of CVA for meeting health needs	
Why population has difficulties to access health services?	In Iraq, health services are provided by different stakeholders, including public (and free) and private services. However, public health facilities having the required services are sometimes at a relatively far distance, which requires transportation. According to protection monitoring data, distance to medical facilities and the associated cost of transportation is ranked by communities as the 3rd main barrier to access health care, while the lack of financial resources to be able to afford the cost of health care is ranked as the 1st barrier. (see above for more detailed information).
Basic needs household expenditure	Based on data provided by the CLCI, 70% of the beneficiaries that have received MPCA consider health as one of the top four priorities. Also, 16% of this population has used MPCA for health services, which is not included in the Survival Minimum Expenditure Basket (SMEB) that informs the transfer value of MPCA. The need of providing additional health support is identified knowing that health is one of the main priorities of the population and MPCA is not covering any health service. Also, HHs that are not receiving MPCA because of limitation of resources but are in a socio-economic vulnerability are facing even greater difficulties to cover basic and health needs.
Use of CVA	CVA has been provided in Iraq since the past years. The population is very familiar and many surveys report that the preference of the population is to receive CVA as a modality of assistance, especially for its flexibility. At the moment, there is no other similar type of assistance to support population in covering the transportation to health services and the cost of the medication. It is important to take in consideration that this CVA for health services cannot be a standalone support, but it is a complementary support to other services that are currently provided by health partners and governmental actors.

When designing the intervention, a mapping of the health service in the specific location should be conducted in order to understand the availability and functionality of the health services in order to provide the most suitable CVA. A health service mapping tool has been developed in these guidelines and can be used by health partners as a reference. The tool can be found in Annex 1.

Risk analysis

A risk analysis is strongly encouraged to be conducted before starting the implementation of an intervention. Each community and location may have specific risks to take in consideration when identifying mitigation measures. This is extremely important for an effective provision and suitable support by not doing harm.

The following table provides an example of a risk analysis with potential risks and mitigation measures to take in consideration in the context of Iraq. This is only an example as a reference for partners and further risks might be identified depending on the contexts. Partners are strongly encourage to conduct their own risk assessment.

Table 3: Risk analysis tool

Description of the risk	Probability level	Impact level	Mitigation measures
Contextual risks			
Movement restrictions caused by security threats and political unrest	Low	High	✓ Regular monitoring of the security situation. ✓ Close contact with local authorities.
Movement restrictions caused by Covid19 pandemic	Low	Low	✓ The possibilities of new lockdowns or curfews are, at the moment, low but in case new measures are in place, access to health services is always guaranteed as a primary need. ✓ Close follow-up with government regulations is needed.
Increase of prices due to devaluation of local currency	Medium	Low	✓ Regular price monitoring. The value of the cash for transportation will be adjusted in case the price increases or decreases. ✓ This risk does not affect the transfer value of the vouchers for the medicines, since it is a commodity voucher. However, the health partner will monitor the prices of the medicines for its procurement.
Programmatic risks			
Social cohesion risks caused by the provision of CVA to specific individuals	Medium	High	✓ Health partners to promote community engagement activities. ✓ Provision of key messages with the selection criteria, type of assistance, etc. ✓ Engagement with local authorities.
Inability to obtain funds when needed	Medium	High	✓ Regular engagement with donors to identify funding needs. ✓ Mapping of donors likely to find this activity.
Cash not spent on intended needs	Low	High	Cash for transportation: ✓ The selection criteria include the need of a health service based on a health condition. This health condition is proved at the identification stage. ✓ Cash is provided once the appointment with a health facility is obtained. ✓ A regular monitoring will be conducted to ensure the beneficiary went to the appointment. Voucher for medicines:

			✓ This is a restricted cash that can be used only for the prescribed medicines. A regular monitoring will be conducted to ensure beneficiaries do not have difficulties in using the voucher.
Identification errors: Selection criteria	Low	High	✓ The protection partners are using standardized selection criteria based on protection concerns and socioeconomic vulnerabilities for the preliminary identification prior to referral to health actors, who are then responsible to determine the person's eligibility based on their health status and needs ✓ A complaints and feedback mechanism should be also in place in case individuals are willing to communicate with the organization.
Non-selected individuals putting pressure on clinics/doctors to get the cash assistance	Medium	High	✓ At the identification stage, proof of having a health condition will be required to be referred to the cash assistance.
Unavailability of service	Medium	Low	✓ The beneficiary will receive cash for transportation to the nearest available service regardless the distance to the beneficiary location.
Beneficiary protection risks			
Dependency on obtaining Non-Communicable Disease (NCD) medication from health partners	Medium	Medium	✓ A commitment should be obtained from the MoH/DoH before beginning implementation, to work in parallel to improve service and NCD medication availability, so that the beneficiaries can be transitioned to the public health system eventually
Difficulties of beneficiaries to meet the health appointment due to restrictions of movement, other constrains or other priority needs	Low	Medium	✓ The health organization is in regular contact with the community to identify any difficulties. ✓ Regular monitoring on the use of cash. ✓ Beneficiaries will have access to a feedback and complaints mechanism in case they experience any difficulty.
Risks for the safety of beneficiaries and staff	Low	High	✓ Regular monitoring of the security situation in the area of intervention (presence of security or armed actors, checkpoints and restrictions on movement etc.). ✓ Engagement with local authorities to ensure acceptance and authorization of the intervention. ✓ Community engagement to ensure understanding and acceptance minimize the risk of backlash and retaliation etc. ✓ Safety and security measures to be in place at partners' facilities.
Gender and age-related risks, e.g. women and adolescent girls being prevented to benefit from the CVA	Medium	High	✓ Conduct a gender analysis to understand the gender-related risks associated to the particular community.

and access health facilities due to conservative sociocultural norms			✓ Ensure women and men are engaged in the process to ensure understanding and enable effective and independent access of women to health care. ✓ Gender and age -related measures are in place at partner's facilities.
Institutional risks			
Health partners transparency	Low	High	✓ Internal SOPs must be in place, including programmatic and financial processes.
Inconsistency with key actors' responses (transfer values, frequency)	Low	Medium	✓ Coordination between health partners, especially in the health cluster. ✓ Follow-up the cash for health guidance.
Data protection leakages	Low	High	✓ Internal data protection policies and safeguards must be in place. ✓ Data protection principles and protocols must be abided throughout the referral process between protection and health actors
Fraud during data collection that impacts in the eligibility of beneficiaries	Medium	Medium	✓ The protection partner conducts the vulnerability assessment, and the health partner re-confirms the eligibility of the health need. ✓ Individuals having access to the feedback and complaints mechanism.
Delays in getting access letters	Medium	High	✓ Regular monitoring with relevant authorities to ensure access letters are provided on time.

Beneficiary identification

The beneficiary identification is done with different steps:

- Protection actors conducts the preliminary identification of beneficiaries using a set of standardized criteria based on socio-economic vulnerabilities and protection concerns. The standardized criteria developed by the Protection Cluster are aligned with the Socio-Economic Vulnerability Assessment Tool (SEVAT) used by the CWG partners. This tool serves as a generic guidance to protection actors. However, each organization can use its own internal tool as long as they are consistent with the standardized criteria.
- Beneficiaries meeting the criteria, expressing a health-related issues and the need for financial support to meet the health needs are selected to be referred to health actors. The beneficiary consent must be taken and a data sharing agreement must be in place to ensure adequate data protection.
- The Health actors are responsible for assessing the health needs of the person and making the final decision on their eligibility.
- If the person is eligible, the health actor determines the frequency and transfer value of the assistance based on a case-by-case approach. This case-by-case approach is because each individual has particular health needs that require different services and medicines. Therefore, the cash assistance will be determined in terms of value and frequency depending on the specific case and it will be different from each individual.
- Health Partner share the feedback on the verification and the defined type of CVA with the protection partner.

This process should take in consideration the time-sensitivity of the needs, since the beneficiaries might have an urgency to reach the health service.

CVA model

Modality of assistance

To achieve the main objective, the modality of intervention has been designed as follows:

Cash for transportation to the health facility for a medical appointment and/or to collect medicines:

Direct cash is provided to beneficiaries. The delivery mechanism used is flexible depending on the implementing partner. This can include Hawala, cash in hand, mobile money transfer, electronic card, etc. Each partner conducts its own Financial Service Provider Assessment.

Vouchers for medicines:

Health partners provide the medicines in-kind to governmental health facilities when these are not available. An agreement will be in place between the health partner and the facility establishing roles and responsibilities. Beneficiaries receive a commodity voucher that equals to the medicines previously prescribed. The prescription of the doctor with the stamp of the clinic is attached to the voucher for double support document at the exchange health facility. The voucher is exchanged for the specific medicines that a doctor has prescribed in advance.

The CVA can be distributed to the specific individual beneficiary or collected by any other family member listed in the PDS in order to mitigate any potential risk/incapability of the individual beneficiary not being able to approach the distribution site. For Child Headed HH, cash distribution should follow the process of decision making per the developed guidance[1]. The distribution mechanism should be set up in a short period of time and regularly, as there might be cases with emergency needs.

Conditionality and restriction

Cash for transportation to the health service

This assistance is an unconditional and unrestricted cash transfer. That means that beneficiaries do not have to do anything specific to be eligible and that the assistance received is flexible to be used. To ensure that the assistance provided will contribute to the main objective of accessing health services, the targeting system includes different criteria such as the level of vulnerability, the medical condition, the existing referral, or appointment to a healthcare provider, etc.

Regarding the restriction of the assistance, the cash for transportation is unrestricted cash with the assumption that beneficiaries will use the cash for the intended purpose, as having a health need is a primary priority. Direct cash is the most suitable modality because beneficiaries use taxis to reach the health facility.

It is advised that selected beneficiaries reach a minimum threshold of food consumption before they are able to make other investments in other needs. When there is competition for several needs with very limited financial resources, the cash assistance has more risks to be diverted to other needs. In order to mitigate this risk, an integrated programming with other assistance is recommended. Also, a close monitoring will be conducted to ensure that beneficiaries have used the cash on the intended purpose, and to mitigate risks for misuse in issuing the cash for transport.

Vouchers for medicines

Accessing medicines is an unconditional and restricted assistance in the form of a commodity voucher, that specifies all medications to be provided against the prescription. This is because the prescription shows the exact type and quantity of medicines that beneficiaries need, and they cannot receive anything else. A commodity voucher is designed and provided to each beneficiary, that will be exchanged for the specific medicines. The health partner first provides the medicines in-kind to the health provider. The health partner will track the inventory in line with the beneficiaries needs.

Frequency of the assistance

Depending on the health condition of the beneficiary, the frequency of the assistance is determined. For chronic conditions or long-term needs, the frequency will be indefinite, based on project duration and the assistance can be calculated on a monthly basis.

Transfer value

The transfer value should cover all the related costs to access the health facility and to cover the medicines. Therefore, for a successful impact, beneficiaries should receive the amount of money needed to cover their access to the health service and/or medicine.

This can be calculated as follows:

- Cost for transportation (to the health service or to collect the medicines): Each partner calculates the actual cost of a taxi from the beneficiary location to the health facility, including a return trip. A standard cost is established for all beneficiaries living in the same area to easily calculate, make payments and mitigate discrepancies between beneficiaries.
- Cost of the medicines: Since the modality is a commodity voucher, the voucher should include the actual medicines listed in the prescription. The health partner procures the needed medicines and hands them over to the health facility in the form of in-kind support. The beneficiary will provide the voucher upon receiving the medicines listed in the same voucher.

Implementation process

The implementation must be designed based on internal Standard Operating Procedures (SOPs) of the organization following a transparent process.

The basic steps to follow when providing CVA to beneficiaries in need of health support are the following:

- ✓ Identify a place where cash and vouchers can be delivered in a safely and accessible manner;
- ✓ Inform the beneficiary about the type of assistance is going to receive (objective, frequency, amount, etc.);
- ✓ The health partner establishes a feedback and complaints mechanism;
- ✓ The health partner emits the voucher and/or delivers the cash assistance to the selected beneficiaries.
- ✓ The health partner collects supporting documents (beneficiary distribution list, copy of the voucher, copy of the ID, medical report or prescriptions, etc.) as per own internal procedures;
- ✓ Beneficiary uses the assistance.
    - For medicines, the provider should verify the credentials of the beneficiary before dispensing the medicines to the beneficiary and collect the voucher. The provider keeps the voucher once it is exchanged for the medicine. Since the medicines are provided by the health partner to the health facility as an in-kind donation, there is no process of reimbursing the voucher, but the health partner will reconcile the vouchers against the beneficiary list details;
- ✓ Medical staff conducts health monitoring to the beneficiaries, as per needs. Additional cash and voucher assistance can be provided depending on the timeframe and needs;
- ✓ Health partner staff conducts monitoring on the use and impact of cash assistance;
- ✓ Supporting documents are collected and filed;
- ✓ Evaluation is conducted and documented.

***Note on the requirement for identity documentation:**

The lack of identity and civil documentation is a widespread issue among IDP and returnees and represent key barriers for them to access services and enjoy their rights. It is the government's primary responsibility to fulfill its citizens' right to a legal identity and to ensure that IDPs and returnees have access to identity documentation and civil documentation. Humanitarian actors are also responsible for ensuring unrestricted and indiscriminate access to assistance and services to all persons in need, including those who are lacking nationality and civil documentation and even if this means lifting or adapting operational requirements. All persons who meet both socio-economic and health criteria should therefore be considered eligible for CVA for health in any of the following situations:

- The individual has any of the following documents: Identity documentation (Civil Status ID card; Nationality certificate; Unified ID), Civil status document (Birth certificate; Marriage certificate) or any other official document issued or recognized by public authorities (Public Distribution System card; Housing card; MoMD registration document for assistance or return grant; Voter registration card; Driving license; Ownership documentation for housing, land and property etc.)
- The individual does not have any of the above-listed documents, but the head of household does and can be used as a substitute. This applies to both female-headed and child-headed households.
- All type of documents should be accepted, including valid and expired documents as well as physical and electronic copies.

Monitoring and evaluation

Monitoring and evaluation activities

The monitoring process is critical to ensure successful results and a positive impact on beneficiaries. A rigorous monitoring based on case management is recommended, including different levels, such as:

- Follow-up consultations: The beneficiary can receive follow-up visits from the organization's medical staff to monitor the adherence to treatment, and if the medicines were indeed provided without costs;
- Spot-checks: The organization staff conduct spot check visits at the medicines provider to monitor the use of the voucher;
- Feedback and complaints mechanism: Establishing a robust mechanism allows identifying and addressing challenges and constraints faced by the beneficiaries including feedback if all medicines were obtained for free;
- Post-Distribution Monitoring (PDM): This is a survey administered to a sample size of the beneficiaries after the CVA has been used. This survey includes questions related to the use, quality, impact and satisfaction of the assistance received. Also, it can be used to identify potential ways of improvement and adjustments of the intervention.
- Case studies: Individual case studies are conducted to understand in detail the success of the intervention, document success and lessons learned and use it for visibility purposes;
- A final and/or mid-term evaluation is conducted to revise, if required, the implementation process, the approach, the results and collect lessons learned for future interventions. It is important to document all the process, since this can be used by other organizations as well.

Indicators

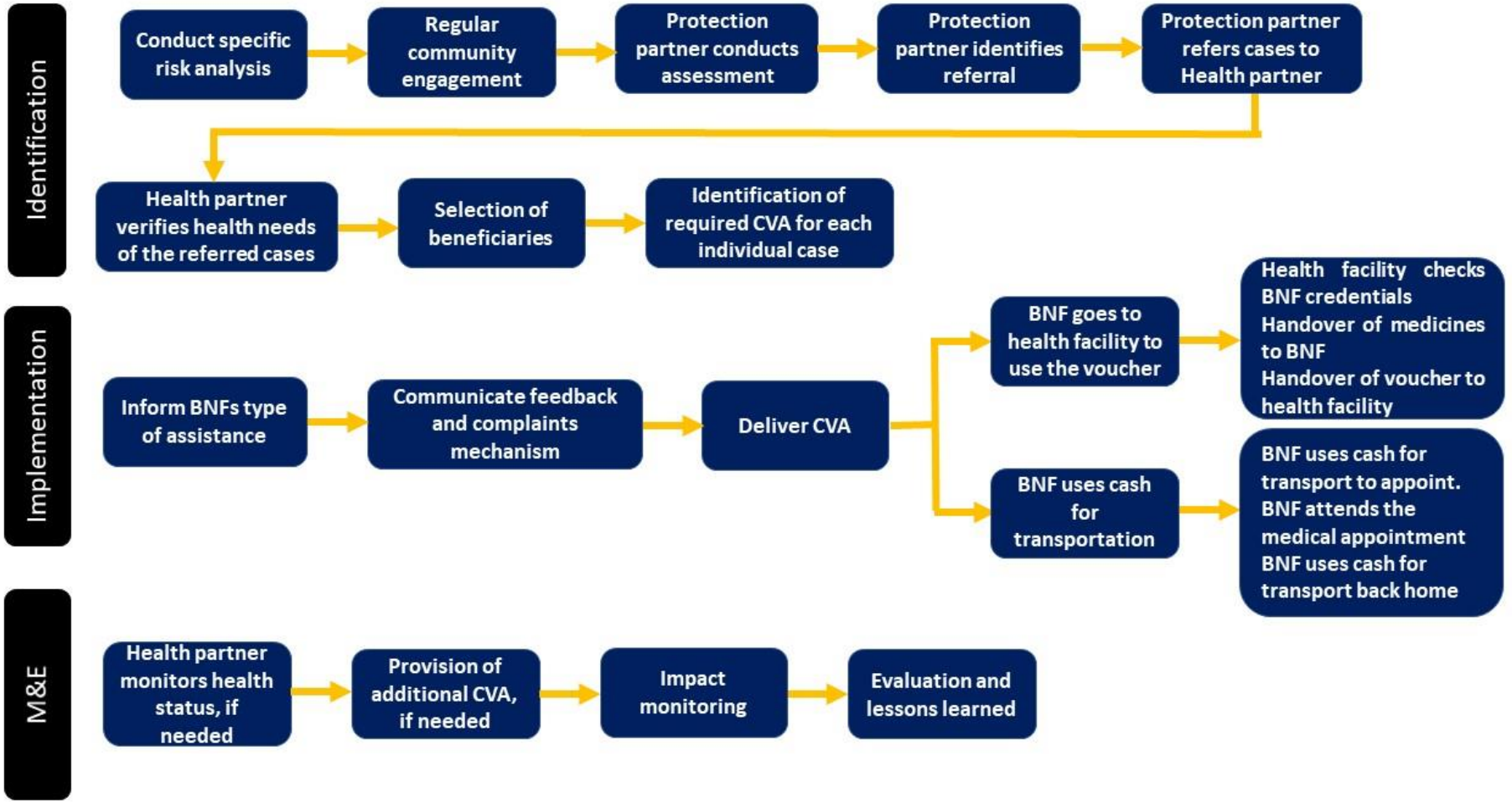
Specific indicators must be included to assess the achievements of the intervention. The indicators noted below are tentative indicators defined by the Global Health Cluster as they relate to CVA for health outcomes.

The indicators are organized by the three barriers to accessing health services, including availability, accessibility (including financial availability) and acceptability.

Indicator	Barriers*
% of households that report physical access as an obstacle to accessing health services (including transportation)	Contact coverage Accessibility coverage
% of households able to access a quality service when in need to use such service	Contact coverage Accessibility coverage
% of HH that had to sell assets, borrow money from family or take loans to pay for a health service	Contact coverage Accessibility coverage
Proportion of HH who report utilization of health services	Effective coverage Contact coverage Acceptability coverage Accessibility coverage Availability coverage
Proportion of HH who report utilization of health services	Effective coverage Contact coverage Acceptability coverage Accessibility coverage Availability coverage
% households that prioritized other needs over health (delay or not seeking care when in need of a service).	Effective coverage Contact coverage Accessibility coverage

*Barriers are based on Tanahashi

Summary of the process



Annex 1: Health Service Mapping Tool

A mapping tool has been developed to identify the health services in a specific location. It is important to do this mapping before starting the intervention to understand the availability and functionality of the health service and provide the assistance accordingly. Health partners can use this tool as a reference.

The tool is divided in 3 areas: Primary Health Care, Secondary Health Care and list of pharmaceuticals. The full tool can be found in this document attached:

Health Service Mapping Tool

Annex 2: Key recommendations from MoH

The Ministry of Health (MoH) has endorsed this guideline with a set of key recommendations to partners when implementing activities. The Health Cluster and the CWG recommend partners to read and consider these recommendations:

Letter from the MoH in Arabic:

MoH Letter on CVA for Health Arabic.pdf

Unofficial translation in English:

Unofficial%20translation%20of%20MoH%2