

CVA FOR HEALTH

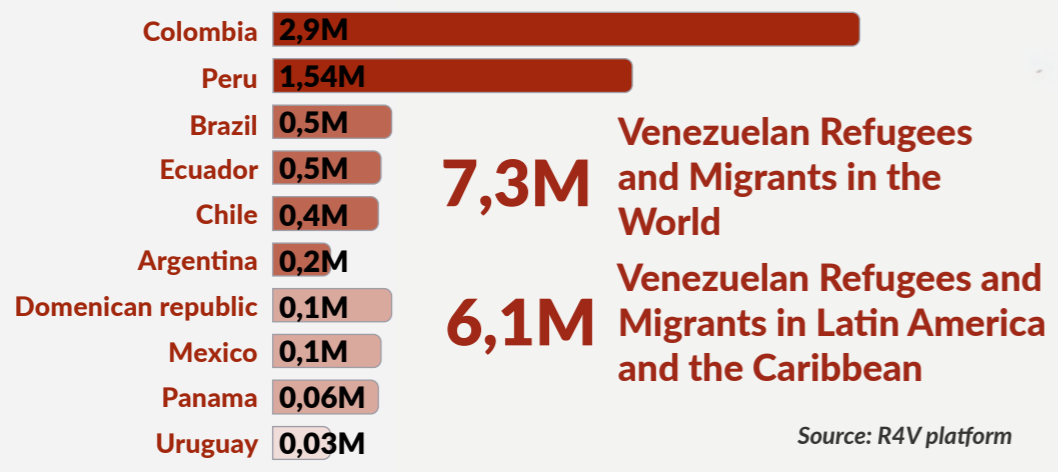


A CASE STUDY FROM SAVE THE CHILDREN INTERNATIONAL IN PERU

A HEALTH CRISIS WITHIN A MIGRATION CRISIS

Venezuela's deteriorating economic and political situation has caused a mass exodus to other countries in Latin America, with Peru admitting the second largest number of Venezuelan refugees and migrants in the world after Colombia.

As of November 2023, 1,54M Venezuelan migrants and refugees had arrived in Peru, mainly Venezuelan women with small children (0-5 years old) and young adults (ages 18 to 24)



HEALTH NEEDS

were among the most important priorities for vulnerable Venezuelan migrants in Peru (RMRP, 2021)

The most common diseases were asthma (39%), followed by hypertension (18%), arthritis (5%), diabetes (5%), heart disease (4%), and cancer (2%). Among those who had migrated with their children, 46% had at least one school-age child with preventive care needs.

A HEALTH CRISIS FED BY POVERTY

While 44% of the Venezuelan population in Peru has health issues, 81% of those seeking private care mainly go to a pharmacy or self-medicate, 8% seek care in a private doctor's office and 18% in a public health center. The reasons for not seeking care in public or private health services were mostly due to lack of money (40%) to cover the costs of appointments, exams, and other medical expenses for treatment follow-ups (RMRP, 2021).

HEALTH CONCERNS WERE OFTEN DEPRIORITIZED...

... by Venezuelan migrants before SCI intervention as the need for basic need coverage was an immediate priority, especially food and rent. Venezuelan migrants prioritized access to health care when they had already undertaken a health diagnostic, identified the necessary treatment and/or if the health concern was serious.¹

LACK OF INFORMATION/DOCUMENTATION AND STIGMATIZATION

There was also an important lack of access to healthcare-related information and knowledge among both the Venezuelan population and health service providers. Although the national public health service (SIS for its acronym in Spanish) is available for those most in-need, both from the host and migrant populations, only 10% of the total Venezuelan population in Peru has effectively accessed it (R4V, 2020) and when they did so, they often faced discrimination and mistreatment by doctors in hospitals. 82% of Venezuelan migrants under 18 were not affiliated to any health insurance, and only 29% of children under 5 have access to the SIS, even though they have the option of receiving free healthcare (R4V, 2021). Lack of documentation was a key impairment preventing Venezuelan migrants accessing the public health care system.²

In July 2020, most Venezuelan pregnant women and children under the age of 5 (around 60%) had been cared for outside the national public health service (SIS for its acronym in Spanish), and in 2021, while 7% of migrant women were pregnant, more than half (51%) of them had not receive prenatal care³ and one out of five (20%) had not received regular check-ups (INEI, 2020).

DIVERSITY OF HEALTH NEEDS

Identified health issues varied widely according to age and gender, from chronic diseases such as hypertension and diabetes, which are most common, to specific needs that require diagnosis, emergency treatment, work-related ailments and mental health. The main issues affecting children were anemia, asthma and ophthalmologic problems, while adolescents suffered as well more from mental health issues, including anxiety. Women faced more issues related to reproductive systems, and when pregnant they often not access pre/post-natal care. Adults were mostly affected by health issues at the workplace (i.e. carrying heavy loads leading to muscular issues such as hernias) or when traveling from/to the workplace (i.e. in need of emergency care following a road accident).

1. Qualitative data from interviews with SC health team in the country office.
2. Qualitative data from interviews with Venezuelan migrants participating to SCI intervention
3. Although they are automatically eligible to access these services through the SIS

CVA FOR HEALTH SUMMARY - BHA & BPRM ACTIVITIES

INTEGRATED PROGRAMMING:

Between September 2021 and August 2023, Save the Children (SC) delivered a holistic humanitarian response to address the multi-sectorial needs of Venezuelan refugees and migrants, either settling in or transiting through Peru, as well as of host community members, by implementing two programs in an integrated manner:

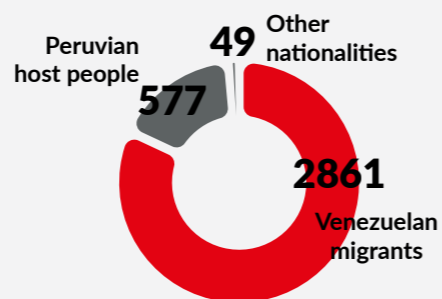
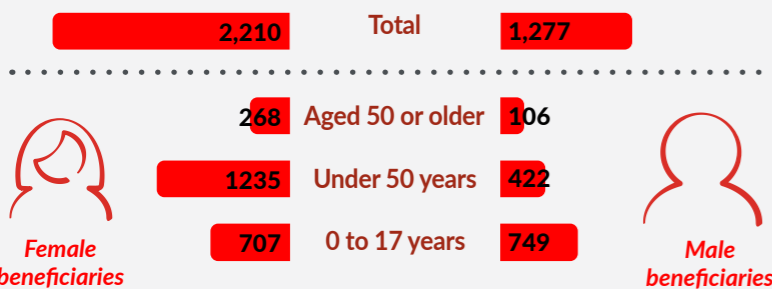
→ **The BHA-funded program “Families Without Borders”** aimed to provide immediate, lifesaving assistance to vulnerable and at-risk Venezuelan migrants in Peru, to cover their basic needs to achieve, maintain, or improve food security, together with supplementary nutrition interventions to improve the nutrition practices and outcomes of pregnant and lactating women and children under 5.

→ At the same time, **the BPRM-funded program “A path to integration”** aimed to strengthen the inclusion of at-risk, vulnerable Venezuelan refugees, migrants and host communities in Peru, through secure and stable livelihood opportunities and access to essential health & MHPSS services. BHA beneficiaries who expressed health/MHPSS/livelihood needs were automatically referred to the BPRM-funded program.



3,487

Beneficiaries reached through cash (year 2 of implementation)



1,613

Pregnant and lactating women, children and adolescents reached

BHA ACTIVITIES



FOOD ASSISTANCE:

- Unconditional and unrestricted cash to access food, non-food items and hygiene products



NUTRITION:

- Maternal, infant, and young child nutrition in emergency (MIYCN-E): (a) MIYCN-E practice promotion/awareness-raising among Venezuelan migrants and Peruvian host communities, (b) breastfeeding friendly spaces and (c) health worker trainings

BPRM ACTIVITIES



HEALTH:

- Cash for health for cases with specific health needs
- Disseminate key health messages on available local health and protection services, health and protection referral routes, basic health, hygiene and protection messages through social media networks and educational virtual spaces
- Health campaigns with other local and INGOs, as well as with the public health centers, in communal spaces and schools
- Advocacy actions with the Ministries of Health, Education and Superintendence of Migrations to canalize government's health strategy



PROTECTION:

- Orientation package, itinerant CFS, PSS workshops

LIVELIHOODS: (employability and entrepreneurship pathways)

- E-learning platform available 24/7 with 23 vocational training courses and 17 entrepreneurship courses for self-training
- Life-skill trainings and mentorship groups to provide information and orientation on different subjects such as regularization of migratory status, financial literacy, personal image, business formalization, etc.
- Cash assistance (seed capital) to develop/restore entrepreneurship activities or strengthen employability.
- Cash assistance to reduce employment barriers (course enrollment, buying supplies to be hired, payments to regularize the migratory status, etc.)



MHPSS:

- Virtual MHPSS sessions, using social media and other communication channels
- Community-centered actions and peer-to-peer listening, reflection and dialogue sessions to strengthen support networks with both migrant and host families in child and adult & friendly spaces
- Referral of complex/special cases to national health service or other specialized organizations
- Disseminate key MHPSS messages on family-/self-care and positive discipline
- Psychosocial Assistance during in-transit interventions, through child-friendly spaces and during fairs/campaigns

September 2021

BPRM PROGRAM

August 2023

July 2021

BHA PROGRAM

July 2024

CVA CHARACTERISTICS AND COMPLEMENTARY HEALTH ACTIVITIES

CVA FOR HEALTH CHARACTERISTICS



Types of CVA for health

Type 1: Cash for medical consultation/diagnosis
Type 2: Cash for pregnant women and postpartum,
Type 3: Cash for people with disabilities,
Type 4: Cash for people with chronic diseases,
Type 5: Cash for people with acute illnesses,
Type 6: Cash for screening children under 5

Frequency

Up to three times

Conditions/Restrictions

Unrestricted

No conditions for type 1 and type 6.
Type 2-5 conditions: Medical diagnosis by a health specialist, referral orders for consultation/exams, medical prescription and/or other documents according to the health condition and need for healthcare requiring cash & voucher assistance

Delivery mechanisms



OR



Mobile money for cash over-the-counter

Pre-paid cards to withdraw cash in ATMs or directly at VISA Point of Services

COMPLEMENTARY HEALTH ACTIVITIES



HEALTH CAMPAIGNS were introduced at the end of the Program Phase 1 in coordination with health-specialized local partners, such as the Red Cross. Through these campaigns, SC teams and partners were able to directly identify vulnerable Venezuelan and host community with health needs, which fastened the targeting and selection process. Additionally, screening days for children were also undertaken in schools in coordination with local health centers;



ACCESS TO THE NATIONAL HEALTHCARE SYSTEM: considering that vulnerable migrants not possessing the Foreigner's Card (EC) may only be granted access to a limited range of specific health services in the public system, SC referred those cases to partners/allies throughout the program intervention to support migrants' access to the EC and affiliation to the national public healthcare system (SIS);



STRENGTHENING HEALTH PRACTICES: SC delivered complementary key messaging according to the health needs frequently identified by SC health teams when undertaking medical diagnosis and counter-verifications. Face-to-face group workshops, online webinars and infographics were delivered on health issues commonly faced by program participants related to mental health/disorder (i.e. autism), emergency newborn care and breastfeeding practices;



FOLLOW-UP ON CASH UTILIZATION AND HEALTH CONDITIONS: Phone-based follow-ups were undertaken by SC health teams to CVA Type 1 (medical consultation/ diagnosis), Type 5 (acute illness) and Type 6 (U5 children screening) beneficiaries to monitor and assess cash utilization. Health teams reiterated the objective of the CVA for health and motivated participants to use it for such a purpose when not used as initially planned. SC health teams gathered more information on the diagnosis and assessed if another CVA Type was also needed.



Some of the CVA Type 5 (acute disease) was also delivered to cover health-related debts previously contracted by beneficiaries in order to access necessary emergency treatments not covered by hospitals. In such cases, SC health teams followed-up by phone to assess cash utilization. In coordination with the social service of hospitals, the team also conducted hospital visits to unaccompanied beneficiaries to assess their health condition, deliver a pre-paid card and request for consent for boarding.



CVA DELIVERY CHARACTERISTICS

TARGETING AND SELECTION CRITERIA:

1. Venezuelan migrants and members of the Peruvian host community with economic vulnerabilities falling under the below five categories:

- children and adolescents
- pregnant and lactating women
- people with disabilities
- people with chronic illness
- people with acute illness with or without the need for hospitalization

2. And who express a health problem and require financial assistance to cover the costs of a diagnosis for preventive or responsive medical care;

3. And/or who presents medical diagnosis/health prescriptions,

4. And/or who are not covered or only partly covered by the SIS/EsSalud

The targeting and selection criteria were designed to address the socioeconomic and demographic vulnerabilities as well as the financial health barriers that aggravate Venezuelan migrants' situation. Additionally, the targeting and selection process was mostly undertaken remotely through a phone-based assessment survey. As COVID-19 restrictions decreased the process was more and more conducted face-to-face.

SELECTION:

SC health teams assessed health needs upon direct identification, referral or on-demand requests, either face-to-face or remotely by phone:

Scenario #1 - CVA Type 1 (to obtain a medical diagnosis) and Type 6 (health screening for U5): the household member(s) expressed a health problem that required a diagnosis, and the health officers/promoters undertook a health needs assessment to confirm healthcare needs;

Scenario #2 - CVA Type 2 (pregnancy/postpartum and U2), Type 3 (disabilities), Type 4 (chronic illness) and Type 5 (acute illness): household member(s) provided medical evidence/health prescriptions, disability cards and/or medical certificates. The health officers/promoters verified the medical evidence/prescriptions. All medical evidence had to be signed-off by an accredited physician or health professional with a professional association number and without blurred information, erasures or amendments. A validity check of the professional association numbers was also done through the website of the Medical College of Peru (CMP).

REFERRAL:

Internal referral: Participants to the BHA- and BPRM-funded program with a medical diagnosis/prescription or having a health concern with or without a medical diagnosis were automatically referred through a Kobo-based tool to SC health teams for a counter-health assessment.

External referral: local and international NGOs as well as government health partners (Social Service of Public Hospitals) could refer cases while using a standardized inter-agency Kobo-based form.

Direct identification: Cases with health concerns were also directly identified by SC mobile teams in transit hot spots, during health campaigns organized by SCI and partners/allies as well as during the "Days for Integrated Support⁵ organized by SCI teams.

On-demand registration: vulnerable migrants were given the opportunity to register on-demand through the SC's call center.



5. Days for Integrated Support aimed to deliver multi-sectorial assistance face-to-face to settled migrants and host community members by SC Peru (Cash, Nutrition, MHPSS and Livelihoods) in the targeted regions

DUPLICATION AND VERIFICATION:

Checks with the BPRM-BHA internal database and inter-agency online platforms were then systematically conducted to limit risks of duplication and exclusion. A sample of cases was also asked to provide proof of ID during a face-to-face follow-up visit.

TRANSFER VALUES:

Transfer values were calculated and adapted according to (a) the sub-national price variations of health services and medications as well as (b) the types of health issues to be covered, either for preventive healthcare or treatments, in order to ensure the delivery of a tailor-made assistance based on individuals' specific needs and current market dynamics. A five-step approach was undertaken to calculate transfer values:

- Definition of types of medical services, procedures and medications required by Venezuelan migrants and host community members
- A mapping of available healthcare services/medications in each of the five targeted sub-national regions of Peru, focusing on the districts with high percentages of the target population
- A costing of these healthcare services/medications in each of the five regions
- The definition of six Types of healthcare profiles according to the assessed health needs and the services/medications each profile required
- The calculation of transfer value ranges for each of those six Types of healthcare profiles to be applied nation-wide

Local transportation costs were also factored in the below transfer values to ensure access to the health facilities as well as to the local cash agents of the financial service provider. The final costing of health services was then shared to all health teams in order for them to determine the exact transfer values needed for each case and within the nation-wide transfer value ranges defined for each Type of CVA for health. The calculation of transfer values was therefore flexible and need-based to cover the specific health needs of the beneficiary as determined by the health officer and/or health promoter. **Please refer to the table next page for more information.**

CONDITIONS & RESTRICTION:

While all CVA types were delivered without any restrictions, most CVA types (Type 2 – PLW; Type 3 – disabilities; Type 4 – chronic illness; and Type 5 – acute illness) were delivered upon compliance with two conditions:

Provision of health support documents: a medical diagnosis delivered by an accredited physician or health professional with a professional association number, or a referral order for consultations/exams, or a medical prescription and/or any other documents confirming the health condition and the need for healthcare.

Verbal confirmation of not having access to a private health insurance and/or that healthcare is **not being delivered on time;**

On the other hand, the CVA for medical consultation/diagnosis (Type 1) and for U5 screening (Type 6) were delivered unconditionally.

FREQUENCIES AND DURATION:

Beneficiaries could receive up to three cash transfers for health according to their specific health needs and for a total value not exceeding 918 USD between the different Types of CVA for health. Cash transfers were delivered on average 5 to 7 days after registration, with the exception of migrants in-transit and/or requiring emergency cases who could receive CVA within 24 hours upon registration.

TRANSFER VALUE DETERMINATION

| | Types of health voucher | T.V. 1 | T.V. 2 | Target | Process | Condition(s) |
|---------|---|-----------------------|---------------------|---|---|--|
| Type 1: | CASH FOR MEDICAL CONSULTATION (to obtain a medical diagnosis) | \$26 - \$53 | \$40 - \$66 | Cases with health issues but without a medical diagnostic yet and/or had an old medical diagnosis (more than 6 months) and needed a medical reevaluation to confirm the diagnosis | Review and confirmation of the health status/needs of the case by the health officer/promoter. | Verbal confirmation of not having access at all to the national healthcare system (SIS) and/or verbal confirmation that healthcare is not being delivered on time. |
| Type 2: | CASH FOR PREGNANCY/POSTPARTUM AND PEOPLE WITH CHILDREN UNDER 2 | \$32 - \$132 | \$31 - \$131 | Pregnant women, postpartum up to 42 days and lactating women with children U2 | The participant manifests the need for health care and presents medical evidence confirming health needs (i.e. laboratory test order, ultrasound, pharmacological treatment, medical consultation with specialists, gestation control card, etc.); Health officers/promoters verify the medical evidence/prescriptions, and based on the medical prescription, they calculate the transfer value to be disbursed. | (1) Provision of medical evidence of pregnancy status and medical need; (2) Verbal confirmation of not having access at all to the national healthcare system (SIS) and/or Verbal confirmation that healthcare is not being delivered on time. |
| Type 3: | CASH FOR PEOPLE WITH DISABILITIES (Including physical/motor disabilities, sensorial disabilities, intellectual disabilities and psychic disabilities) | \$32 - \$211 | \$31 - \$918 | People with disabilities | The individual manifests the need for health care for disabilities and presents evidence of the disability condition such as a disability card and/or a medical certificate (either issued in Peru or Venezuela) and of medical needs existing at that time (i.e. laboratory test order, pharmacological treatment, rehabilitation therapy, etc.). Health officers/promoters verify the medical evidence/prescriptions, and upload it to the evaluation matrix. | (1) Provision of evidence of the disability condition (either issued in Peru or Venezuela) and of medical needs (i.e. laboratory test order, pharmacological treatment, rehabilitation therapy etc.); (2) Verbal confirmation of not having access at all to the national healthcare system (SIS) and/or Verbal confirmation that healthcare is not being delivered on time. |
| Type 4: | CASH FOR PEOPLE WITH CHRONIC DISEASE | \$32 - \$211 | \$31 - \$918 | People with chronic disease | Provision of evidence of the chronic disease diagnosis and prescriptions (i.e. prescriptions for tests, medical certificate, medications/ supplements, etc.). Health officers/promoters verify the medical evidence/prescriptions, and upload it to the evaluation matrix. | (1) Provision of evidence of the chronic disease diagnosis and prescriptions; (2) Verbal confirmation of not having access at all to the national healthcare system (SIS) and/or Verbal confirmation that healthcare is not being delivered on time |
| Type 5: | CASH FOR PEOPLE WITH ACUTE DISEASES (Including people hospitalized or awaiting low or medium complexity treatment that will require surgery/hospitalization, generated by situations in the course of an illness or due to accidents.) | \$132 - \$2,115 | \$31 - \$918 | People with acute disease (Includes medical emergencies due to accidents) | Provision of medical evidences/health prescriptions; Health officers/promoters verify the medical evidence/prescriptions. | (1) Provision of evidence of the acute disease diagnosis and prescriptions; (2) Verbal confirmation of not having access at all to the national healthcare system (SIS) and/or Verbal confirmation that healthcare is not being delivered on time. NB: In case of hospitalization, the beneficiary's family must attach evidence of the expenses already owed and/or a proforma of the expenses to be incurred. Officers can visit the individual at the hospital to confirm hospitalization. In the case of reimbursements, the evidence may be considered under the following condition: reimbursements of expenses incurred by the beneficiary and/or policy holder will be considered up to 20 days prior to the verification interview call. In case of surgeries, individuals must attach a proforma of the expenses to be incurred issued by the healthcare establishment. |
| Type 6: | CASH FOR HEALTH SCREENING FOR U5 (VISUAL/NUTRITIONAL/PEDIATRIC/DENTAL SCREENING) (N.B. In year one, there were 2 different types of cash for this group: one was a preventive cash and the other a responsive cash. The amounts were the same.) | \$ 32 - \$132 | \$ 31 - \$131 | Children below 5 | Parents/caregivers express having a child < 5 who has not attended their Growth and Development control (CRED for its acronyms in Spanish), immunizations or their screening check, which includes dental, nutrition, and ophthalmology services. Review and confirmation of the health status/needs of the child by the health officer/promoter. | None. |

SUCCESS / ACHIEVEMENTS⁶

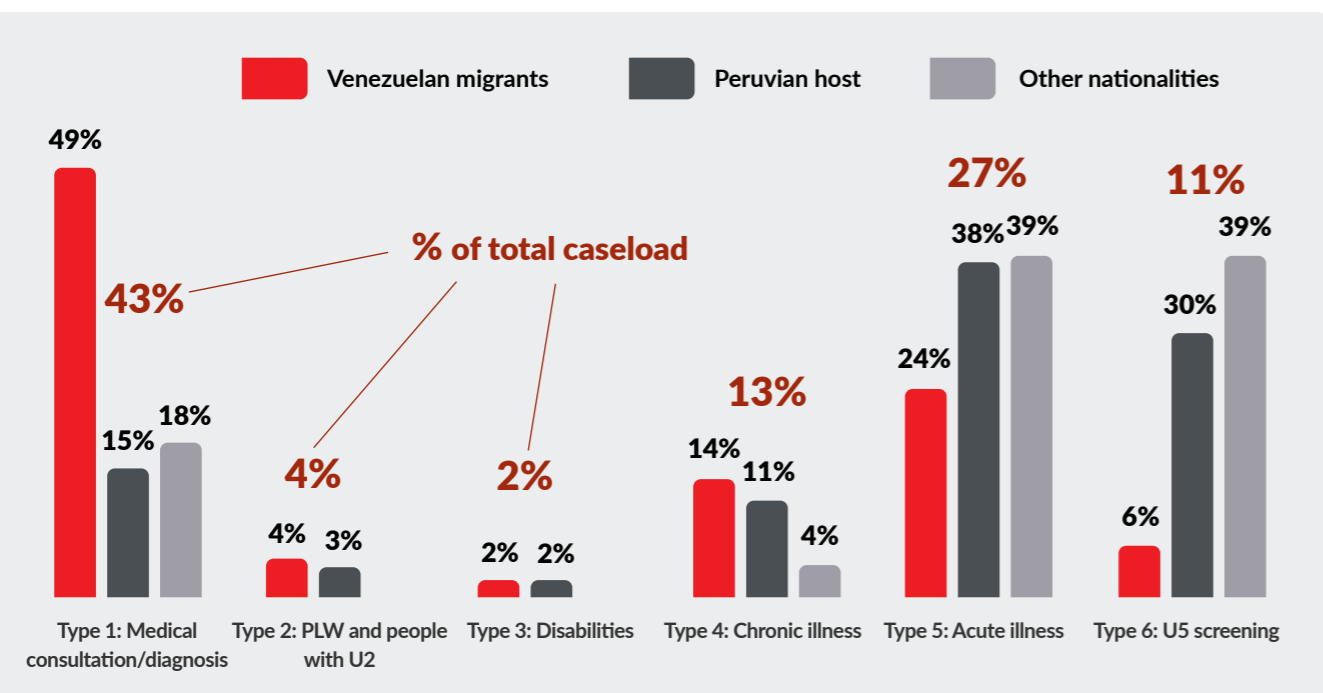
19,764 individuals benefited from interventions across livelihoods, MHSSP and the health sectors throughout the two years of BPRM program implementation. **42%** of them received a CVA for Health (8,228 individuals).

The following results are based only on the 3,487 individuals having benefited from the Cash for Health during the second year of implementation.

Referrals: Most health participants (61%) were referred internally from the BHA project interventions, followed by direct identification through health campaigns or children's health screening campaigns (20%), external referrals from local partners (14%) and finally 6% were referred internally from the BPRM project sectors (Nutrition, Livelihoods and MHPSS).

Delivery frequency: Although CVA could be delivered up to three times, on average beneficiaries received between 1.1 (per individual) and 1.3 (per household) cash transfers depending on their health needs as some of them received a first cash for diagnosis (type 1) and then an additional one for treatment.

Disaggregation of beneficiaries per types of cva for health outcomes



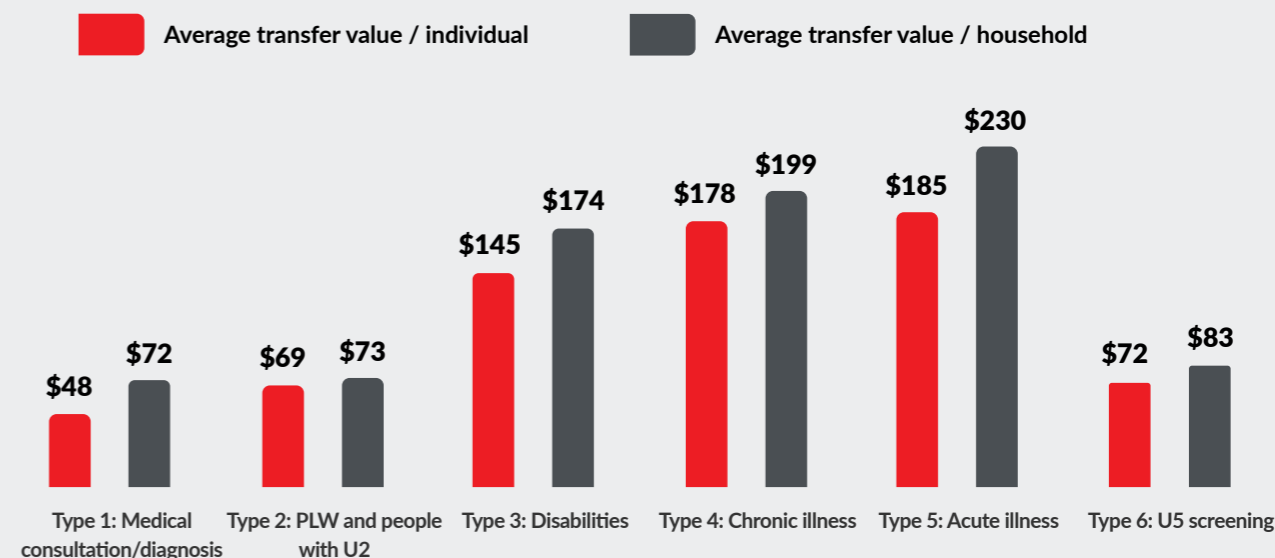
43% of the CVA for Health was delivered to beneficiaries falling under Type 1 (medical consultation/diagnosis), followed by 27% under Type 5 (acute diseases), 13% under Type 4, (chronic disease), 11% under Type 6 (health screening for U5), 4% under Type 2 (PLW) and 2% under Type 3 (disabilities).

Analysing the type of CVA received according to nationalities, it is noticeable that Type 1 (medical consultation/diagnosis) was the most needed assistance for Venezuelan migrants while host Peruvians needed more the Type 5 (acute diseases).

Peruvians from the host community requested, to a larger extent compared to Venezuelan migrants, CVA for acute illnesses (Type 5), which required more expensive health services and good coverage than CVA for medical consultations/diagnosis (Type 1) which was more requested from Venezuelan migrants. In turn, the transfer value for Peruvian host community members was on average \$147 per household and \$102 for migrating Venezuelan households.

6. Focusing on Year 2 programming

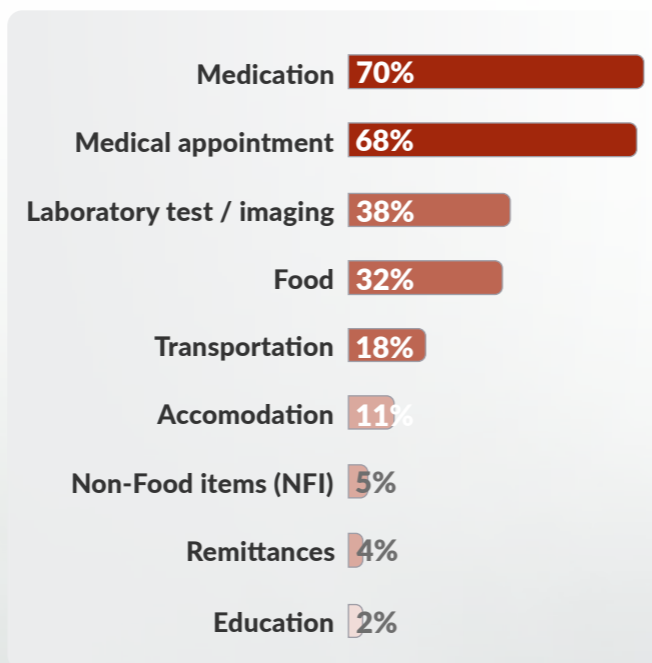
Average transfer values per types of CVA for health outcomes



SUCCESS / ACHIEVEMENTS

Most commonly reported utilization of the CVA

Although the CVA for health outcomes was partly conditional (from CVA Type 2 to Type 5 - see above) and fully unrestricted, the project teams sensitized beneficiaries with key messages on CVA for Health objective. **88% of the beneficiaries who received the CVA for Health fully spent the assistance on health-related expenditures: 70% to buy medicines, 68% for medical appointments and 38% for labs/imaging.**

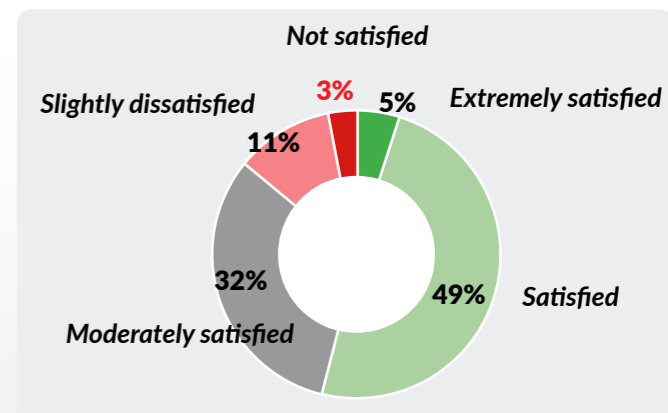


The remaining **12% (987 individuals)** did not fully use the CVA for the agreed health purposes. Over half of them (55% - 493 individuals) mentioned using the CVA for other medical expenses than for those the CVA was initially targeting; 9% (89 individuals) expressed that although they had the money they could not receive medical care, 9% (89 individuals) said that the money was not enough for the medical treatment they needed, 9% (89 individuals) did not know health establishments, and 18% (178 individuals) mentioned other reasons.

Recognizing the multi-dimensional nature of poverty and vulnerabilities affecting Venezuelan migrants and vulnerable Peruvians from the host communities, 32% of beneficiaries also used the assistance to cover food needs, 18% for transportation costs, 11% to pay rent/accommodation, 5% to buy NFI, 4% to send remittance and 2% to cover education-related costs.

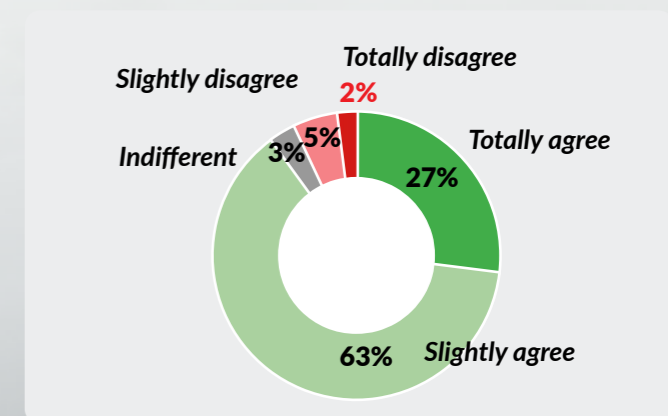
Level of satisfaction with the transfer values

49% of the beneficiaries stated being very satisfied and 5% being extremely satisfied with the transfer values of the CVA for Health, while 32% mentioned being moderately satisfied, 11% being slightly dissatisfied and 3% not being satisfied.



Level of satisfaction with timeliness of assistance

91% surveyed individuals agreed (with 27% totally agreed and 64% agreed) that the CVA had been delivered in a timely manner while approximately 10% were either indifferent (3%), slightly disagreed (5%) or totally disagreed (2%).



LESSONS LEARNT AND GOOD PRACTICES: CHALLENGES AND ADAPTATIONS

Developing a network of health allies: although the intervention was initially designed to only accept internal referrals from the BHA project, SC opened targeting by setting up external referral pathways through partnerships with public hospitals, the Red Cross, INGOs and local NGO as well as direct identification through joint health campaigns by which staff directly identified and referred beneficiaries to receive CVA for health outcomes. A Kobo-based referral form was designed to achieve this objective.

Health campaigns: health campaigns carried the benefits of identifying vulnerable members of the target groups, assess their needs and vulnerabilities and refer them to various services, all at the same time, in an effort to provide the most comprehensive package of support needed to address their multi-dimensional vulnerabilities. The SC health teams were able to counter-refer cases to other sectorial interventions under the BHA/BPRM program according to needs identified during the health campaigns. In turn, such a strategy reduced the time necessary for targeting, selection and registration that could be done all at-once in the same location.

These campaigns also allowed beneficiaries to access a free-of-charge basic medical consultation by one of SC's partner who then referred cases to SC's health team to undertake a follow-up assessment may there be a need to determine more specialized/complex health services for these cases. Eligible beneficiaries were also able to collect their pre-paid card on the day of the health campaigns, which greatly reduced delays between beneficiary registration and access to the CVA for health.

Transfer value calculation and adaptations: as mentioned above, the health teams undertook a meticulous process to calculate transfer value ranges for each types of health needs while considering market price variations at sub-national level. This was instrumental in ensuring that the CVA for Health is designed to cover appropriately the variety of identified health needs among the target population.

Transfer values were subsequently adapted during implementation: high and unrestricted transfer values carried the risk of incentivizing CVA utilization for other sectorial needs beyond health-related expenditures considering high levels of vulnerability. The transfer value for the costliest CVA Type (Type 5 for acute illness) was decreased due to budget constraints and the number of follow-up visits was increased instead.

On the other hand, the variety of types of chronic diseases, disabilities and subsequent treatments may be very costly. Consequently, the transfer value range of the Type 4 of CVA (chronic illness) was increased during the second year of implementation.



Video presentation on integrated health campaign

Initial transfer values did not include the costs of transportation to the health providers, which initially limited beneficiaries' ability to receive medical attention. Program adaptations were made during the second year of implementation to include such transportation costs.

FSP capacities: many acute cases required low-/medium-complexity treatments such as surgery/hospitalization at high costs. In parallel, the contracted financial service providers were not in a position to deliver such large amounts into a single transfer, in turn forcing SCI to split the cash transfer into lower values, which added some administrative burden on both the project teams and the cash recipients. However, in some cases this limitation was an opportunity to follow-up more closely with beneficiaries

about their health situation and their utilization of the CVA.

Cash transfer delivery times:

Health cases often require immediate attention. Establishing clear flows and agreements with the provider is crucial to limit delays between registration and access to the CVA/healthcare services. In the first phase, a speed-up protocol was established with the FSP for cases requiring emergency hospital care within 24 hours. Additionally, a comparative delivery mechanism assessment was undertaken to determine the exact time required between registration and access to the CVA for each delivery mechanism. Accessing the CVA through ATMs was the fastest delivery mechanism.

Cash amounts assessment and approval:

As every health case needed a differentiated cash amount, the SC team created a dynamic online matrix to evaluate and approve each case and its corresponding amount. During the first year, the matrix had three evaluation levels: Level 1 - Cases with amounts below \$133 were assessed and approved by the Health Specialist; Level 2 - Cases with amounts between \$134 and \$933 were evaluated and approved by the health specialist and a territorial coordinator; and Level 3 - Cases with amounts above \$934 were assessed

and approved by the health specialist, the territorial coordinator, and the project manager. During the second year of the project, the levels were reduced to two: Level 1 - Cases with amounts less than \$133 were assessed and approved by the Health Specialist; Level 2 - Cases with amounts equal to or greater than \$134 and above, were assessed and approved by the Health Specialist, the territorial coordinator and a health officer from another territorial office. This practice allowed SC to quickly amend identified errors, ensure the consistency of the health cash allocation, reduce subjectivities in cash amounts and promote transparency.

KEY RECOMMENDATIONS

The main recommendations to strengthen future CVA for Health outcomes programs are as follows:

1. CVA for health outcomes should be complemented (Cash +) with other health activities and other sectorial interventions (i.e. basic need coverage, accommodation, livelihoods, WASH, protection and psychosocial support depending on the context/needs assessment) to deliver a comprehensive package of support that may address the multi-dimensional nature of vulnerabilities and poverty.
2. Identify the health needs of the target population, map service providers in each target locations and determine healthcare costs at market level in each target location;
3. Develop new partnerships and leverage those already in place with a large number of health service providers to ensure timely and appropriate referrals and in turn the coverage of the vast variety of health needs across the target caseload;
4. Deliver tailor-made cash transfers, with transfer values adapted to the specific needs of each health cases through the calculation of ranges of transfer values for each of the main types of assessed health care needs;
5. Consider direct payments to some health service providers for high-cost health-care processes/treatments and emergency cases requiring immediate hospitalization;
6. Factor the debts previously contracted by some beneficiaries at hospitals and to be covered by the agency when developing the project's budget in order to ensure the achievement of positive health outcomes;
7. Dedicate sufficient internal resources to plan regular follow-up visits to monitor beneficiaries' healthcare process and CVA outcomes;



Health campaigns in Lima and La Libertad, during which Save the Children and its strategic local organizations provide key health messaging, undertake health diagnostics, refer cases for specialized services and register beneficiaries for the cash for health assistance

8. Ensure the existence of a secured IT system that ensures the confidentiality of personal/sensitive health information and data protection in general while being able to share key and non-sensitive data to appropriate sectorial teams for referral and monitoring purposes;
9. When the assessment is done via telephone, consider having a support team to schedule assessment appointments for beneficiaries, as this will help save time in locating hard-to-reach beneficiaries;
10. Consider providing socioemotional support to the health team involved, as the emotional burden during the assessment of health cases may cause them anxiety and stress;
11. Provide specialized information on the prevention of recurrent chronic diseases in the intervention through WhatsApp, open webinars, etc;
12. Include a psychology expertise within the health team to better assess the neuro-diversity of cases;
13. May cash for health cover dental care, clearly specify the levels/types of dental care coverage according to the level of urgency of the need;
14. Coordinate closely with the Department of social services of partner hospitals, including through a database management protocol, to ensure appropriate referrals of vulnerable cases.