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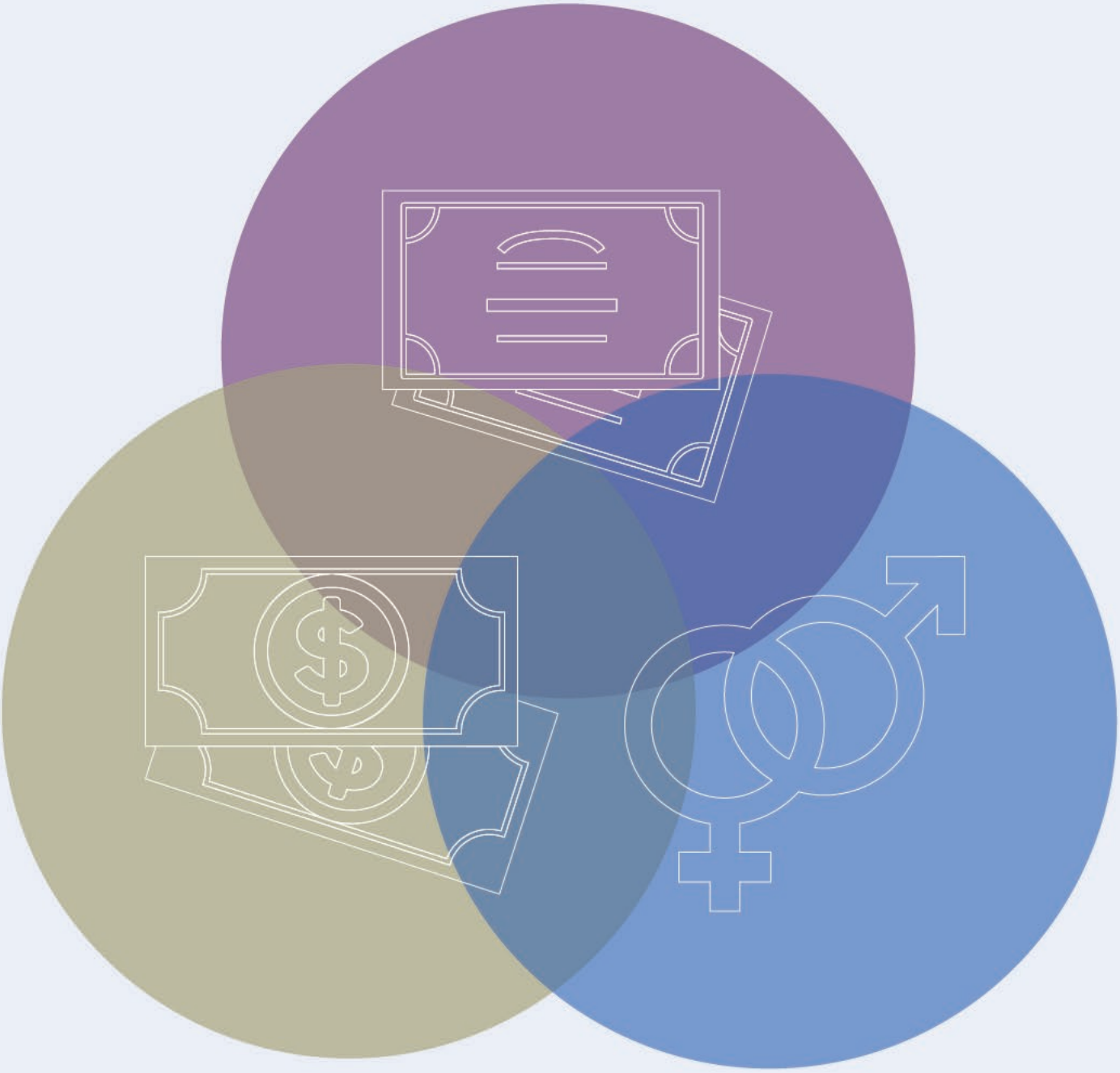

Case Studies: Afghanistan and Yemen

Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian emergencies

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Contents

Abbreviations

AFN	Afghan Afghani
ANC	Ante-Natal Care
BARAN	Bu Ali Rehabilitation and Aid Network
BPHS	Basic Package of Health Services
CALP	Cash Learning Partnership
CCT	Conditional Cash Transfer
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CVA	Cash and Voucher Assistance
DHS	Demographic Health Survey
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunisation
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
ID	Institutional Delivery
IUD	Intra Uterine Device
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt für Wiederaufbau/German Development Bank
KII	Key Informant Interview
LARC	Long Active Reversible Contraceptives
KIT	Koninklijk Instituut voor de Tropen/Royal Tropical Institute
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MOPH	Ministry of Public Health (Afghanistan)
MOPHP	Ministry of Public Health and Population (Yemen)
MOVE	MOVE Welfare organization
MWRA	Married Women of Reproductive Age
OOP	Out of Pocket
PM	Permanent Methods
RH	Reproductive Health
Shura	Village health committee (in Afghanistan)
SM	Safe Motherhood
SRHR	Sexual Reproductive Health and Rights
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WRC	Women's Refugee Commission

List of terms

Cash and Voucher Assistance (CVA)
"CVA refers to all programs where cash transfers or vouchers for goods or services are directly provided to recipients. In the context of humanitarian assistance, the term is used to refer to the provision of cash transfers or vouchers given to individuals, household or community recipients; not to governments or other state actors. This excludes remittances and microfinance in humanitarian interventions (although microfinance and money transfer institutions may be used for the actual delivery of cash). The terms 'cash' or 'cash assistance' should be used when referring specifically to cash transfers only (i.e. 'cash' or 'cash assistance' should not be used to mean 'cash and voucher assistance'). This term has several synonyms but Cash and Voucher Assistance is the recommended term."(1)

Cash Assistance
"The provision of unrestricted assistance in the form of money - either physical currency or e-cash - to recipients (individuals, households or communities). The terms 'cash' or 'cash assistance' should be used when specifically referring to cash transfers only (i.e. 'cash' or 'cash assistance' should not be used when meaning 'cash and voucher assistance')."(1)

Cash Transfer
"The provision of assistance in the form of money - either physical currency or e-cash - to recipients (individuals, households or communities). Cash transfers are by definition unrestricted in terms of use and distinct from restricted modalities including vouchers and in-kind assistance."(1)

Conditional Transfer/Conditionality
"Conditionality refers to prerequisite activities or obligations that a recipient must fulfil in order to receive assistance. Conditions can in principle be used with any kind of transfer (cash, vouchers, in-kind, service delivery) depending on the intervention design and objectives. Some interventions might require recipients to achieve agreed outputs as a condition of receiving subsequent tranches. Note that conditionality is distinct from restriction (how assistance is used) and targeting (criteria for selecting recipients). Examples of conditions include attending school, building a shelter, attending nutrition screenings, undertaking work, training, etc. Cash for work/assets/training are all forms of conditional transfer."(1)

Minimum Expenditure Basket (MEB)
"A Minimum Expenditure Basket (MEB) requires the identification and quantification of basic needs items and services that can be monetized and are accessible in adequate quality through local markets and services. Items and services included in an MEB are those that households in a given context are likely to prioritize, on a regular or seasonal basis. An MEB is inherently multisectoral and based on the average cost of the items composing the basket. It can be calculated for various sizes of households." (1)

Modality
"Modality refers to the form of assistance – e.g. cash transfer, vouchers, in-kind, service delivery, or a combination (modalities). This can include both direct transfers to household

level, and assistance provided at a more general or community level e.g. health services, WASH infrastructure." (1)

Multipurpose Cash Transfers (MPC)
"Multipurpose Cash Transfers (MPC) are transfers (either periodic or one-off) corresponding to the amount of money required to cover, fully or partially, a household's basic and/or recovery needs. The term refers to cash transfers designed to address multiple needs, with the transfer value calculated accordingly. MPC transfer values are often indexed to expenditure gaps based on a Minimum Expenditure Basket (MEB), or other monetized calculation of the amount required to cover basic needs. All MPC are unrestricted in terms of use as they can be spent as the recipient chooses. This concept may also be referred to as Multipurpose Cash Grants (MPG), or Multipurpose Cash Assistance (MPCA)." (1)

Unconditional Transfer
"Unconditional transfers are provided without the recipient having to do anything in order to receive the assistance, other than meet the intervention's targeting criteria (targeting being separate from conditionality)." (1)

Unrestricted Transfer
"Unrestricted transfers can be used as the recipient chooses i.e. no effective limitations are imposed by the implementing agency on how the transfer is spent. Cash transfers are by definition unrestricted in terms of use." (1)

Value Voucher
"A value voucher has a denominated cash value and can be exchanged with participating vendors for goods or services of an equivalent monetary cost. Value vouchers tend to provide relatively greater flexibility and choice than commodity vouchers but are still inherently restricted as they can only be exchanged with designated vendors." (1)

Voucher
"A paper, token or e-voucher that can be exchanged for a set quantity or value of goods or services, denominated either as a cash value (e.g. $15) or predetermined commodities (e.g. 5 kg maize) or specific services (e.g. milling of 5 kg of maize), or a combination of value and commodities. Vouchers are restricted by default, although the degree of restriction will vary based on the programme design and type of voucher. They are redeemable with preselected vendors or in 'fairs' created by the implementing agency. The terms vouchers, stamps, or coupons might be used interchangeably" (1)

1 Introduction to the case studies

1.1 Background

Cash and voucher assistance (CVA) refers to programs where cash or vouchers, exchangeable for goods or services, are directly provided to community members. The term is often used interchangeably with Cash transfer Programming, Cash based Interventions, Cash Based Assistance, and Cash and Voucher Programming (1).

CVA can be useful to improve access to and utilisation of health services, by reducing direct and indirect financial barriers and/or by incentivising the use of free preventive services. In addition, there is a growing body of evidence that highlights that CVA should always be considered complementary to other supply- and demand-side interventions rather than a stand-alone action (2).

Following commitments related to the Grand Bargain, donors and aid organisations are increasingly encouraged to consider CVA in their health response option analysis. While the body of evidence around CVA for health is growing, most of it comes from development contexts rather than from humanitarian settings. Given the major differences in a wide range of areas/dimensions, it is not always possible to directly transfer evidence generated in development contexts to humanitarian ones.

Sexual and Reproductive Health and Rights (SRHR) services are an essential component of the humanitarian response and include:

- Maternal health services (ANC, safe delivery, PNC)
- Family planning/contraception
- Abortion
- STIs and HIV/AIDS services
- Gender-based violence (intimate partner violence, FGM/C, chid marriage)
- Information/education/counselling on human sexuality and reproductive health
- Infertility.

In spite of a growing interest to include CVA while planning and providing SRHR services, there is limited evidence about its effectiveness and feasibility, and about its overall effect on SRHR outcomes, particularly in humanitarian settings. Therefore, there is a need to consolidate existing evidence around CVA for SRHR services, document current practices, and discuss the findings with key actors, with the aim of defining its potential role in the planning and provision of SRHR services in humanitarian settings.

1.2 Overall research questions

1. What are the effects of CVA on SRHR outcomes in humanitarian settings?
2. What is the operational feasibility of CVA within or complementary to other SRHR interventions in humanitarian settings?
3. What are the comparative advantages/disadvantages of CVA within or complementary to other interventions as a means to reduce financial barriers and/or increase access and utilisation for SRHR services in humanitarian settings?
4. What are the lessons learned and the operational recommendations for future CVA for SRHR programming?
5. What are appropriate guidelines and tools aimed at assessing feasibility and assisting implementation of CVA in humanitarian settings?

In order to answer these research questions, a global desk review was carried out, and guidelines and tools used to assess feasibility and to assist during the implementation of CVA for SRHR services in humanitarian emergencies were reviewed. In addition, two case studies

were developed aiming to document the learnings acquired while implementing cash and voucher components within SRHR programmes in Yemen and Afghanistan. The findings and products will be presented to and discussed with a selected group of humanitarian actors directly involved with the implementation of CVA for SRHR services aiming to validate deliverables and to contribute to the dissemination of evidence and to the learning process in this field.

1.3 Method for the case study

Through the literature review, different programs in humanitarian settings were considered as potential candidates to be included as a case study. Authors of relevant studies and key actors in the field were contacted, to explore the possibility and relevance of including their programmes. As part of this process, the following options were explored:

- A program that uses CVA in Raqqa, Syria, as described in an article by Alexandra Blackwell (3). Our efforts to connect with the program managers involved through the author were unsuccessful.
- A demand-side financing intervention for maternal health in DRC managed by Cordaid, as described by Dumbaugh et al (4). Cordaid highlighted that the program was no longer operational and that no such programs were running at the time. In addition, the relevant advisors had little time available to participate in a case study.
- A voucher scheme for maternal and child health in Myanmar (5). Upon contacting the Ministry of Health in Myanmar it became apparent that the setting of this intervention did not fit the criteria as it was not a humanitarian setting.
- Through WHO Nigeria, we connected with UN-OCHA, UNFPA and the SRH technical working groups of Borno, Yobe and Adamawa states to explore if any CVA for SRHR is being implemented. We found out that this has not yet been a particular area of focus in North-East Nigeria.
- A CVA program in Cox's Bazaar, Bangladesh was initially one of the suggested case studies to include, however, due to the current political environment, CVA for refugees has been put on hold by the government. Therefore, it was not feasible to include this setting as a case study.

Two case studies were selected and included in this review, based on the following criteria:

- Consent from and availability of key informants involved in the programs
- Program outcomes have been measured and described
- Project documents were available
- Program used CVA for an SRHR program in a humanitarian setting.

The following case studies were selected:

- The Conditional Cash Transfer program to improve the use of maternal health services, implemented by MOPH and UNICEF in Afghanistan.
    - Peer-reviewed literature and project documents were reviewed
    - Four key informants were interviewed, from the Ministry of Public Health and UNICEF.
- The voucher assistance program for family planning and safe motherhood, implemented by Yamaan Foundation for health and social development in Yemen.
    - Peer-reviewed literature and project documents were reviewed

- Three key informant interviews were conducted with a manager of Yamaan, a consultant involved in the start-up of the project and a representative from the Ministry of Public Health.

The framework of Levesque et al (6) was used in this study to classify the reported effects (both intended and unintended) of CVA on access and utilisation of SRHR services. Levesque's framework conceptualises access to health care as a comprehensive and dynamic concept, identifying determinants impacting access at the health system and providers level as well as factors at the individual and population level. The framework indicates five dimensions of accessibility (generating access on the supply side), which include; approachability, acceptability, availability and accommodation, affordability and appropriateness. These dimensions correlate with the abilities of people to interact (from the demand-side), including the possibility to identify health care needs, to seek health care services, to reach the services and use them, and to have an actual health care need fulfilled (6).

Following the logic of the framework we explored, on the demand-side, the effects of the CVA on financial and non-financial barriers to access SRHR services (e.g. ability to perceive, seek, reach, pay, engage). On the supply-side, we explored the effects of CVA on approachability, acceptability, availability, affordability and appropriateness. See Figure 1.

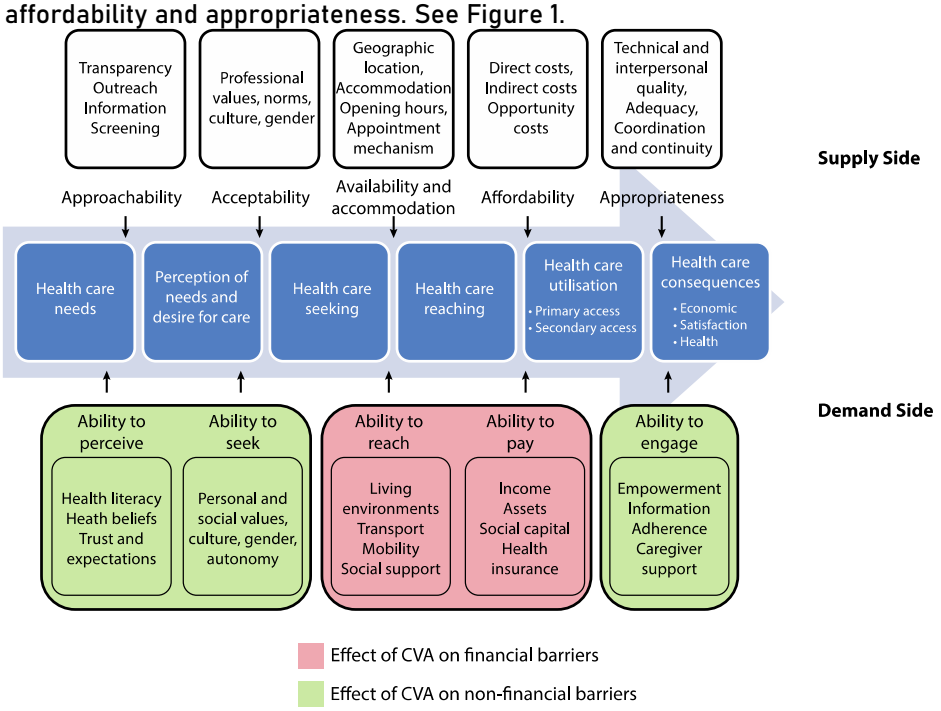

Figure 1. Levesque framework of acceptability to health care (6)

2 Case study 1: Afghanistan: Conditional Cash Transfer for maternal health

2.1 Context description

This case study reviews the one-year pilot project 'conditional cash transfer for maternal health' in three provinces in Afghanistan:

- Badghis (West Afghanistan, 512,518 population/55 health facilities/20% of women received ANC from a skilled provider/6.3% of women delivered with skilled provider/5.9% of women delivered in a health facility). (7)
- Bamyan (Central Afghanistan, 462,144 population/107 health facilities/72% of women received ANC by a skilled provider/46.9% of women delivered with a skilled provider/46.2% of women delivered in a health facility). (9)
- Kandahar (South-east Afghanistan, 1.279,520 population/119 health facilities/48.2% of women received ANC from a skilled provider/36.4% of women delivered with a skilled provider/35.5% delivered at a health facility). (9)

2.2 Demand and supply conditions before the start of the program

The Basic package of health services (BPHS) has been the cornerstone of the Afghanistan health system since 2003. Thanks to the BPHS, the population's access to basic services has improved substantially. This is not only due to improvements in the availability of facilities but also the fact that basic services are free at the point of care. However indirect costs, food, transport costs and costs for medicines[1], and availability, contribute to high Out Of Pocket (OOP) expenditure (with 7% for transport costs)(7,8). UNICEF's key informant confirmed that the high OOP[2] costs have been and remain a key barrier for women while deciding to go for institutional delivery. Quality of care and shortage of staff are key health system challenges (9).

Before the start of the CTT project, and despite a series of HSS efforts aiming to boost the supply side, there was low utilisation of maternal and child health services in the implementation sites, especially in rural areas. According to the DHS in 2015, home delivery remained high, with 52% births at home. Low-income was found to be the strongest factor for low service utilisation; with a strong association between wealth status and institutional delivery (10). Literacy and distance to health facility (lack of transport/high transport cost) were some of the factors negatively influencing skilled birth attendance in Afghanistan (7).

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[1] Although medicines are included in the Basic Package of Health Services and provided for free, regular stock-outs mean people often need to buy them at a private pharmacy.

[2] Out-of-Pocket costs include cost-sharing, self-medication and other expenditures paid directly by private households (OECD, 2009)

2.3 Program description

This case study focuses on a Conditional Cash Transfer Program (CCT), implemented by UNICEF and the Ministry of Public Health (MOPH). Key informants explained that this program followed an earlier CCT program funded by GAVI (2009 – 2011)(11). Lessons learned from the initial project were used to develop the new one (including improved cash management, monitoring and community awareness) (KII, UNICEF).

The aim of the program was to increase demand for institutional deliveries and ultimately to improve maternal and neonatal health outcomes by reducing financial barriers through the provision of cash incentives to women and Community Health Workers (CHWs). The secondary objectives of the CCT were to incentivise pregnant women and household decision-makers to plan for and arrange transport to health facilities at the onset of labour, and to improve the motivation of CHWs to counsel and escort or refer pregnant women to health facilities for labour (7).

Based on an initial market analysis done by the MOPH, the cash transfer for women giving birth at a BPHS centre was set at 1000 AFN. After delivery, this was directly given to the women by the midwife at the clinic. A letter was sent to health facilities, stating that the cash could only be given to the women themselves, not to their brothers or husbands. Although this is not a component of a traditional CVA modality, this CCT program included the provision of financial incentives to CHWs, who received 300 AFN for each pregnant woman referred to a BPHS centre for delivery (7, 9).

2.3.1 Assessment and selection criteria

Before the start of the program, formative research was done. A household survey, focus group discussions, and KIIs were conducted to get a better understanding of the barriers associated with care-seeking for institutional deliveries. The findings of this research identified that the lack of money to pay for services, the lack of transportation, and restrictions imposed by family members were the key barriers preventing women from opting for institutional delivery. The scope of this initial research did not include a deep exploration of possible solutions to address such barriers (8). At a later stage, interviews with women of reproductive age, male heads of households, and village leaders were organised to collect their points of view. The findings of this research suggested that in addition to a cash transfer, home visits from CHWs, to raise awareness and support women to reach a health facility for assisted delivery, would be of most use to families, showing that a combination of interventions would be required to increase institutional deliveries (9). For the pilot study, districts were chosen based on a set of fixed criteria, including; availability of basic and comprehensive health centres, ambulances, midwives and/or physicians and an active CHW system. Areas relatively secure from violence were given priority during the selection. Although there was a set of criteria for this selection, no standard set of tools was used during the assessment phase (KII, MOPH). To test the acceptability of the intervention among different population groups and to increase the chances to generalise results, provinces hosting populations with different characteristics were chosen. (KII, MOPH).

The key arguments given for linking maternal health services with the CCT program included the high maternal mortality ratio and the high proportion of home deliveries, linked to the barriers preventing access to institutional deliveries, as identified in the preliminary research (7). Yet, there is no clear description of any further analysis done to identify other

SRHR services that could be linked to the CCT program, such as antenatal care, postnatal care, family planning, or services for survivors of sexual and gender-based violence.

To understand the main barriers that women faced while opting for an institutional delivery, the MOPH and UNICEF conducted a desk review, and consulted with women in the community in the three provinces:

> *"We went to speak with the women in the community in the three provinces and asked them, "why are you not going to the health facility to deliver? What is the problem? How can the ministry or others help you reach the health facility?" (KII, UNICEF)*

2.3.2 Governance and administrative arrangements

A steering group was established to strengthen the MOPH in its leadership role and to provide technical support and consultation for the CCT program. The participation of the Village Health Committees (Shura) in the steering group ensured the representation of the community in all stages of the project. Implementing NGOs providing health services (in light of the contracting out approach for service delivery used in Afghanistan) were also engaged at all stages through the steering committee.

During KIIs, different views about the role of UNICEF in decision-making were shared by interviewees. A key informant working for UNICEF emphasised that the ownership of the program fell on the MOPH, while UNICEF's role mostly focused on the M&E and advocacy components of the program. This view is in agreement with that shared by other interviewees. A representative of the MOPH mentioned that the selection criteria used to define the target group came from UNICEF, whilst others emphasised that UNICEF was mainly providing technical and financial support and that decision-making was mainly with the steering committee and the MOPH. The KIIs also highlighted the importance of continuous and fluid coordination between the different stakeholders.

> *"Coordination between the MOPH, implementers, and donors [is important]. We piloted a lot of projects in other provinces, but the results are not so good. This is because the donors, such as UNICEF, World Bank, USAID, or the MoH, sometimes implement these projects (separately). If they were to jointly implement these projects, the results would be good." (KII, MOPH).*

The total cost of the project implementation was approximately 19.5 million AFN (+/- 250,000 USD). Of this, 6.8 million AFN (35%) were transfers for women, 0.8 million AFN (4%) were incentives for CHWs, and 11.9 million AFN (61%) were indirect costs (7).

UNICEF and BPHS implementers (BARAN in Kandahar and in Bamyan-cluster 1; MOVE in Badghis, and in Bamyan-cluster 2) signed a contract and funds were transferred to the bank accounts of the implementing agencies in the form of advanced payment (although the MOPH key informant stated that everything was transferred in cash, as banks are only functional in the centre of the provinces). This approach implies some risks concerning compliance and could result in a lack of funds from providers to pay upfront for the costs of the program. Aiming to reduce such risks, CVA programs implemented elsewhere tend to work with systems where suppliers are reimbursed for the transfers made upfront. CHWs distributed brochures to the women in the community and women at Antenatal Care (ANC) visits received a brochure. Midwives (or CHW supervisors) were authorised to distribute the cash.

At the facility, the mother received cash after delivery. In the operations manual, this is described as follows: "Incentives are kept in safe custody at the facility level. Only one or two of the health facility staff (mostly the midwife, Community Health Supervisor) will be authorised and made in charge of incentive distribution. The team leader of the health facilities will oversee the payment process in order to ensure families receive the incentive amount." (12), see Figure 2. There were monitoring calls to identify if the cash transfer was received and a complaint mechanism through the Shura was established (7). A key informant explained:

"There is a four-colour voucher given initially to the midwife, who handles them; one copy is kept in the health facility, one copy is given to the client, one to the NGO provincial office, and one to the central office of implementer NGOs. For each voucher there is a phone number and location, so this can be cross-checked to see if the mother received the money or not." (UNICEF, KII).

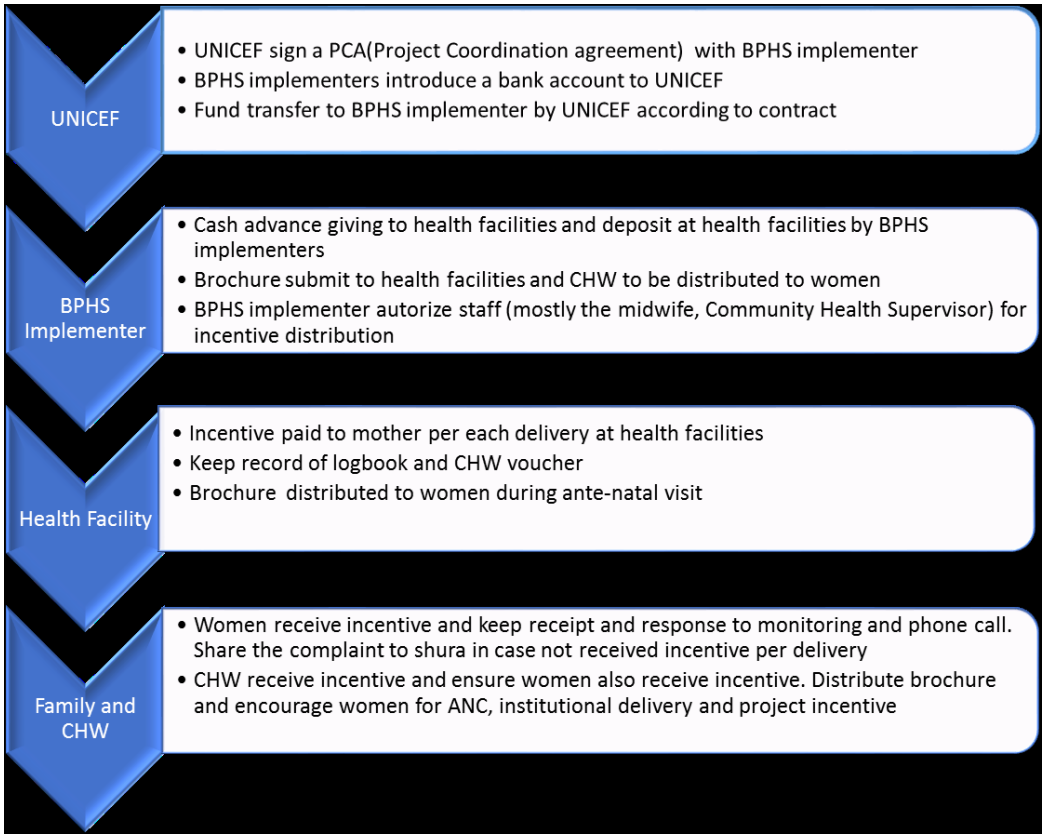

Figure 2: Incentive flow diagram (12)

2.3.3 Safety, security and protection considerations

Key informants explained that for insecure areas, clinics will get a higher amount of money as a means of risk mitigation, contracting local, trusted people to deliver the money to the clinics. It was not possible for the MOPH and UNICEF to do the monitoring in these insecure areas and clinic staff were responsible for raising awareness about the program in their community. Despite this remote management and insecurity, the programs ran smoothly overall, with only one security incident in Bamyan province, where a billboard was destroyed. According to the MOPH key informants, this could be due to inadequate dissemination of information about the program, or due to conservative male beliefs in this area.

2.3.4 Supporting activities

Edmond et al described that health facilities in control and intervention districts received a health system strengthening package over two-years prior to and during the intervention period, including a training package in essential new-born care and Basic and Emergency Obstetric and New-born Care (9).

Two trainings were provided to orient service providers (404 people reached in total):

- Orientation package for technical and managerial staff of service implementers
- Orientation module for CHWs and community health Shura.

Repeated awareness sessions were conducted for community members (1,589 people reached), including health Shura members, elders and mullahs. Leaflets were printed and billboards with information were installed (7). In addition, the CHWs played a big role in disseminating the information in the community (KII, MOPH), not only to inform people about the CCT program but also about the services available: *"At the district level, some people do not know what services are available at the facilities. Some women said they were not aware that services are offered in our district".(KII, MOPH)*

2.3.5 Monitoring and evaluation

A joint monitoring plan was developed by the MOPH and UNICEF, and they developed their own checklist for M&E. The plan was to do monthly joint monitoring, but in reality this was sometimes only done every quarter due to security constraints and the busy work schedules of the monitoring team (KII, MOPH). Security constraints also hampered the monitoring of activities at the district level. In those situations, the monitoring team remained at the provincial level reviewing records, vouchers, plans and reports, while provincial staff went to the field to complete the monitoring activities. Remote monitoring, through phone calls, was considered insufficient as staff would just declare that everything was going on well.

Indicators used for monitoring included: the number of women and CHWs who benefitted from the program, the increase in institutional delivery, the number of community members and health staff oriented or trained about the CCT concept, the number of billboards fixed, CHW payments, and the availability of brochures.

Whilst in Post-Distribution Monitoring, as guided by the CaLP toolkit CVA programs usually look at process, outcome and output, in the CCT program in Afghanistan, post-distribution monitoring was not done. Women were asked (by phone call, or home visit) if they received the money, but there was no intention to find out more about how the money was used. Supply-side indicators, including the quality of care given at the health facilities, were not included in the monitoring (KII).

An impact evaluation of the project was performed by an independent firm, ATR, using mixed methods baseline and end-line surveys. ATR conducted a non-randomised population-based intervention study. Two intervention and two control districts in three provinces (Bamyan, Badghis and Kandahar) were selected. All women aged 15 years and above were eligible to be included in the study.

2.3.6 Tools and guidelines used

Key informants said that the program developed their own tools for M&E, implementation and assessment (e.g., standard operating procedures, monitoring tools, vouchers, financial flow, concept notes, implementation guidelines, training guidelines, orientation guidelines) according to the MOPH key informants. Tools from countries like Ethiopia, Ghana, Nepal and Sri-Lanka were used as examples (KII, MOPH).

2.4 Results of the program

The project implementation report reveals that in total 7,069 women and 2,363 CHWs received incentives during the lifetime of the project (1 year).

There was a gradual increase in institutional deliveries and referrals by CHWs during the project implementation period. The trend increased faster in Kandahar compared to the two other provinces. The number of referrals by CHWs slightly increased from 3,559 in 2016 to 3,647 in 2017 in the intervention districts (7). Overall, facility delivery increased in intervention villages by 14.3% and control villages by 8.4% (9). One of the key informants highlighted that the program really works in poverty affected populations, yet Edmond et al found that the effects on women from poorest areas were less marked. The key informant explained that this was due to the short duration of the program, which did not allow sufficient time to inform people about the program, as people who live in the rural areas of Afghanistan are scattered, making it harder to reach poor women in areas situated far from the clinic. "CCTs really work in the context where poverty is high, and problems are monetary in nature. For example, the travel time is too long or that they do not have money to pay for transportation/services. CCTs give more opportunities to people as opposed to us buying something for them." (Key Informant, MOPH)

2.4.1 Intended and unintended effects on the supply side

(approachability, acceptability, availability, affordability and appropriateness).

There were different and conflicting views among the key informants about the impact of the CCT program on health facility staff. The review yielded no results to substantiate these views on either side. One of the MOPH key informants initially feared that the increase of the workload would create discontent among health providers or lead to "burnout" if the CCT did not include an incentive for health workers, or if the CCT was not coupled with any form of PBF. In contrast, another MOPH key informant observed that the CCT program was a stimulating factor for health providers, as when the demand increased, it also helped the health facility to reach their targets. It was further explained that districts were selected based on their low performance (unable to reach targets for health provision). As such, the original situation, where they were not able to reach its targets, could have resulted in a warning letter or even worse, a reduction in their salary. The key informant further elaborated that the program did lead to improved collaboration and partnership between clinic staff, CHWs and the community Shura.

> *"The CHWs are responsible for the referral of women to the facilities. Before the CHWs were non-functional and their relationship with the health facilities was not so good. After implementation, the midwives and the female doctors were very happy, because they were achieving their targets, and their relationship with the CHWs improved. This was not only true for institutional delivery. When women come to the clinic, they also utilise other services, such as vaccination, ANC, PNC and more. All the targets in the clinic increased." (KII, MOPH)*

Edmond et al. also found that as the intensity of the conflict increased, CHW home visits decreased in the intervention sites. This decrease, however, was bigger in the control sites, which suggested that the CHWs were motivated by the incentives of the program (5).

Whilst the effects of the program on quality of care were highlighted as one of the key issues related to access to safe delivery care prior to the program (9), they were captured in the monitoring framework. However, a key informant involved in the monitoring observed that due to close monitoring of the intervention clinics, as well as the increase in demand, and the follow up of referrals by the CHWs, the health providers were motivated to provide good quality care and their attitude towards patients improved (KII, MOPH).

One key informant suggested that the program also seemed to have an unintended effect on corruption, as before the program there were under the table payments made by clients to the health staff, which changed after the implementation of the program. *"Before the implementation of the program, if the patient went to give birth at a clinic, the midwife has to be given a sweet, we call it sherni in Afghanistan, they give around 500 to 1000 Afghani in kind to the doctor or the midwife. But after the implementation of the program, the situation changed." (KII, MOPH)*

2.4.2 Intended and unintended effects on the Demand side

(e.g., ability to perceive, seek, reach, pay, engage)

Edmond et al found that there was only a 3% increase in facility delivery associated with the CCT program during the intervention period and that this increase was not statistically significant [3]. (9) They linked this to low program awareness, especially among the poorest people. Only 27% of women in intervention areas reported that they had heard about financial incentives or the CCT program. The effect of the CCT program was also lowest among the poorest women. Due to distance and reported lack of trust, CHWs had challenges reaching the poorest families. It was found that more consideration should be given to including the perspectives of the most disadvantaged families (9).

Edmond et al found that the intervention was associated with improvements in both ANC and PNC coverage, although only the change in ANC was statistically significant. Probably this was as a result of the ANC and PNC messages that were included in the IEC campaigns linked to the program (9).

The impact of the program on new-born health was not reported in any of the reviewed documents and did not come up in the interviews.

Key informants had different assumptions on how the cash transfer was used. Whilst some highlighted that it was mainly used for transport, another key informant thought it was mainly used to buy supplies and food for the baby. Key informants highlighted that they learned from interaction with the beneficiaries that both the CCT and the provided services were well accepted in the community, and that the program had a direct impact on one of the key

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[3] Overall, facility delivery increased in intervention villages by 14.3% and control villages by 8.4% (adjusted mean difference [AMD] 3.3%; 95% confidence interval [− 0.14 to 0.21], p-value 0.685).9. Edmond KM, Foshanji AI, Naziri M, Higgins-Steele A, Burke JM, Strobel N, et al. Conditional cash transfers to improve the use of health facilities by mothers and newborns in conflict-affected countries, a prospective population-based intervention study from Afghanistan. BMC pregnancy and childbirth. 2019;19(1):193.

barriers, namely the high costs of transportation. But it also enabled women to better care for themselves and their babies:

> *"I also went for monitoring visits and the mothers really appreciated this cash. Some of them even they cried when they received the money. They said that the money would help them a lot in terms of support during the postpartum period. Some of them mentioned that they were not able to eat enough food during the time of the delivery and that as they had no job they struggled to afford a taxi home." (KII, UNICEF)*

Some key informants noted that the project had a positive effect on empowering women: *"In Afghanistan, the money makers are usually men. When women bring in money, their standing in their family improves and so they are empowered."* Although this effect was not measured through the M&E of the project, one of the key informants highlighted that the *"CCTs also increase the woman's authority in the family and that they can purchase things which they think are a priority. This also improves the local market."* It was further said that there were no protection-related impacts of the program. The key informants did not hear of any report of jealousy, discontent, social pressure or gender-based violence as a result of the cash given to the women. According to one key informant, it was attributed to the involvement of the health Shura.

> *"Another best practice, and it could be our lesson learned, is that we involve the local health committee. The local health committee educated the husbands, which meant that the husbands readily accepted this program.....If they (Shuras) accept the program, we consider that the village also accepted the program." (KII, MOPH)*

Nevertheless, as highlighted by UNICEF's key informant, the monitoring did not check whether or not the woman had a say on how the money was used. This is important, as, in many parts of Afghanistan, women are not authorised to use their own money:

> *"But the challenge for us is we don't know what happened to the cash because some of the women at household level in Afghanistan don't have the right to spend their money, they have to give it to their husband, and the husband has the authority to utilise this money. Actually, we don't know if this money was kept by the women or was the money given to her husband or what happened, this is a problem yeah."*

Additionally, one key informant highlighted that despite the CCT, women would not come to the health facility for delivery, or as they would say *"this is not in my culture"*. Women who deliver at home are supported by Traditional Birth Attendants (TBAs), but there was no concern raised related to the acceptability of the program by the TBAs, especially due to the acceptance and involvement of the health Shura.

2.4.3 Factors influencing the program uptake and outcomes

Several factors influencing the uptake of the program were identified. Weather conditions, such as a harsh winter and heavy snowfall, were mentioned as barriers by staff from MOVE. Another factor influencing the program uptake were the opening hours of the health facilities.

Selected BHCs and SHCs were only open for eight hours a day, six days a week and institutional delivery outside of opening hours was not possible (9).

Furthermore, the security situation in Afghanistan was volatile. Various key informants agreed, for example, that the difference in institutional delivery between Waras and Muqor district, was due to insecurity in Muqor state, where institutional delivery was much lower. In Kandahar, security was an issue, firstly because women felt insecure when going to the health facility, and secondly because security concerns delayed the transfer of money to the facilities, so staff did not always get their incentives in a timely manner. However, thanks to good road conditions and absence of mountains in some areas of Kandahar, as well as the population density and the short distance to the health facility, the institutional delivery rate in Kandahar increased more quickly in comparison with other provinces.

"In Kandahar, institutional delivery is higher as there is a strong focus on antenatal care during which women are encouraged to come for institutional delivery. The health education for pregnant women was really good. The community in Kandahar mainly reach the men, and they receive a brochure through religious and community leaders, this is also a good lesson for us because when we go through religious and community leaders, their influence is much stronger in comparison to other key players." (KII).

It was also seen that cultural issues influenced the uptake of services, for example, there is a difference in assisted delivery between Badghis and Bamyan. This was further explained by one of the interviewees. According to an interviewee, the Bamyan population tends to show better health-seeking behaviour compared to other Afghan groups. *"People there are considered intellectual, and it is part of their culture to encourage their family to go to clinics. In addition, there is more availability of female staff."* In Badghis, people are more conservative, and it is less common for people to deliver at the health facility.

Finally, the delay in payment from donor to implementing NGOs was reported as a challenge for the successful implementation of the project, as it leads to discontent from both the women and the CHWs (7)

2.5 Main lessons learned

Points for reflection while transferring the experiences from Afghanistan to other settings.

The modality and chosen design for the intervention, where the women received the money after delivery, failed to address the actual barriers of women having difficulties reaching the health facilities due to distance and in finding transportation. In this case, the cash transfers handed out at the facility after the delivery were not helpful for those who were unable to get transport to reach the facility either because they could not pay the costs upfront or because they had difficulties finding suitable transport. If the intention was to help women coming from households with less financial resources, or those who live in areas where it is difficult to get transport, doing a robust situation analysis with the participation of women and communities to understand what modalities would be more appropriate to address the identified barriers would be desirable. The consideration of a different modality or different timing of cash distribution (e.g. during antenatal care visits) should be carefully assessed.

The formative research showed that cultural factors act as barriers preventing some women from seeking care. Although it seems unlikely, it is not known if and how the financial

incentives could influence the decision-making process in the family prior to the moment of the delivery. Taking a closer look at how household dynamics play once people are aware of the financial incentives and having a better understanding about how the money that is given to the women is spent, could help clarify how far-reaching the effects of the financial incentives are. This could have been done by performing gender and power analysis prior to the start of the program.

The documentation mentions that the CCT intervention had a complementary health systems strengthening component which aimed to improve the capacity of health providers (via trainings) and to equip facilities with the supplies needed to deliver services. While these efforts are commendable, they do not address the problems of staff shortages or short opening hours. These, added to incidental interruptions/delays in the flow of funds for the financial incentives, can actually discourage women and CHWs from using or referring women to services. In relation to the capacity of the facilities to absorb extra work, it remains unclear what has a more powerful effect on the staff of the health facility, the stress which arises from targets not being met, or the difficulties they may face when there is a sudden increase in workload following the improved access to services and awareness resulting from financial incentives provided to both mothers and CHWs. Even though health workers at the health facilities are not directly benefitting from the CCT program, the program does help them to reach their targets, for which clinics, in turn, receive incentives. These issues may reflect points for improvement with governance, oversight and programming but do not seem related to the modality of delivering assistance.

Despite the fact that there was an observed increase in the utilisation of maternal services, only the increase in antenatal care was significant. The duration of CVA projects needs to be taken into account, as a 1-year project is not enough time to allow people (especially in the poorest households) to be made fully aware and make use of the project. Key informants contributing to this case study all agreed that one year is very short for such a program. That being said, a key informant claimed that one year after the end of the project, the proportion of institutional deliveries in the intervention districts remained at the same level as it was during intervention. The stabilisation of this proportion, could be explained by the increase in awareness, and positive experiences while using services. (MOPH, KII).

"The level of the indicators remained the same. Probably because when a woman comes to the facility to deliver, she becomes aware of the services provided at the facility level. She will then also share her experience with other women located at the same village, and these woman will also come to the facility." (KII, MOPH)

Considering that access and utilisation of services respond to the interaction of multiple factors, it would seem necessary to take a closer look at this claim.

Furthermore, it would have been good to consider cash assistance along a continuum, (ANC, delivery, PNC and immunisation/growth monitoring for the child) as well as the need to anticipate what happens when delivery is complicated and referral for comprehensive emergency obstetric care is needed, accounting for costs for referral and interventions, like a caesarean section.

An MOPH key informant also highlighted that there is a need for a systemic look at all interventions, considering PBF mechanisms alongside the CCT intervention. They felt that if demand is increased, there would be additional work for the health workers and that the

quality of the work would reduce if the work is not incentivised, leading to dissatisfied patients and low uptake of services.

"I believe that CCTs should be implemented in a way that there is also something from the health workers."(KII, MOPH)

Key informants from the MOPH said that in the future, CHW guidelines should be used (now developed), the program should be of longer duration, and a more thorough assessment should precede a future program, including additional variables for a baseline assessment, to avoid the exclusion of some communities.

Public awareness activities, adequate targeting and information dissemination at the community level helped to increase demand and utilisation of the services. Good coordination and improved stakeholder engagement were found to be key for successful program implementation.

It was felt that the incentives given to CHWs were a successful way to improve the referral system (CHWs are otherwise unpaid in Afghanistan). A key informant elaborated that they observed that CHWs become more motivated, they engaged more with the system, they persuade more women to go to the facility, they passed more messages to the community, their work improves, and their collaboration with the health facility increases.

Post Distribution Monitoring was not done, and monitoring was mainly facility and not community-based. This resulted in a lack of information about the process, the satisfaction, and how the cash was actually used by the women after distribution.

3 Case study 2: Yemen: Vouchers for Family Planning and Safe Motherhood

3.1 Context description

Since March 2015, the security situation in Yemen has been deteriorating, resulting in irregular funding for health from the central government to the governorates. More than half of the health facilities are non-functional (damaged, destroyed, or lacking in funds) (13). Health services in Yemen are mainly provided by the public sector in rural areas. In urban areas, there is a strong presence of private providers, accessible only for those who can afford it (14, 15). Seventy per cent of Yemen's population lives in rural areas and about 2.9 million people have been internally displaced (84% for more than a year)(13).

3.2 Demand and supply conditions before the start of the program

Access to family planning is a huge challenge in Yemen. Although family planning services are provided for free in public facilities and by partners such as UNFPA and Save the Children, often Long Active Reversible Contraceptives (LARCs) and Permanent Methods (PMs) are unavailable. As a result, clients are asked to pay for or provide missing commodities and supplies themselves. In addition, before the voucher program, staff were poorly trained on inserting Intra-Uterine Devices (IUD), implants could only be done by doctors and sterilisation was only done at larger hospitals. Family planning services provided by private facilities are scarce and costly (15).

The National Demographic Health Survey (NDHS) 2013 found that the national contraceptive prevalence rate (CPR) for modern methods was 29.2% (urban 40.2%, rural 24.0%) and for LARCs/PMs 8.9% (urban 15.1%, rural 5.9%). The latter was mainly used in larger cities and by the wealthiest quintile (15.9%), compared with a rate of only 1.6% among the poorest quintile (15).

The NHDS 2013 also found that 28.7% of married women of reproductive age (MWRA) have an unmet need for family planning of which, 43% are among the poorest women and 18% among the wealthiest women. Despite the unaffordability of private sector services for most women, 53% of women get family planning from the public sector, 44.3% in the private sector, and 1.2% from NGOs (15).

The UN agencies group estimates the Maternal Mortality Ratio (MMR) in Yemen in 2015 at 385 per 100,000 live births, the rate is higher among women in rural areas (16). While some progress had been made prior to the conflict, Yemen has the lowest level of antenatal care coverage in the region, women continue to encounter multiple barriers to the uptake of institutional delivery, and most mothers still deliver at home. Twenty-three per cent of rural women deliver at a health facility and 34% of rural women give birth with the help of a skilled birth attendant, compared with 73% in urban areas. Barriers include insecurity and long

distances to travel as well as financial barriers, such as transportation costs, opportunity costs and fees for maternal health services. Challenges in accessing health care were reported by 4 in 5 women during the 2013 NHSD for reasons such as not wanting to go alone, the lack of a female provider, and the distance to a health facility. The conflict has likely worsened these access barriers (14).

One of the key informants described that whilst several supply-side programs are being implemented in Yemen (e.g., training of community midwives and training staff on emergency obstetric care, rehabilitation of community health facilities)[4], accessibility and acceptability of maternal health and family planning services provided remained an issue.

"... the question is how the community can access these 'fancy' facilities? There is poverty in Yemen for a long time now, and people cannot even afford to come to these health facilities. When we come to the results of the program, it increased the FP and safe motherhood service utilisation and it showed that the key barriers are not only the acceptability and the accessibility of the services. There are a lot of complexities (regarding utilisation), but transportation and poverty are the key indicators. So when access to these services is made easier and at the same time women's awareness of the services provided is improved, the uptake will also increase. Otherwise, the women will stay in their communities and probably die there with their new-borns." (KII, Yamaan)

3.3 Program description

The voucher program is running in three governorates in Yemen; Lahj (11 districts), Ibb (10 districts) and Dhamar (6 districts), and in Amanat Al Asimah a third phase will start, targeting IDP and host communities in five districts. (see Figure 3).

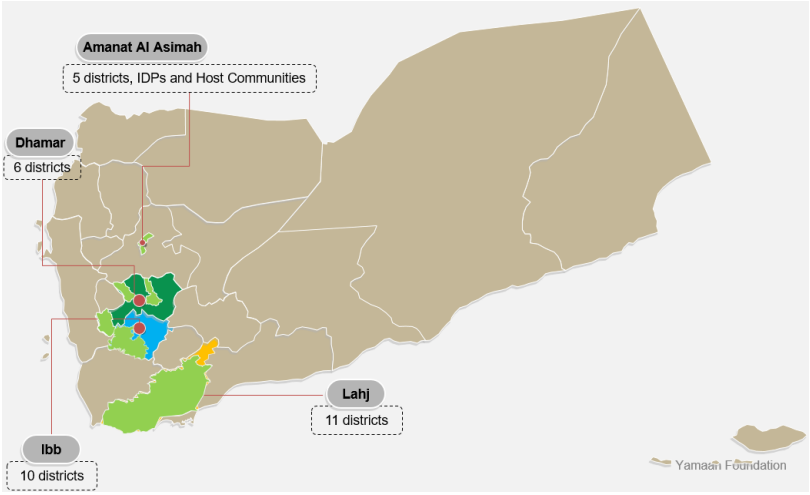

Figure 3: Map of Yemen, indicating the governorates where the voucher program is running (17)

[4] Supply-side challenges to be acknowledged, including health care workers not being paid as a result of the conflict and disruption (https://reliefweb.int/report/yemen/saving-lives-without-salaries-government-health-staff-yemen)

The voucher program intends to increase the demand for safe motherhood and family planning (including both short term methods, LARCs, IUDs, and implants) in three governorates in Yemen, and there are plans to extend it to five governorates soon. The safe motherhood voucher provides services (including four ANC visits, safe delivery, management of complications and caesarean section, two PNC visits and postnatal family planning services), free transport to the health facility for delivery and support for food and accommodation for a chaperone (husband) (14).

"This was an attempt to mitigate the culture of not bringing women for institutional deliveries for fear of the extra costs that they will incur if they have to stay in the facility." (KII, Voucher Consultant)

Funds are channelled to contracted providers, including both public health facilities as well as the private sector. In this way, the voucher is addressing financial and other access barriers at the demand-side, and at the same time provides financial support at the supply-side, thereby contributing to quality improvement (14, 15). Figure 4 illustrates how the funds flow.

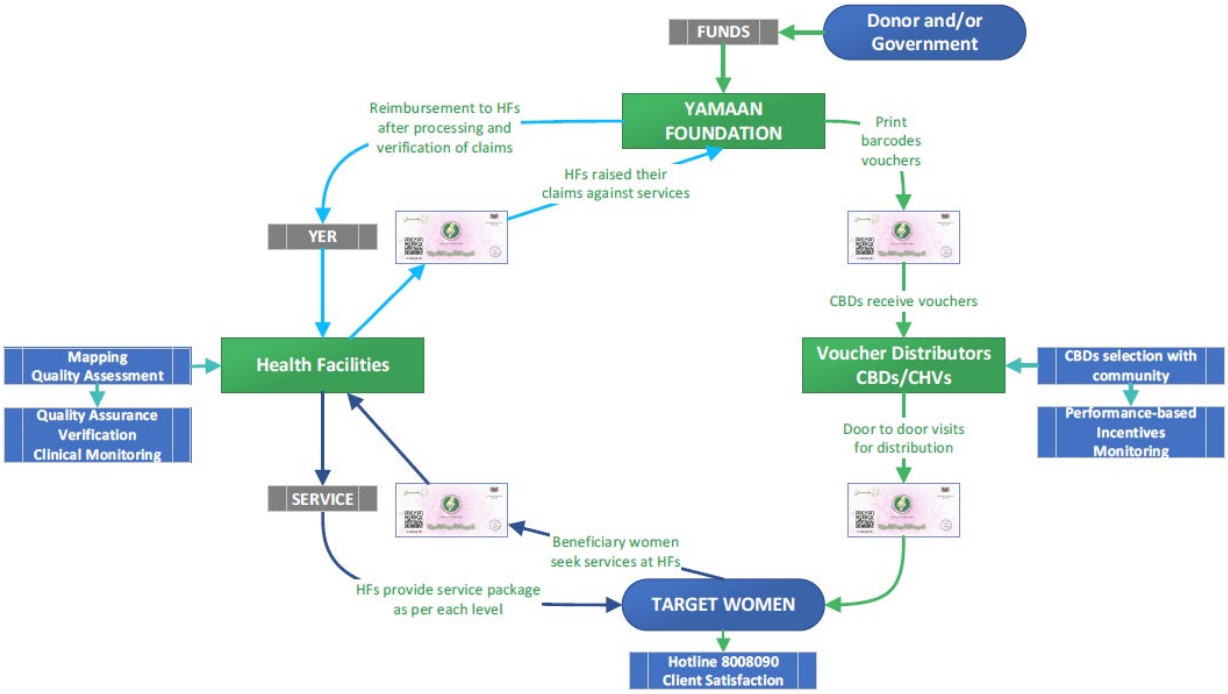

Figure 4: Work flow illustration of the voucher program(17) * YER= Yemeni Rial

A Yamaan key informant described the following components of the program:

a) Quality assurance and accreditation of providers for inclusion in the program.
b) Distribution component of the voucher booklets to the community (by visiting every house in the community/goes together with awareness-raising).
c) Verification for the services provided by the accredited facilities.
d) Reimbursement of services provided using a performance-based approach for claims processing to make sure that the reimbursement is identical in terms of quantity as well as quality.

The overall goal is to contribute to the reduction of maternal mortality and morbidity. The secondary goal is to increase skilled birth attendance, the use of modern contraceptive

methods (especially the long-acting contraceptives), and to also contribute to the reduction of neonatal morbidity and mortality (KII, Yamaan). The expectation was that people would change their health-seeking behaviour through the use of the vouchers (KII, Voucher Consultant).

To achieve these goals the benefits package of the program included:

Safe Motherhood Voucher:

- Four ANC visits
- Delivery – normal or CS
- Two PNC visits (+ family planning)
- Referral services
- Complications for the mother or newborn
- Transportation and Referral: during delivery and complications: home-facility-home/home-facility-facility-home
- Payment for accommodation for one relative in case of C/S or any hospital admission for complication

Family planning voucher:

- Counselling
- Short term methods
- Long term methods (IUD + Implants)

A range of public hospitals, rural health units and community midwives (a quarter being private sector providers) was contracted for the program. The program is mainly focused in rural areas with public facilities (14, 15). Advances for transport vouchers are paid to the facilities. Drivers have not been contracted, they are drivers from the area of the woman (and can be informal services by a person who owns a car). After transporting a woman to the health facility, an invoice will be signed by the medical person receiving the woman, and the driver can take this to an officer at the health facility to receive payment. The same mechanism applies to referral between facilities. The amount of the payment depends on the distance between home and the facility or between facilities, and the rates agreed upon. This is shared with Yamaan in the claims, which is verified to ensure payment and amount paid. Yamaan still faces challenges in this area and is considering working through money transfer services, using technology linked to their system (KII, Yamaan).

3.3.1 Assessment and selection criteria

A Yamaan key informant explained that the early design period started in 2010-2011, with consultation meetings carried out both inside and outside Yemen to discuss the technicalities of the program. The program actually started in 2013. Before the voucher program started, health staff went to communities (mainly in Lahj) to distribute questionnaires to ask women which services (ANC, PNC, institutional deliveries, caesarean sections) they thought should be included if a voucher program was implemented.

The two key things noted by the women in the communities were that neonatal services, and the transportation and accommodation should be included. These were identified as the key barriers to health services access (KII, Yamaan). The community also had remarks about the price of the voucher booklet. If the voucher booklet is free, it will lose its value for the community. There should be some form of community participation (a nominal fee of around 200 Yemeni riyals). After these discussions, a questionnaire was distributed among the

women in the community asking their opinion regarding the appropriate price for a voucher booklet. This was only applicable for safe motherhood and not FP and it was decided that the FP should be provided free-of-charg to encourage its use. There were a lot of cultural barriers with regards to usage of FP, and so providing free FP services was seen as a kind of promotion.

Once the assessment was done, pilot programs were implemented in two districts: one in Lahj governorate (Al Hawtah district) and one in Ibb governorate (Jiblah district). A poverty targeting approach was pilot tested in four districts in Lahj (excluding most non-poor women, which constituted to 40% of the population), and in the other eleven, (poorer) districts all women were considered eligible. This resulted in an estimated eligible population size of 809,379 women (14). However, the targeting tool was not considered to be an appropriate tool by everyone. During the pilot, all women were labelled as eligible. When reasons for this were investigated, the distributors said that they preferred to visit the houses where they thought that the targeting tool would score well. Several stakeholders were also of the opinion that a targeting tool was not culturally appropriate. It was then decided to work with geographical targeting and to only work in districts of Lahj and Ibb where most people are poor. (KII, Yamaan and voucher expert)

Several key informants agreed that for the second phase in Ibb and Lahj Governorates, the targeting tool won't be used, as these will be rural areas where everybody will be eligible. However, in the third phase when the target groups are different, for example, in urban areas or Internally Displaced Populations (IDP), the targeting tool will become relevant again (KII, Yamaan).

The pilot was implemented for six months and after this, the program was evaluated, and modifications were made based upon the lessons learned. For example, on quality assessments, voucher distribution, the voucher booklet, how claims processing was done, and what kind of systems are required for the program to run (KII, Yamaan). A full operations manual (OM) was designed by 2015, including a description of how to run the program. In the selection of CHWs/community health volunteers (CHVs), preference was given to women to account for the cultural aspect of safe motherhood (SM) and FP. Furthermore, a needs assessment of the facilities was also done to identify what kind of training and information are needed for the provision of services and the distribution of vouchers (KII, Yamaan).

Health facilities are also being assessed by the MOPHP prior to being enrolled into the program. Together with the MOPHP, GIZ developed a quality improvement tool to assess if health facilities are up to quality standards needed to be included in the voucher program, and to identify what is needed to further improve. This can lead to three different outcomes:

1. Enrolment conditions in QIP and Voucher Scheme are not fulfilled and need to improve, requiring more time
2. Enrolment conditions in QIP and Voucher Scheme are partly fulfilled and GHO can fulfil them in a short time
3. Enrolment conditions in QIP and Voucher Scheme are fulfilled.

The results are shared with the facilities and they are encouraged to use the voucher income to improve their quality.

Quality Improvement Tool.docx

3.3.2 Governance and administrative arrangements

Starting from the early days of the program, there was a cooperation between Yamaan and Options Consultancy Services, with the support of KfW (German development bank) to develop a voucher scheme. KfW was the initial financial driving force behind the initiative, and Options advised Yamaan at the time of program conception. The MOPHP gave permission to do first a pilot and then they assessed the results and decided they wanted to continue and scale-up the use of vouchers. GIZ helped Yamaan to modify the quality assurance tool, which was developed by the MOPHP, supported by GIZ, so that it could be applied in the voucher programme. The QA tool was used to select the health providers as well as to quality assure the health providers during the programme. 'Medical Insurance Specialists', Yemen's first insurance company, was contracted to do the claims processing of voucher invoices and pay the providers. Furthermore, *"the involvement of the directors of the health offices of the governorates in Lahj and Ibb. reflects the needs of the people at the governorate level and not only at the central level of the ministry." (KII, Yamaan).*

Yamaan, acting as the voucher management agency, receives funding and contracts service providers. Yamaan assesses, recruits and trains service providers on SRHR and on how to manage the voucher program and is responsible for quality assurance (6).

3.3.3 Safety, security and protection considerations

Accessibility issues related to safety and security were important considerations taken by Yamaan: *"With the current situation in Yemen, people's access to the services, especially women as a vulnerable group, is a key barrier. So with the security situation, we are mindful of the difficulties in accessing services. Even if we are careful, you cannot really guarantee safety especially in a conflict setting like Yemen. For example, in one of the governorates, the initial plan of Yamaan was to include Hajjah in the scheme but because of the continued airstrikes and high-risk to safety, it was very difficult to include the area. The people there are also have a hard time accessing health facilities and many of the facilities have been destroyed by the conflict. What we tried to do is to facilitate community bonding, so we could at least manage it to some extent. For example, the driver should come from the same community, and the husband or the companion should at least be sure that they know the way to these facilities." (KII, Yamaan).*

Gender-based violence was mentioned as one of the protection risks for women affected by conflict in one of the project documents reviewed, which was linked with the increased risk of unintended pregnancy and associated risks (13). In key informant interviews, it was highlighted that a possible unintended negative effect of a voucher program can be that the voucher exposes women to gender-based violence, and issues related to power dynamics. Yamaan was not able to assess if there were any unintended risks of the CVA, such as incidence of gender-based violence related to the program, as many women do not have access to their own phone, there a lack of confidentiality, meaning these questions cannot be asked. In addition, when they visit the homes to interview women about their client satisfaction and to verify services, there are often other family members present.

"For the FP, we try our best to promote the services, but we cannot ensure that the husbands are actually allowing the women to select what they really want, and not force them to make a decision that is not their own." (KII, Yamaan).

3.3.4 Supporting activities

Before the distribution of vouchers, two activities were implemented:

1. Training of distributors (most of them are CHWs/CHVs already involved in such programs. They are given two days of training about the key concepts of the voucher program, community health concepts, FP, and SM. They often have been trained previously by other NGOs about the RH components.
2. Community leader orientation session: One-day training where all community health leaders are gathered (religious and/or key leaders) and oriented about the voucher program (the aim of the voucher, what is the role of these community leaders in order to facilitate the distribution or encouragement of the community to participate). The community leaders, in turn, promote awareness by spreading the word in their communities (e.g., through speeches in mosques, or door-to-door visitations)

"Word of mouth is the key to the success of the program." (KII, Yamaan)

Another supporting activity which started in 2018/19 is contact tracing through the 'Contact Centre' helpline. After the distribution of the vouchers, the women are approached (contact numbers are provided and consent is given for a follow-up) and asked about the RH services, vouchers, if there are any gaps. Also, before delivery time, the women will receive calls from the contact centre (a welcoming call) to encourage them to deliver in health facilities. (KII, Yamaan)

3.3.5 Monitoring and evaluation

The program works with a platform to monitor the vouchers, monitoring when they are given out and by whom, who received the voucher, and when it was used (see Figure 5). There are also random checks to monitor the vouchers and to ensure that the facilities have complied with the agreed minimum standards of care. Facilities are given feedback with regards to which components they are doing well and those which need improvement (KII, Yamaan). If there is an expectation that claims are fraudulent, the call-centre will call women to make sure that the services were indeed provided and if they were of good quality. This approach was also used to check if the distributors were demanding too much money for the voucher. These were checks done randomly but also based upon risk, depending on the analysis.

"Real-time monitoring is needed, especially when working with private hospitals as they might try to make more profit and abuse the voucher through over-servicing (providing services which are not needed) or even submit claims for services not provided. And even several of the public hospitals have shown such tendency. Therefore prevention and control of fraud and doing this in real-time are key. The sooner one detects providers are tempted to abuse the vouchers the sooner one can give out warnings and prevent worse behaviour. In situations like Yemen were you do not have many functional health providers; one does not want to have to end the contract with the provider." (KII, Voucher consultant).

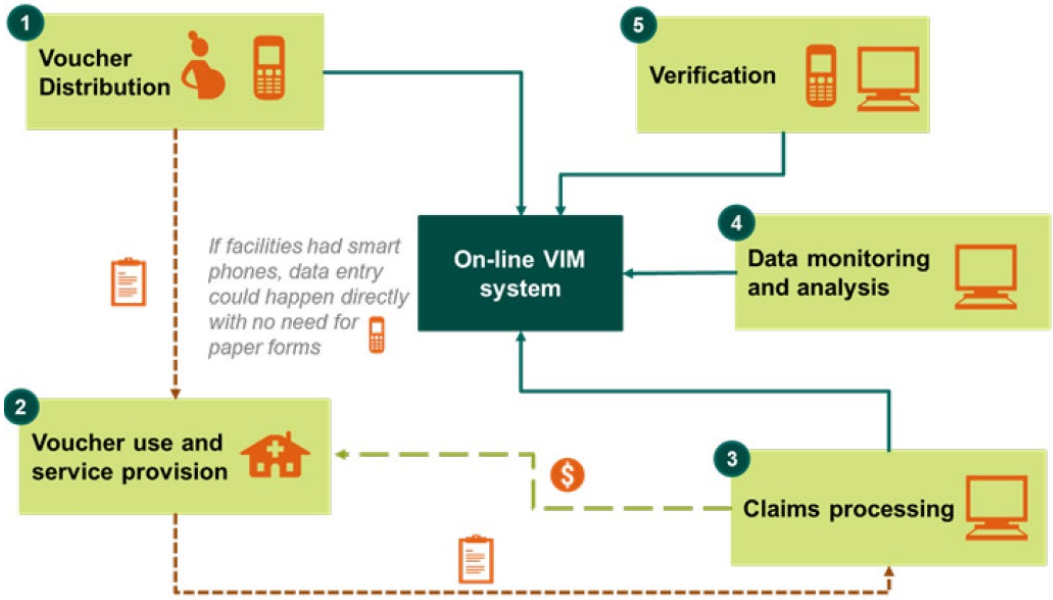

Figure 5: On-line VIM system for monitoring of the program (17)

3.3.6 Tools and guidelines used

Various tools were developed for the voucher project. They were adjusted from different organisations and aligned with the MOPHP protocols. A key informant involved in the setup of the project felt that an open-source platform, where data can be gathered, centralised and linked with the DHIS would have added value. A start was made on developing a platform with Red Rose (an organisation working in the humanitarian and card payment sectors), however, the system showed too many errors.

Tools for distribution

For voucher distribution, Yamaan has very clear selection criteria and a curriculum for the training of the selected distributors (orientation sessions). Since 2016-2017, mobile application tools have replaced paper-based data collection. A web-based platform is used to assess all the data gathered in the field.

Client satisfaction tool

Feedback from beneficiaries is gathered through a client satisfaction tool, which is an important tool for understanding the effect of the program. The thematic focus points include issues of service quality, dignity, and courtesy.

Call centre

A toll-free number is printed on the back page of the voucher. Women can call this number to reach the contact centre if there is an issue or a complaint about the services provided. These complaints are collated in a form and assessed by the management. (KII, Yamaan)

3.4 Results of the program

Up until the end of 2019, the total number of unique women beneficiaries from SMH vouchers was 114,676, and 39,410 from the FP vouchers (17). The MOPHP key informant said that most

women look for the SMH voucher, and not FP, as the latter is provided for free by the government, Save the Children and UNFPA. It was expected that through the distributors (CHWs/CHVs), the awareness of both SMH and FP increased.

"By giving the women the opportunity to hear about the FP services, its benefits and the aim of our program, we were hoping that this will increase utilisation of services, and we did see that after distribution. The FP voucher was also beneficial for the health facilities because they get something for every service provided (e.g. IUD - 1500 Yemeni riyals)." (KII, MOPHP).

The MOPHP key informant further elaborated that not only did they notice an increase in the uptake of safe motherhood services in the health facilities, they also saw a reduction in maternal and child morbidities, as deliveries were now assisted by skilled providers.

"Before the program, there were reports of obstructed labour happening in the community. Now, because the mother can access the services, those with obstructed labour can have a caesarean section in the health facilities, instead of delivering at home which increases the probability of morbidity and mortality." (KII, MOPHP)

"Especially in the rural areas, women who have preeclampsia will only go to the pharmacy and get medicine. They will only go to the hospital when they are already gravely ill, but the voucher program gave them the chance to access the facilities easily when complications were detected during the pregnancy or after giving birth." (KII, MOPHP).

Boddam-Wetham and Grainger both describe the program in Lahj, over the course of two and a half years (2013 – 2015), 56,000 FP vouchers were distributed, of which 12,000 (21%) were redeemed (7). The explanation given for this by Boddam-Whetham is the closure of health facilities and supply chain interruptions due to the war. In addition, around 50,200 SMH vouchers were distributed in Lahj and in 2014, nearly 70% of women used their vouchers to access services despite the worsening security situation which made travel difficult. More than 50% of the women used the voucher within two months of receiving it, others used it later in their pregnancy (14).

The use of maternal health services increased by at least 25% after the voucher program, the actual figure is probably even higher, as not all deliveries in contracted facilities were voucher clients. For ANC 1 visits there was an increase of 31%, for ANC 2 the increase was 24%, delivery by a skilled birth attendant increased by 17%, institutional delivery by 25%, and PNC attendance increased with 32%. (14). The use of family planning services also increased (again, not all services were by contracted providers or through vouchers, with about half of clients being voucher clients and half non-voucher, according to health providers). For example, there was around a 50% increase in the use of implants and IUDs, compared to what would have been expected without a voucher program. On the other hand, sterilisation numbers remained lower, possibly linked with the preference for IUD or implants when they are made available. CPR for modern methods (mainly LARC and PM) increased from 13% in 2003 to 19% in 2006, and to 29.2% in 2013 nationally. The uptake of FP services in voucher areas in 2014 was 720, 38% higher than the 521 expected (15).

3.4.1 Intended and unintended effects on the supply side

(approachability, acceptability, availability, affordability and appropriateness).

"I feel that the voucher program is the only program that covers the needs of the pregnant women and their families. There are other programs that bring new equipment, and replenish supplies, but they do not think about accessibility. With the voucher in the hands of the woman, she can go to any facility contracted by Yamaan and be treated there. The voucher takes care of not only her but also her family." (KII, MOPHP)

The voucher program had a positive effect on the availability of FP and SMH services, which were often limited due to a lack of medicines and equipment. At the facility level, around 40% of the income generated by the vouchers was meant to be used to pay for staff incentives, and 60% to improve the facilities. But in practice (when the war started), most of the money from the vouchers was spent to replenish supplies and most of the money went to facilities that were able to provide BEmONC and CEmONC (KII, Voucher Consultant). The positive effect of the FP vouchers was partly due to the effect that vouchers have when distributed house-to-house and where potential clients receive information on FP services and methods, are counselled on the benefits, and receive a personal invitation to visit the health facility (reducing socio-cultural barriers); partly because the voucher reduces financial barriers; and partly because vouchers motivate health providers to cater better to their clients, more user-friendly and ensuring supplies and materials are available (reducing provider-related barriers). In the case of SMH vouchers, the greatest barriers for mothers delivering in the health facility are transport and service costs. These were reduced considerably by providing payment to transporters as well as payment to health facilities for all SMH services the mother needed, including management of maternal and neonatal complications, which can be very expensive. The distribution of vouchers and the provision of related services might have triggered women to seek services, but in the case of SMH, the financial barriers are more important than the socio-cultural barriers. The extra money health facilities receive also plays an important role, and even more so with the progression of the war, when salaries were no longer paid and supplies/equipment dwindled (KII, Voucher Consultant).

Funds continued to flow to the facilities when government funds were interrupted due to the crisis, and the incentives through the vouchers, private and public facilities invested in upgrading maternal health facilities and training on family planning methods and the choice of methods became wider for the women. Four facilities were even upgraded from health units (not providing institutional delivery) to health centres, now providing delivery services, and one health centre could contract new midwives and doctors, enabling the centre to provide BEMONC services 24/7. Also, despite the ongoing conflict, thanks to the voucher program, women were able to continue to access health services in Yemen even if public facilities were closed, as private facilities were included (14, 15). The clinics obtained medicines and supplies from the private market. With the further escalation of the war, stock-outs became much more frequent, and the voucher money became even more important to ensure facilities could continue providing health services.

"So what they do is that they will not refuse anyone without a voucher, because the reimbursements that they acquire can be used also to help those that do not have money that comes to the facilities. Basically, the vouchers also maintain the functionality of facilities especially during the war. They had problems with the flow of the money to the facilities due to insecurity, but with the vouchers, the money goes directly into the facility, and they know exactly what they need (replenish supplies, pay staff, help other people)" (KII, Voucher Consultant).

"At the health facilities, they make use of the budget to purchase resources/maintain equipment. They concentrated on prevention of infections, training of midwives, physicians for the new FP methods. They also introduced Implanon, and so they also trained midwives on how to administer Implanon. With Marie Stopes, the midwives were also trained for manual vacuum extractions, especially in the rural areas to reduce the amount of women suffering from postpartum bleeding." (KII, MOH)

It is important for program implementation to take into account the widespread gender and power inequality and the marginalisation of women and girls in Yemen, exacerbated by the conflict. The voucher program addressed this to some extent. In order to ensure acceptability by men and women in the community, the vouchers were distributed to both men and women, by male and female distributors. Analysis by one of the key informants showed that the utilisation rates were the same if it was distributed by men and women at the time.

"The men were able to reach farther away, which was logical because the women in Yemen cannot travel that easy. They needed to be accompanied. If the man said, "my wife wants to plan our next baby" then a family planning voucher is given, and if the man said, " My wife is pregnant", then a safe motherhood voucher is sold, but at a 'symbolic' (minimal) price." (KII, Voucher Consultant).

In addition to gender-based violence, other negative, unintended effects of the program, mentioned by one of the key informants were the risk of fraud and/or overtreatment, especially in private facilities (for example putting babies in incubators unnecessarily) (KII, Voucher Consultant).

3.4.2 Intended and unintended effects on the Demand side

(e.g. ability to perceive, seek, reach, pay, and engage)

The vouchers helped poor women and their families in rural areas to come for institutional delivery, taking away a financial barrier. Another important effect described by Grainger et al was that the voucher program could address stigma and discrimination faced by poor and marginalised women, as the safe motherhood was found to give value to the women (14).

The impact of the voucher program on the ability of people to perceive care is not really measured.

"Unless an interview for beneficiaries is done, these aspects of the voucher can be seen. But we need to develop a tool to measure this. [....] The best feedback I received came from the governorate of Lahj, and he said, "the reason why people are coming for institutional deliveries is because of the transport money". This has been a huge barrier for the people and not the direct cost. They told me, that if we have to take away something [...], take away the fees from institutional deliveries, but you cannot take away the transport and the assistance (payment) for the husband for accommodation in case they needed to stay near the hospital." (KII, Voucher Consultant).

The effects on the ability to seek care appear to be predominantly restricted to married women. Any woman of childbearing age can get a voucher, it is not asked whether or not she is married.

"But the problem is when she comes to the health facility, then they will ask her if she is married. They will still give her the family planning, but it will be like a "story" in the health facility" (KII, MOPHP).

The MOHPH key informant explained that as FP for unmarried women in Yemen is not accepted, they usually don't take the voucher and don't go to the health facility. They get their contraceptives from the local pharmacy.

The ability to seek care for post-abortion care was also considered to be improved by the voucher program:

"If by chance that they had spontaneous, incomplete, or any type of abortion during this period, they can use the SMH voucher to have post-abortive care such as manual extraction of the placenta. Then, medications for a week are also given." (KII, MOPHP)

3.4.3 Factors influencing the program uptake and outcomes

The MOPHP key informant highlighted that at the beginning of the war, it was difficult for women to reach health facilities as roads were destroyed. Nevertheless, the distribution of the vouchers could continue because most of the distributors came from the same village. Referrals, from the district facilities to the bigger hospitals where caesarean sections are performed were also restricted due to the war.

"After the war, there was only one hospital who could do the caesarean section, but after a year of rehabilitation of other health facilities then the situation improved, with three more hospitals able to perform caesarean sections. Yamaan also contracted a private hospital in the north because at that time people could not access Lahj governorate". (KII, MOPHP)

In 2015, the worsening of the conflict and heavy fighting in Yemen caused challenges in the supply chain and the closure of some facilities, which led to a drop-in voucher redemption (11). In Lahj, this led to a 21% redemption rate of the FP vouchers, whilst it was expected to be 40% (15).

Another challenge expressed was that resources needed to provide the services, such as delivery or caesarean sections were not always available at the time when needed, which influenced the acceptability of the women to come to the health facility (KII, MOPHP).

3.5 Main lessons learned

Points for reflection when trying to transfer the experiences from Yemen to other settings.

Since the start of the program in Yemen, one of the concerns is that this could be a donor-driven program, possibly affecting its sustainability in the long term. It is very costly, and it requires significant funding to have a program with a good and sustainable quality standard. If a voucher program were to include the full components of SRHR, the costs would even be higher. To address this, Yamaan would like to explore the feasibility of Public-Private Partnerships (with local and international NGOs, insurance companies and the ministry), and explore how to replenish the available resources using different approaches like a social-insurance scheme taxes, revenues, or donations.

"This voucher will act like a "seed", as a base for other programs to work. We have to encourage local partners to support this kind of program at a national scale, especially in the high-risk areas such as maternal and child health. There should be someone who takes the initiative, otherwise, sustainability will remain an issue, and it will continue as a donor-driven program." (KII, Yamaan).

The results gathered from the past years of experience of the voucher program show that the system is very helpful in increasing the uptake of services and that the program was resilient as it continued despite the escalating war.

There remains a constant need to evaluate the costs of the vouchers themselves, the services included and how these costs could be reduced, in terms of verification and claims processing, to ensure the most cost-effective approach.

The case of the Yemen voucher program shows that to stimulate the demand, the supply side should also be supported, including those facilities that did not initially qualify to be included in the scheme. A mix of performance-based financing and a transport voucher scheme would make the voucher program more cost-effective and would increase accessibility (KII, Yamaan). Another argument given by one of the key informants to consider supply-side financing is that you can be more flexible.

"With the voucher system you can only address a specific need (such as safe motherhood or family planning), but with PBF you can be flexible with your priorities if the indicators have changed. (KII, Voucher Consultant).

Another area to look into is the work in the communities. Community engagement should be increased, which came to the fore in all interviews.

"For example, a health facility committee can be included in the community meetings, so that the facilities can also hear the voices of the people regarding the services provided. Traditional birth attendants (TBA) should also be included. With all of these interventions, some women still come to the TBAs. These connections will stimulate social change in the community and increase the uptake in the utilisation of the services. Increasing utilisation would also affect the cost-effectiveness of the program: as utilisation increases, we would have better cost-effectiveness in the program. (KII, Yamaan)

The voucher program has had a positive effect on awareness from both health care providers and the community. For health facilities, it increased their awareness about the possibilities of improving their facilities and maintaining the quality of services (for instance through capacity building and/or paying incentives), for which they did not have the means before the program. For the community, both men and women had the chance to increase their awareness about the availability of the family planning services and the maternal services, as well as the advantages of institutional deliveries and spacing of births.

One of the challenges faced by this voucher program is the way to transfer money due to the difficulties in opening bank accounts in Yemen.

Finally, it is worthwhile to consider expanding the program to include other SRHR services, such as addressing gender-based violence, adolescent reproductive health or infertility treatment, among other comprehensive SRHR services.

4 Key findings and conclusions

The CVA supported both the demand for SRHR services and improved the supply of services. In both settings, the CVA helped to motivate providers to continue with service provision despite the harsh conditions by using the market forces to encourage the provision of services. In addition, the CVA appeared to be contributing to quality improvement of the health services, but this needs to be measured better. In Afghanistan, key informants reported that service uptake remained at the same level even after the program ended. The outcomes of both programs differed; the uptake of the service in the CCT program did not increase much, whereas, for the voucher program, there was a significant increase in the use of the services covered by the voucher. This could be attributed to the fact that in Afghanistan services were already free of charge through the basic package of health services (BPHS), whilst in Yemen for the maternal health program, there were costs linked to the service use for women who don't have a voucher.

Whereas in Yemen the women in the voucher program only received vouchers and no cash, in the CCT program in Afghanistan, money was given directly to the women. The timing of the payment in the CCT program (after delivery) was found to remain a barrier for women accessing services prior to delivery. It could be an important consideration to make transfers part of a continuum in SRHR services.

Both programs were donor-driven and donor-dependent. The short funding streams for some of the programs, in combination with the inability of governments to take on the costs of a CVA program, made the programs less sustainable. Including the private sector and considering public-private partnerships for CVA in humanitarian settings was proposed as an option to improve sustainability.

Monitoring is a key aspect of CVA. Both programs had good tools and mechanisms, but Post Distribution Monitoring was not done in Afghanistan. Monitoring provided information about the utilisation of services and the distribution of the assistance. No information was collected about how the money was used, or about any unexpected effects on determinants of SRHR. This, as well as other issues described in these case studies, could have been prevented by using the CaLP PQ toolkit as a point of reference. This toolkit is a reference concerning good practices for CVA.

In both settings, it was found that awareness-raising (about the SRHR services, the CVA and SRHR issues) and community engagement (especially community leaders) were key factors to make the programs work and to be accepted. Cultural and gender norms need to be addressed as a component of the CVA program in order to ensure acceptance of the program (e.g. including a payment component for a husband to accompany his wife/engage female CHWs). Considerations need to be given to the agency of women to have ownership over the cash or voucher and to have the ability to choose what services they want to take up. Considerations also need to be given to ensure the SRHR services are truly accessible for all women and adolescent girls. In both settings, access for unmarried women and adolescents was not sufficiently addressed.

Both programs developed their own tools or adapted tools from other countries or different agencies. There could be a real benefit of a centralised database with tools adaptable to each context. The coordination between all partners involved at all levels (from local to national), including the community, and throughout all stages of the program (from assessment till evaluation) seems to be key for success.

The CCT program in Afghanistan only addressed facility-based deliveries and did not intend change for other SRH services, whilst in Yemen, both maternal health and family planning components were included. In both settings, some reflections were made for expanding the focus to include

other SRHR services in the program (GBV, Adolescent RH, infertility), but this action did not materialise.

These case studies show how CVA can be used in humanitarian and fragile settings aiming to increase utilisation of SRHR services and that there are different solutions depending on the context. To select the most appropriate modality, there is need for an analysis of the context, assessing indicators including SRHR related problems, existing health system functionality, cultural acceptability of SRHR services, gender and power dynamics, community preferences for different modalities, infrastructure for payment mechanisms, and the stakeholders involved. Some of the problems and issues identified could have been avoided by using the CaLP PQ Toolkit as a point of reference. The sustainability of such interventions remains an issue as institutions in the field depend on the commitment of donors to continue funding CVA components on top of more traditional supply-side interventions.

5 References

1. CaLP. The Cash Learning Partnership Glossary of terms 2020 [cited 2020 27 March]. Available from: https://www.calpnetwork.org/learning-tools/glossary-of-terms/.
2. WHO. Working paper for considering cash transfer programming for health in humanitarian contexts. 2018.
3. Blackwell A, Casey J, Habeeb R, Annan J, Falb K. Women's status and qualitative perceptions of a cash assistance programme in Raqqa Governorate, Syria. 2019.
4. Dumbaugh M, Bapolisi W, van de Weerd J, Zabiti M, Mommers P, Balaluka GB, et al. Evaluating the comparative effectiveness of different demand side interventions to increase maternal health service utilization and practice of birth spacing in South Kivu, Democratic Republic of Congo: an innovative, mixed methods approach. BMC pregnancy and childbirth. 2017;17(1):212.
5. Teerawattananon Y, Tantivess S, Werayingyong P, Kingkaew P, Tin N, Myint P. Evidence-informed policy formulation: the case of the voucher scheme for maternal and child health in Myanmar. WHO South-East Asia journal of public health. 2014;3(3):285.
6. Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International journal for equity in health. 2013;12(1):18.
7. Ministry of Public Health IRoA. Project implementation Report, Stimulating demand for utilization of maternal health and newborn care services by using conditional cash transferring scheme. 2018.
8. Higgins-Steele A, Burke J, Foshanji AI, Farewar F, Naziri M, Seddiqi S, et al. Barriers associated with care-seeking for institutional delivery among rural women in three provinces in Afghanistan. BMC pregnancy and childbirth. 2018;18(1):246.
9. Edmond KM, Foshanji AI, Naziri M, Higgins-Steele A, Burke JM, Strobel N, et al. Conditional cash transfers to improve use of health facilities by mothers and new-borns in conflict affected countries, a prospective population-based intervention study from Afghanistan. BMC pregnancy and childbirth. 2019;19(1):193.
10. Mumtaz S, Bahk J, Khang Y-H. Current status and determinants of maternal healthcare utilization in Afghanistan: Analysis from Afghanistan Demographic and Health Survey 2015. PloS one. 2019;14(6).
11. Witvorapong N, Foshanji AI. The impact of a conditional cash transfer program on the utilization of non-targeted services: Evidence from Afghanistan. Social Science & Medicine. 2016;152:87-95.
12. Ministry of Public Health IRoA. Operations manual: Stimulating demand for utilization of maternal health and newborn care services by using conditional cash transferring scheme. 2016.
13. Yamaan. Respecting, Protecting and fulfilling Sexual and Reproductive Health and Rights in Conflict; Completion report: November 2017 to June 30, 2019. 2019.
14. Grainger CG, Gorter AC, Al-Kobati E, Boddam-Whetham L. Providing safe motherhood services to underserved and neglected populations in Yemen: the case for vouchers. Journal of International Humanitarian Action. 2017;2(1):6.
15. Boddam-Whetham L, Gul X, Al-Kobati E, Gorter AC. Vouchers in fragile states: reducing barriers to long-acting reversible contraception in Yemen and Pakistan. Global Health: Science and Practice. 2016;4(Supplement 2):S94-S108.
16. WHO. Trends in maternal mortality: 1990 - 2015 estimates by WHO, UNICEF, UNFPA, World Bank Group and the United nations Population Division 2015
17. Yamaan. Yamaan Foundation for Health and Social Development; PowerPoint presentation2019.

6 Annex 1: Topic guide

Topic	Guiding questions	Probes
General introduction	1. Name 2. Organisation working for 3. Position 4. Country/location 5. What is your personal involvement in the CVA programme	-
Programme description	6. What is the name of the intervention? 7. Can you briefly describe the CVA programme? 8. If conditional; what type of conditionality? 9. Who are the beneficiaries of the CVA? 10. What are the criteria for inclusion? 11. What is the selection procedure 12. What is the SRHR service provided in connection with the CVA? 13. What other interventions are linked with the CVA? (which intervention is the main? Cash-Plus vs Plus-Cash) 14. Since when is the program running? 15. What is the expected end date? 16. Is there an exit strategy? Please describe 17. Who funds it? 18. Who are other key partners? 19. How is/was the community involved in the design/monitoring and evaluation of the CVA programme?	Modalities (restricted/unrestricted/conditional /unconditional/cash/voucher/ Urban/Rural Women/men/boys/girls/ Age group Vulnerable groups (LGBTI/refugees/host/people with disabilities/ethnic groups etc.) Who selects? In the community? At health facility? (Maternal health/STI/HIV/SGBV/Family planning/Adolescent SRHR/Safe abortion/infertility/counselling Peer support groups/Gender norms transformative programmes/Income generation/Education & Information/training of staff/supply side financing/etc.

	20. Do you have any reports or evaluations of the programme? What are the key findings of those? Could you please share the reports?	
What is the operational feasibility of CVA within or complementary to other SRHR interventions in humanitarian and selected development settings?	21. At the start of the CVA, what was the supply of SRHR services like? 22. At the start of the CVA, what was the demand for SRHR services like? 23. What was the situation of the financial and administrative infrastructure at baseline? 24. At the start of the program, what protection-related risks were identified? 25. Overall, how do you see the acceptance of the CVA by authorities? 26. How do you see the acceptance of the CVA by the beneficiaries? 27. How do you see the acceptance of the CVA by non-beneficiaries? 28. What is your, or your organizations' learning of the cost-efficiency/cost effectiveness of the CVA programme so far?	(Public/private/actors/urban/rural/ quality/range of services/community services…) Contraceptive use/abortion and unsafe abortion/SGBV survivors reaching out to a clinic/maternal mortality/Skilled Birth Attendance/Adolescents accessing SRHR services/HIV/STI uptake of services/Stigma Banks, electronic money, ATMs, monitoring mechanisms GBV, robbery, intimidation, corruption etc.
What are the effects of CVA on SRHR outcomes in humanitarian and selected development settings? / What are the comparative advantages/disadvantages of CVA within or complementary to other SRHR interventions in humanitarian settings as a mean to reduce financial barriers and/or increase access and utilization for SRHR services?	29. What are effects of the CVA on the ability to perceive SRHR services that you have observed or were reported? 30. What are the effects of the CVA on the ability to seek SRHR services that you have observed or were reported? 31. What are the effects of the CVA on the ability to reach SRHR services that you have observed or were reported? 32. What are the effects of the CVA on the ability to pay for the SRHR services that you have observed or were reported? 33. What are the effects of CVA on the ability to engage with SRHR services? 34. What effects of the CVA on the utilisation of the SRHR services have you observed?	Health literacy/health beliefs/trust/expectations Personal and social values, culture, gender, autonomy Living environment, transport, mobility, social support Income, Assets, Social capital, Health insurance Empowerment, information, adherence, caregiver support Number of women accessing services, number of people from vulnerable groups, number of SGBV survivors accessing services

	35. What effects of CVA have you observed or was reported on the supply side of the health system? 36. Were/are there any contextual factors that influence the effect of CVA on the access and utilization? Can you explain?	within 72 hours *(timely care), increase in delivery by skilled birth attendant, increase contraceptive prevalence, decrease unsafe abortion figures Approachability, acceptability, availability, accommodation, affordability, appropriateness Gender, religion, security, civil unrest, infrastructure
What are appropriate guidelines and tools aimed at assessing feasibility and assisting implementation of CVA in humanitarian settings?	37. What tools are you using to guide the implementation of your CVA programme? 38. What tools are you using to assess the feasibility of the CVA programme? 39. What tools for assessing feasibility or for implementation of CVA are you missing? What could be helpful?	What aspects of these tools make it useful? What is less useful?
What are the lessons learned and the operational recommendations for future CVA for SRHR programming?	40. What are the main lessons learned from the programme so far? 41. What are your recommendations for other actors who would like to setup CVA for SRHR in a humanitarian setting?	What would you do different? What works well?