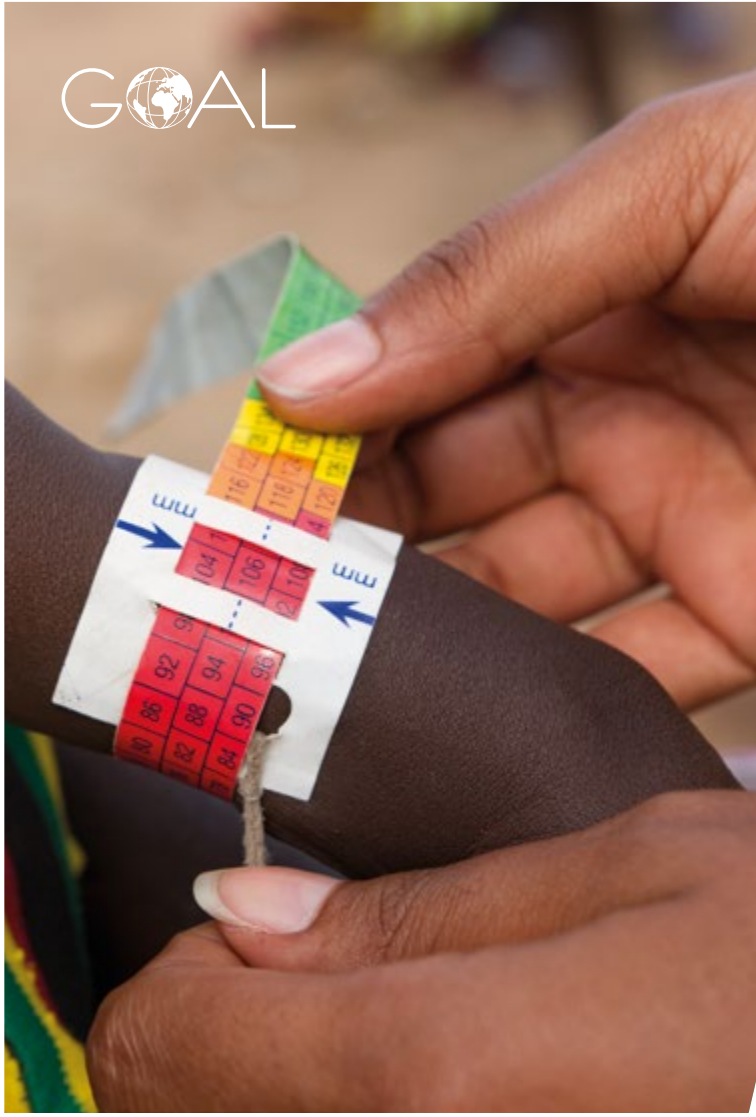

A GLOBAL MAPPING OF GOAL'S CASH, VOUCHERS AND SOCIAL PROTECTION INTERVENTIONS LINKED WITH HEALTH

ACKNOWLEDGEMENT

This report is a result of the extensive time and invaluable insights offered by GOAL staff from the 13 GOAL Country Offices located in different parts of the world. We would like to acknowledge the enormous support received from Ciara O' Malley- Global Cash Advisor, Marie Hallissey, and Daniel Muhungura Global Health Advisors throughout this exercise.

Thank you to the participants from each country who actively participated in the data collection exercise and provided all the necessary documentation to ensure this process was a success.

This mapping exercise including report writing was conducted by Lucy Njue, GOAL consultant, under the leadership of Ciara O' Malley, GOAL, who oversaw the whole exercise and led in editing of the report.

ACRONYMS

BHA	Bureau for Humanitarian Assistance
BPRM	Bureau of Population, Refugees, and Migration
CLA	Community-Led Action
CVA	Cash and Voucher Assistance
DFID	Department for International Development
DCF	Donor Cash Forum
EA	Effective Altruism
ECHO	European Civil Protection and Humanitarian Aid Operations
ERFS	Emergency Response Funds
FBO	Faith Based Organisations
IAERF	Irish Aid Emergency Response Fund
IFRP	International Food Relief Partner
IRC	International Rescue Committee
IPC	Integrated Food Security Phase Classification
IOM	International Organisation for Migration
MEAL	Monitoring, Evaluation, Accountability and Learning
MOH	Ministry of Health
MOU	Memorandum of Understanding
MPCA	Multi-Purpose Cash Assistance
MUAC	Mid-Upper Arm Circumference
NHIF	National Health Insurance Fund
NIPP	Nutrition Impact and Positive Practice
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OFDA	Office of U.S. Foreign Disaster Assistance
PDM	Post Distribution Monitoring
PWD	People with Disabilities
RUTF	Ready to Use Therapeutic Food
SMAC	Social Mobilization Action Consortium
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
UNOCHA	United Nation's Office for the Coordination of Humanitarian Affairs.
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisations
WFP	World Food Programme

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South Sudan Cash Transfer recipient

EXECUTIVE SUMMARY

The global mapping of GOAL`s Cash and Voucher Assistance (CVA) and Social Protection interventions with linkages with health aim to inform the GOAL global CVA strategy that is currently under development. The overall objective of this exercise was therefore to map out GOALs projects that have linkages between CVA and health, including nutrition. The mapping and categorization of the projects was guided by the CVA definition by CaLP which states that CVA refers to all programs where cash transfers or vouchers for goods or services are directly provided to recipients.

DEFINITION OF 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 micro-finance in humanitarian interventions (although micro-finance and money transfer institutions may be used for the actual delivery of cash). (CaLP Glossary)

Key Findings:

The key findings of this exercise were that GOAL had adopted various strategies to offer financial assistance to increase access to health and nutrition services. Some of these interventions fit the standard definition of CVA, some are more fitting as Social Protection interventions and some do not fall within either category. Out of the 58 health and nutrition projects identified; 29% (17) were implementing CVA approaches in line with the definition. This included:

i. The payment of transport and incidental costs to facilitate referrals to health services
ii. The use of CVA at the household level to improve nutrition outcomes among household with malnourished children.

Financial assistance interventions that do not qualify as CVA included:

i. Payment of hospital bills directly to service providers on behalf of community members
ii. Payment of transport costs directly to transport service providers to facilitate referral for health services.
iii. Salary support for health care workers (partially or in full)
iv. Grants to the Ministry of Health (MOH) to implement project activities.
v. Payment of daily subsistence allowances to health care workers and community volunteers.

Among non-health specific projects utilizing CVA modalities, the findings show that health and nutrition aspects were integrated within the project cycle. This was achieved mainly through the following approaches:

i. Inclusion of health and nutrition factors in the selection criteria
ii. Implementation of health and nutrition activities like health education and community sensitizations
iii. Facilitating referrals of community members to access health services
iv. Responding to health crisis like COVID-19 with CVA and
v. Monitoring of health and nutrition-related indicators

Challenges:

The key challenges faced by the projects included the logistical challenges faced by GOAL offices while making payments to community members in remote areas and difficulties in forecasting and planning since the disbursements are dependent on the occurrence of an unpredictable event e.g. need for an emergency referral. Unlike in the case of Multi-Purpose Cash Assistance (MPCA) where disbursements are standardized, payments for health purposes are individualised hence time-consuming and demanding to the financial and logistical teams. Where government agencies were required to share specific documents before reimbursements, the offices reported that the process was often marked with delays.

However, the main challenge associated with the implementation of CVA in health is perhaps related to the need to support or ensure the availability of quality health services and supporting access to such services.

Best Practices:

One of the best practices was the application of financial assistance to complement other health financing options. This was being implemented in Sudan and South Sudan through a combination of provider payment-based mechanisms (to reduce user fees) with CVA targeting the specific needs of a patient (transport costs). Other best practices included the close collaboration and coordination between the health and non-health departments to plan and implement interventions jointly e.g. provision of health and nutrition services during cash distributions.

Recommendations:

The following are the key recommendations of this exercise:

i. Consider making changes to some of the current interventions to make them more CVA-oriented like including elements of vouchers among projects that are paying service providers directly, on the behalf of community members.
ii. Consider the use of a combination of approaches e.g. use of provider payment-based mechanisms (to reduce the user fees) with CVA targeting the specific needs of a patient.
iii. Whenever possible, allocate cash for health needs when coming up with the Minimum Expenditure Basket, recognising that this is often an inter-agency initiative.

Lastly, this report recommends the need for a more detailed study to further inform the effectiveness and perhaps the impact of the mapped-out interventions.

01 INTRODUCTION

1.1 Background

GOAL is currently developing a global Cash and Voucher Assistance (CVA) strategy. One of the strategic commitments of the strategy is to carve-out organizational competence in connecting CVA with health. **A broad view of health was adopted to incorporate nutrition-related outcomes.** To inform the process, GOAL commissioned a mapping exercise to document the formal and informal ways it has been linking social protection, cash and voucher assistance with health and nutrition.

1.2 Objective of the Exercise

The overall objective of the exercise was to map out GOAL`s projects with linkages between CVA and health, including nutrition.

Specific Objectives

1. To map out components of financial assistance among projects with health/nutrition-specific outcomes.
2. To map out projects using cash and /or voucher assistance for non-health or non-nutrition outcomes that have health/nutrition-related components integrated into the project cycle.
3. To make recommendations on how financial assistance which does not fall into the CaLP definition of 'CVA' should be categorized by GOAL.

1.3 Methodology

The first step in conducting the exercise involved a desk review of some of the GOAL`s project documents to familiarize with the project designs and strategies. This was followed by a global literature review to find out and gain an understanding of how CVA, health, and nutrition have been linked in the past as well as generate evidence on best practices.

The target of this action was GOAL's active projects as well as those completed within the last two years i.e. from 2020. A total of 198 projects were reviewed based on projects that have been delivered since 2020, as per GOAL's Grant Management System data. Grants that did not entail the delivery of assistance using cash, vouchers, in-kind, or services were not included, for example, research grants and institutional funding for the management of country offices. The projects were categorized by the country of implementation. This was followed by country-

specific meetings where each of the projects in the list was discussed to first classify it as either being health-specific or non-health-specific but with CVA components. For projects with health and nutrition-specific outcomes, the focus of the discussion was to identify any financial assistance given by the project to any institutions or individuals. For those with non-health-specific outcomes, the focus was to identify any linkages with health and nutrition in the project cycle. Following data analysis and report writing, the findings of the study were presented to GOAL project teams from the participating countries.

1.4 Limitations of the mapping exercise

Due to the high number of projects listed for this exercise, it was difficult to do a comprehensive analysis of all them. Based on the findings, this report recommends that GOAL should consider conducting a more detailed analysis of data from specific projects, preferably those implementing CVA interventions (as per the standard definition) combined with other health financing options. This will provide an analysis of how well the models are complementing each other in improving health outcomes.

1.5 Findings of the mapping exercise

Out of the 198 projects listed, a total of 58% (114) projects were found to have elements of financial assistance linked to health and nutrition. Fifty-eight (58) of these projects had health and nutrition-specific outcomes, while fifty-six (56) had non-health-specific outcomes, but were offering financial assistance with linkages to health and nutrition components. The rest (84) included projects that were not offering any financial assistance and had no elements of linkages with health and nutrition.

The findings of the mapping exercise are presented in tables 1 and 2. The tables show the linkages between health and nutrition and financial assistance which may or may not be defined as CVA. Table 1 maps out components of financial assistance among projects with health/nutrition-specific outcomes while Table 2 maps out CVA for non-health or non-nutrition outcomes which have health/nutrition-related components integrated into the project cycle.

[1]Global Health Cluster and WHO (2018). Working paper for considering cash transfer programming for health in humanitarian contexts ; cash task team https://www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf

South Sudan, cash transfer

Table 1: List of projects with financial assistance for health outcomes

Project Name	Country	Donor	Project objectives related to financial assistance	Financial Assistance Interventions	Does it fit the CVA definition?
Section A: Projects that meet transport costs to facilitate referrals for health services					
Irish Aid Allocation 2021 – including Health & Nutrition programming in Zinder region (2021)	Niger	Irish Aid	To improve health and nutritional status of vulnerable populations	Reimbursement of cash for fuel (to facilitate the transfer of patients after referral) and maintenance of ambulances. The cash is paid to the Ministry of Health through the district offices. The reimbursements are done upon provision of receipts (prove of expenditure), to the GOAL office	No since the cash is paid to the government
Supporting formal and informal health systems to improve the health and nutritional status of vulnerable populations in Tanout and Belbedji Districts, Zinder Region (2019-2020)		ECHO			
Support Informal and formal health systems, aiming to improve health and nutrition of vulnerable populations in Tanout and Belbedji Districts(2020-2021)		CERF			
Improve the well-being of IDPs and host communities in Ouallam department, Tillabery Region(2021-2022)		OCHA			
Lekani Nkhanza - The Spotlight Initiative Malawi - Year2 (2021)	Malawi	UNFPA	To strengthen linkages to sexual and reproductive health and rights.	Cash is given to community committees to facilitate the transport of GBV survivors. The community members reach out to the committee members whenever there is a case in need of support The committee provides the cash to the community member to help them pay for transport to the health facilities.	Yes
The Spotlight Initiative Malawi (2019-2021)					
Saving Lives II Programme – Health systems support for improved Maternal and Child health	Sierra Leone	FCDO	To improve reproductive maternal and child health outcomes	Payment to facilitate referrals for health services. The cash was paid to transport service providers	No
SL_IA_21_Programme Funding –including Adolescent Sexual & Reproductive Health in Kenema, Kambia, and Western Area of Freetown (2021)		Irish Aid			
Provision of essential primary health care and nutrition services for the conflict-affected vulnerable children and families in Kajo-Keji, Central Equatorial State with integrated Mental Health and Psychosocial Support (MHPSS) to Sexual Gender Based Violence (SGBV) survivors, HIV/AIDS, and Tuberculosis (2021-2022)	South Sudan	ECHO	To provide integrated and life-saving primary healthcare and nutrition services	Payment of cash allowance to community members to facilitate referrals e.g. pregnant women in need of obstetric care like caesarian section, severely malnourished children, and GBV survivors. The financial support is given directly to the community members and is meant to meet transport costs and for upkeep while in hospital)	Yes
Provision of lifesaving Emergency Health and Nutrition Services in Abyei Administrative Area (AAA) (2021-2023)					
Nutrition Health and Livelihoods (2018-2019)	Sudan	IMC			
Integrated Response for the Conflict-Affected Population of North Darfur and South Kordofan, Sudan		OFDA			
Provision of an integrated response for the conflict-affected populations of Kutum and Alwaha, North Darfur (2019-2020)		OFDA			
Multi-sector lifesaving response for Kutum and Alwaha localities, North Darfur (2019-2020)		UNOCHA			
Integrated Multi-Sector - FSL, WASH, Health, Nutrition, and Protection - program in South Kordofan State (2019-2020)		UNDP			
ECHO Multi-Sector Response in North Darfur and South Kordofan (2020-2021)		ECHO			
SHF Allocation Multi-Sector Response North Darfur (2020-2021)		SHF			

Irish Aid GOAL Allocation (2021)	Sudan	IA			
Integrated multi-sector - Health, Nutrition, Protection & Education - program in South Kordofan State (SHF First Round 2021 Allocation) 2021-2022		SHF			
Multi-Sector Response in South Kordofan and North Darfur (2020-2021)		OFDA			
Reduced morbidity and mortality among conflict and displacement affected communities in Tigray and Amhara Region, Ethiopia (2021)	Ethiopia	IA ERFS	To provide integrated and life-saving primary healthcare and nutrition services	Payment of cash allowance to GBV survivors to facilitate access to health services. Cash is meant to meet transport, meals, and other related costs that the community member may incur while seeking care. The amount is based on the estimated duration of hospital stay (usually 9 days)	Yes
Reduced morbidity and mortality among conflict and displacement affected communities in Tigray Region (2021)	Ethiopia	IA ERFS			
Section B: Projects that Meet Hospital Bills					
Provision of essential primary health care and nutrition services for the conflict-affected vulnerable children and families in Kajo-Keji, Central Equatorial State with integrated Mental Health and Psychosocial Support (MHPSS) to SGBV survivors, HIV/AIDS, and Tuberculosis (2021-2022)	South Sudan	ECHO	To provide integrated life-saving primary healthcare and nutrition services	Payment of hospital bills to meet the medical costs of patients referred for specialized care (pregnant women in need of obstetric care, GBV survivors, severely malnourished children	No
Provision of lifesaving Emergency Health and Nutrition Services in Abyei Administrative Area (AAA) (2021-2023)					
Nutrition Health and Livelihoods (2018-2019)	Sudan	IMC			
Integrated Response for the Conflict Affected Population of North Darfur and South Kordofan, Sudan (2019-2020)		OFDA			

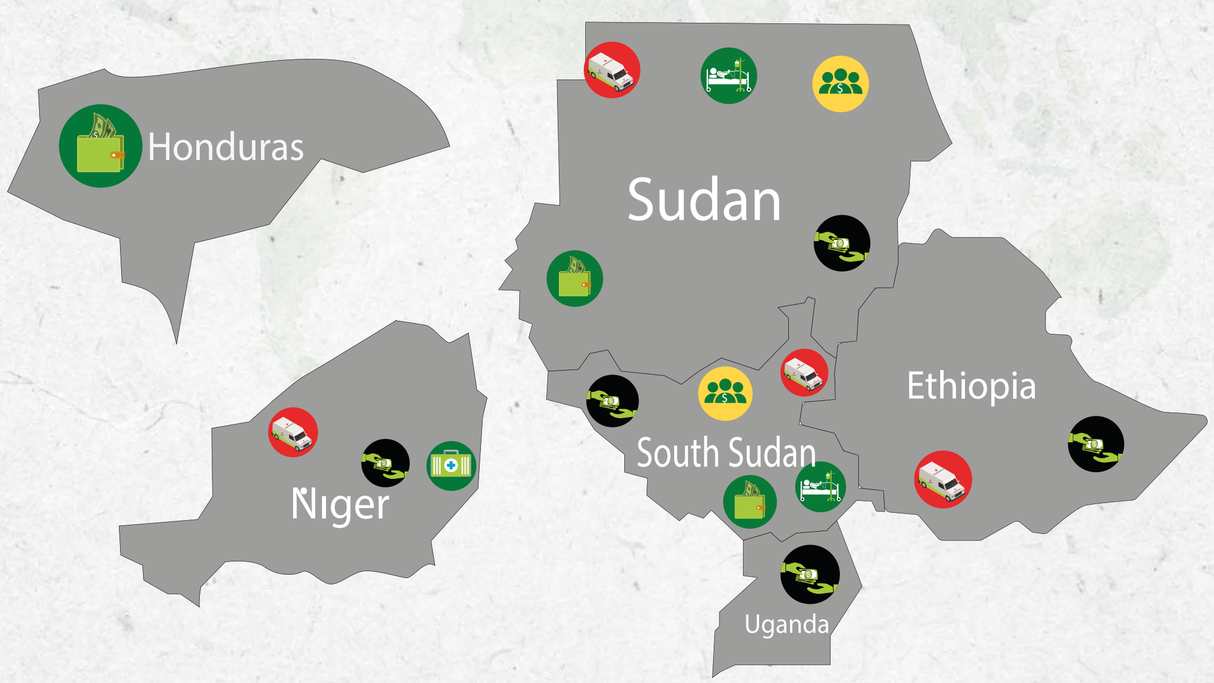
Provision of an integrated response for the conflict affected populations of Kutum and Alwaha, North Darfur (2019-2020)		OFDA		Payment of hospital bills to meet the medical costs of patients referred for specialized care (pregnant women in need of obstetric care, GBV survivors, severely malnourished children)	No
multi-sector lifesaving response for Kutum and Alwaha localities, North Darfur (2019-2020)		UNOCHA			
Integrated Multi-Sector - FSL, WASH, Health, Nutrition, and Protection - program in South Kordofan State (2019-2020)		UNDP			
ECHO Multi-Sector Response in North Darfur and South Kordofan (2020-2021)		ECHO			
SHF Allocation Multi-Sector Response North Darfur (2020-2021)		SHF			
Irish Aid GOAL Allocation (2021)		IA			
Integrated multi-sector - Health, Nutrition, Protection & Education - program in South Kordofan State (SHF First Round 2021 Allocation) (2021-2022)		SHF			
Section C: Projects that offer salary support for health care workers (partially or in full) through MOH or directly					
Emergency response: Provide administrative, procurement, and logistical support to increase GoH COVID-19 response capacity of Medical Brigades and Center of Triage to prevent, detect, test, and provide treatment in the Moskitia Region (2020)	Honduras	IDB	To increase government of Honduras COVID-19 response capacity of medical brigades and center of triage to prevent, detect, test, and provide treatment in the Moskitia Region	Salary support for medical staff through the MOH structures.	No

Health System Strengthening in North Darfur (2019-2021)	Sudan	EU	Health system building blocks are supported with capacity building for key actors, infrastructure, and phased subsidies for patient costs to ensure the quality and accessibility of PHC services	Support monthly incentives for health care workers through the MOH structures specifically through National Health Insurance Fund (NHIF). The incentives are paid to staff who are usually government employed. The amounts given are not full salaries but top-ups to motivate the staff.	No
Health Pooled Fund- Health System Strengthening (2019-2020)	South Sudan	HPF	To provide integrated and life-saving primary healthcare and nutrition services	Payment of monthly salary incentives directly to the MOH staff/healthcare workers. The money is paid by GOAL directly to the staff (not through the state structures)	No
Health & Nutrition Abyei Save the Children		ECHO			
Health and Nutrition Equatorias (2019-2020)		ECHO			
Nutrition Flood Response in Ulang (2019-2020)		UNDP			
TSFP Ulang (2020)		WFP			
Provision of lifesaving Emergency Health and Nutrition Services in Abyei Administrative Area (AAA) (2020-2021)		ECHO			
Ulang Resilience (2021-2022)		UNOCHA			
Provision of lifesaving Emergency Health and Nutrition Services in Abyei Administrative Area (AAA) (2021-2022)		ECHO			
Food, Health and Nutrition Security		UNOCHA			
Nutrition, Health, and Livelihoods	Sudan	IMC			
Integrated Response for the Conflict-Affected Population of North Darfur and South Kordofan, Sudan		OFDA			

Provision of an integrated response for the conflict affected populations of Kutum and Alwaha, North Darfur	Sudan	OFDA			
Multi-sector lifesaving response for Kutum and Alwaha localities, North Darfur (2021-2022)		UNOCHA			
Integrated Multi-Sector - FSL, WASH, Health, Nutrition, and Protection - program in South Kordofan State (2019-2020)		UNDP			
Section D: Projects that fund MOH for project activity implementation					
Irish Aid Allocation 2021	Niger	Irish Aid	Support government efforts to maintain routine and essential health and nutrition service provision.	Financial assistance to the Ministry of Health through the district office to facilitate implementation of health and nutrition activities like supportive supervision, training for health care workers.	No
Supporting formal and informal health systems to improve the health and nutritional status of vulnerable populations in Tanout and Belbedji Districts, Zinder Region (2019-2020)		ECHO			
Support Informal and formal health systems, aiming to improve health and nutrition of vulnerable populations in Tanout and Belbedji Districts (2020-2021)		CERF			
Improve the well-being of IDPs and host communities in Ouallam department, Tillabery Region (2021-2022)		OCHA			
Reduce Cholera Propagation in the Mirriah Health District, Zinder Region (2021)		START	Improve government cholera surveillance and rapid response efforts	Financial assistance to the Ministry of Health through the district office to strengthen cholera surveillance. The cash is used to facilitate the MOH team to conduct various activities, e.g. conduct monitoring visits, training, etc.	No

Section E: Projects that give cash transfers to households with children diagnosed with Severe Acute Malnutrition (SAM)					
Integrated Response for Urban Areas (2021-2022)	Zimbabwe	ECHO	To provide integrated and life-saving primary healthcare and nutrition services	Cash transfers made to households with severely malnourished children receiving Ready to Use Therapeutic Food (RUTF)	Yes
Section F: Other Financial Assistance					
Health System Strengthening in North Darfur (2019-2021)	Sudan	EU	Health system building blocks are supported with capacity building for key actors, infrastructure, and phased subsidies for patient costs to ensure the quality and accessibility of PHC services	Co-payment for medication. This is done through state agencies.	No
Irish Aid allocation 2021	Sierra Leone	IA	To provide integrated and life-saving primary healthcare and nutrition services	Payment of monthly incentives to clinical mentors (government officers) to facilitate their transport to offer clinical mentorship	No

Projects with health and nutrition activities	Niger, Malawi, Sierra Leone, South Sudan, Uganda, Zimbabwe Ethiopia	EHF, ECHO, UNOCHA, IA, DBF, EU,	To provide integrated and life-saving primary healthcare and nutrition services	Payment of daily subsistence allowances - Transport, meals, etc. to healthcare workers, MOH officers, and community volunteers when engaged in project activities such as training, sensitizations, and review meetings The cash is used to reimburse short-term costs incurred by the teams during project delivery	No
Projects with health and nutrition activities	Sierra Leone, South Sudan, Zimbabwe	UNICEF, Irish Aid		Payment of monthly allowances to community volunteers – Community Led Action (CLA) facilitators, Nutrition Impact Positive Practice (NIPP) facilitators	No



Legend

- Payment of transport costs to facilitate referrals for health services
- Payment of hospital bills
- Salary support for health care workers (partially or in full)
- Payment of monthly incentives to community teams
- Cash transfers to households with children diagnosed with Severe Acute Malnutrition (SAM)
- Payment of daily subsistence allowances
- Funds to MOH for project activity implementation

Table 2: List of Projects with CVA for non-health or non-nutrition outcomes which has health/ nutrition-related components integrated into the project cycle.

Name of Project	Country	Donor	Project Objective	Financial Assistance Intervention	How it connects with Health/ Nutrition
Section A: COVID-19 Response					
COVID-19 preparedness and response 2020	South Sudan, Sudan	DFID	To meet the basic needs of the most vulnerable households	Multi-Purpose Cash Assistance to support basic needs	The projects were implemented in response to the COVID-19 pandemic. The selection criteria included people most vulnerable to COVID-19 including the elderly people with co-morbidities, and people with disabilities
COVID-19 Preparedness and Response 2020	Sudan	OFDA			
COVID-19 response 2020	Syria	UNICEF			
COVID-19 Response program 2020	Honduras	UNDP			
Section B: Provision of health services including health information alongside CVA activities					
Hurricane Eta Emergency Response (2020-2021)	Honduras	IA ERFS	To meet the basic needs of the affected populations	Multi-Purpose Cash Assistance	Provision of health and nutrition services during the implementation of project activities like food distribution events. In Honduras, the team provided COVID- 19 vaccines and nutrition screening during cash delivery community events (conducted in partnership with the Ministry of Health) They also provided family health kits.
Contribute to increased access to safe shelter and water and sanitation services of those impacted by Hurricane/Tropical Storm Eta in Honduras (2020-2022)		BHA			
Recovery of agriculture activities through seed distribution and inputs in flood and rain affected areas in Nsanje, Phalombe and Chikwawa (2019)	Malawi	DFID	Improve food security	Value Vouchers for purchasing livestock	Health and nutrition sensitization sessions conducted during cash distribution events.
Livelihood recovery for flood affected communities (2019-2020)	Malawi	ECHO	Enhance the self-reliance and resilience of the most vulnerable communities to cope with current and future shocks and stresses.	Voucher to support livelihood inputs	The sensitizations focused on hygiene promotion, COVID-19 prevention, the importance of vaccination and nutrition.
Integrated Multi-Sector - FSL, WASH, Health, Nutrition, and Protection - program in South Kordofan State (2019-2020)	Sudan	UNDP			
Nutrition, Health and Livelihoods (2018-2019)		IMC			
Integrated Response for the Conflict Affected Population of North Darfur and South Kordofan, Sudan (2019-2020)		OFDA			
Provision of an integrated response for the conflict affected populations of Kutum and Alwaha, North Darfur (2019-2020)		OFDA			
Multi-sector lifesaving response for Kutum and Alwaha localities, North Darfur (2019-2020)		UNOCHA			
ECHO Multi-Sector Response in North Darfur and South Kordofan (2020-2021)		ECHO			
Multi-Sector Response in South Kordofan and North Darfur (2020-2021)		OFDA			
COVID-19 preparedness and response. (2020)	South Sudan, Sudan	DFID			

Hurricane Eta Emergency Response (2020-2021)	Honduras	IA ERFS	To meet the basic needs of the affected populations	Multi-Purpose Cash Assistance	
Contribute to increase access to safe shelter and water and sanitation services of those impacted by Hurricane/ Tropical Storm Eta in Honduras (2020-2022)		BHA			
Haiti Southern Peninsula Earthquake Response (2021)	Haiti	IA ERFS	To improve road accessibility following the earthquake	Cash for work	Conducted health education sessions on COVID-19 and nutrition
Emergency Social Cash Transfer (ESCT) – Improving Shock Responsiveness of Social Protection in Mbare suburb – Harare (2021-2022)	Zimbabwe	BHA	Cash for Protection in cases of GBV and Child abuse cases	Cash for protection	Conducted mass media education through radio to educate the public on nutrition, COVID-19 prevention, and vaccination.
Emergency Social Cash Transfer (ESCT) – Improving Shock Responsiveness of Social Protection for Most Vulnerable Urban Households (Chitungwiza) (2021-2022)		UNICEF			
Emergency Social Cash Transfer (ESCT) – Improving Shock Responsiveness of Social Protection for Most Vulnerable Urban Households (Harare) (2020-2021)		UNICEF			

To save lives, alleviate the suffering of those impacted by conflict, and reduce its social and economic impact, through a package of interventions that increase affected households' resilience and capacity to withstand future shocks (2021-2022)	Syria	BHA	To meet the basic needs of the affected populations	Multi-Purpose Cash Assistance	The project links up with other health projects and partners to provide health services like nutritional assessments and screening. e.g. in Syria, community members are referred to the IFRP nutrition funded project
RELIEF II (2021-2022)	Syria	ECHO	To meet the basic needs of the affected populations	Multi-Purpose Cash Assistance	The project links up with other health projects and partners to provide health services like nutritional assessments and screenings e.g. in Syria, community members are referred to the IFRP nutrition funded project
OCHA Winterisation NWS (2021-2022)		OCHA			
Cash-Based Intervention II (2022-2023)		IOM			
Emergency assistance to conflict-affected displaced communities in North West Syria (SNFI) (2020)		OCHA			
Syria Cross-border Humanitarian Fund- Food Security in NW Syria (2020)		OCHA			
OCHA FSL - floods assistance (2022)		OCHA			
Recovery of agriculture activities through seed distribution and inputs in flood and rain affected areas in Nsanje, Phalombe and Chikwawa (2019)	Malawi	DFID	Improve food security	Value Vouchers for purchasing livestock	
Livelihood recovery for flood affected communities (2019-2020)		ECHO		Cash labelled for food	

Section C: Facilitating referral of community members to access health services					
Facilitating marginalized and vulnerable populations' access to services (2020-2022)	Turkey	ECHO	Provide facilitative support to increase access to services	Provided value vouchers to community members to access basic needs. In addition, offered facilitative support- payments to taxi companies to meet the costs of transfer to hospitals.	Facilitated referral of community members to access health /medical services and needs including access management of GBV survivors by organizing taxis to transport community members to hospitals.
LINK III - Facilitating Marginalized and Vulnerable Populations' Access to Services (2020-2022)		ECHO			
Empowering with Dignity - building Green Resilience and Economic Empowerment with inclusion at the centre (GREEN) (2021-2022)		BPRM		Provided cash allowances to community members to access trainings.	Conducted health sensitization during trainings.
Emergency Social Cash Transfer (ESCT) – Improving Shock Responsiveness of Social Protection in Mbare suburb – Harare(2020-2021)	Zimbabwe	BHA	To cushion the vulnerable populations from economic shocks	Unconditional Cash transfers	Provides cash transfers to GBV survivors and child abuse cases to facilitate access to health services. The cash is meant to meet transport and other related costs.
Emergency Social Cash Transfer (ESCT) – Improving Shock Responsiveness of Social Protection for Most Vulnerable Urban Households (Chitungwiza) (2021-2022)		UNICEF			
Protection and Monitoring of IDPs and IDP Returnees in East and West Hararghe zones, Oromiya (2020)	Ethiopia	UNHCR			
Multi-sectoral Integrated Emergency responses to drought and conflict affected households in Gewane (Afar), Gelana (Oromia), and Babile (Somali) Woredas (2021-2022)		UNOCHA			

Community Based Integrated Child Protection and Gender-Based Violence Assistance for the Crisis-Affected Communities in Amhara and Afar Regions (2021-2022)	Ethiopia	OCHA			Provides cash transfers to GBV survivors and child abuse cases to facilitate access to health services. The cash is meant to meet transport and other related costs.
Integrated child protection (CP), gender-based violence (GBV) and psychosocial support services to conflict and natural disaster-affected communities, and displaced persons facing protection risks. (2021)		OFDA	Cash for Protection in cases of GBV and Child abuse cases	Cash for protection	
Crisis-affected communities, women, adolescent girls and children, are protected from violence, exploitation, abuse and harmful practices, receive quality and timely response services and benefit from risk reduction and prevention measures (2020-2021)		EHF			
UNICEF Emergency Social Cash Transfer (ESCT) – Improving Shock Responsiveness of Social Protection for Most Vulnerable Urban Households (Harare) (2020-2021)	Zimbabwe	UNICEF	To cushion the vulnerable populations from economic shocks	Cash transfer to families with children suffering from severe malnutrition	Cash to meet the food and nutrition needs of vulnerable families at risk of malnutrition considering that one household member had SAM

Strengthen resilience in Niger through a multi-stakeholder and multi sectors Integrated Approach focused on social safety nets and risk reduction in Mirriah department (Zinder region) 2020	Niger	WFP	To support their basic needs necessary to keep them in school	Scholarship for education	Encourages community members (girls) to use the cash to purchase sanitary kits for their menstruation hygiene.
Strengthen resilience in Niger through a multi-stakeholder and multi sectors Integrated Approach focused on social safety nets and risk reduction in Mirriah department (Zinder region)- Phase 2 (2021)					
Multi-sectoral and emergency response projects using CVA modalities to meet basic needs and for food security	Sudan, Turkey, Honduras, Colombia, Niger, Zimbabwe, Haiti, Malawi, Syria South Sudan	UNDP, IAERFS, ECHO, BHA, IA, OCHA, IOM, WFP, UNICEF, IRC, OFDA, EA, UNHCR	To cushion the vulnerable populations from economic shocks by helping them meet basic needs including food	Mainly unconditional multi-purpose cash assistance	Selection criteria took into consideration health and nutrition factors. Common factors included households with malnourished children
Multi-sectoral and emergency response projects using CVA modalities to meet basic needs and for food security	Sudan, South Sudan, Ethiopia, Niger, Zimbabwe, Haiti, Malawi, Syria Colombia	OFDA, UNOCHA, DFID, ECHO, OCHA, IOM, UNHCR, BHA, EA, IRC	To cushion the vulnerable populations from economic shocks by helping them meet basic needs including food	Mainly unconditional multi-purpose cash assistance	MEAL framework had health and nutrition indicators incorporated. This included monitoring of negative coping strategies and food consumption scores

Health and Nutrition Interventions among Non-Health specific projects

Cash in response to COVID-19 pandemic

- Honduras
- Sudan
- South Sudan
- Syria

Provision of health and nutrition services e.g vaccination during cash/food distribution, nutrition screening, health and nutrition education

- Honduras
- Syria
- Malawi
- Sudan
- South Sudan
- Ethiopia

Cash to meet food needs for households at risk of malnutrtion

- Zimbabwe

Facilitate referrals to access health services

- Turkey
- Ethiopia
- Zimbabwe

Selection Criteria took into consideration Health and nutrition factors

- Sudan
- Colombia
- Niger
- Zimbabwe
- Malawi
- Syria
- Honduras
- Haiti
- South Sudan
- Turkey
- Ethiopia

MEAL framework had Health and Nutrition indicators incorporated

- Sudan
- South Sudan
- Niger
- Zimbabwe
- Malawi
- Ethiopia
- Haiti
- Syria
- Colombia

02 FINANCIAL ASSISTANCE FOR HEALTH & NUTRITION SPECIFIC OUTCOMES

2.1 Introduction

This section provides a discussion of the financial assistance interventions implemented by GOAL. The mapping exercise found that GOAL was implementing various interventions which offered financial assistance to community members, however, majority did not fall under the standard CVA definition (71%). Most of the interventions for health (and nutrition) outcomes focused on the demand side i.e. supporting access to the consumer. Twenty nine (29%) of the health and nutrition projects assessed were using CVA modalities. The main CVA approaches identified are discussed below:

Health and Nutrition Projects	
Implementing CVA	29%
Non-CVA financial assistance	71%

Table 3: Financial assistance interventions among projects with health and nutrition-specific outcomes

Financial Assistance Interventions	No. of projects	% of H&N projects
Financial assistance that fits CVA definition		
Cash transfers to households with children diagnosed with Severe Acute Malnutrition (SAM)[1]	1	2%
Payment of transport costs to facilitate referrals for health services[2]	16	27%
Total CVA	**17**	**29%**
Financial assistance that does not fit CVA definition		
Payment of transport costs to facilitate referrals for health services (through the government structures)[3]	6	10%
Payment of hospital bills[4]	11	19%
Co-payments for medication[5]	1	2%
Direct support to MOH to implement activities[6]	5	9%
Salary support for health care workers (partially or in full)[7]	16	28%
Payment of monthly allowances to community volunteers[8]	16	28%
Payment of daily subsistence allowances[9]	57	98%

2.2 Financial Assistance Interventions that Fits the Standard Definition of CVA

2.2.1 Cash to meet transport and other related costs to facilitate referrals

The mapping exercise found that 29% (17) of the health and nutrition specific projects drawn from 5 countries were meeting the costs of transport, meals, and other incidentals incurred by the patients and caregivers when referred for specialized services often to hospitals located far away from their localities. This approach is implemented with variations from one country to another as shown in Table 1 Section A. The three main approaches used include:

i. **Reimbursement of transport and related costs directly to community members:** Fourteen (14) projects reported that they were making cash payments directly to the community members to meet transport and other related costs like accommodation and meals incurred during the referral of patients in need of specialized care. This commonly included referral of pregnant women in need of emergency obstetric care, referral of severely malnourished children to stabilization centers, and referral of GBV survivors to hospitals to access care.

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[1] Zimbabwe
[2] Malawi, Sierra Leone, South Sudan, Sudan, Ethiopis
[3] Niger
[4] South Sudan, Sudan
[5] Sudan
[6] Niger
[7] Honduras, Sudan, South Sudan
[8] Sierra Leone, South Sudan, Sudan, Zimbabwe
[9] Niger, Malawi, Sierra Leone, South Sudan, Sudan, Uganda, Zimbabwe, Ethiopia

This approach is used in Ethiopia, Sudan, and South Sudan where community members receive a cash payment either before accessing the health service upon reporting to the office or as a reimbursement. The cash is meant to meet their transport and upkeep costs incurred while seeking services, often in hospitals located far away. In South Sudan for example, the cases are often referred outside the country (in Uganda). The amount provided was often based on estimated average costs. For example in Ethiopia, it was reported that the amount given to GBV survivors was based on the estimated length of hospital stay which in their case was 9 days. The payments are made in cash to the community members.

ii. **Cash grants to community health committees to facilitate referrals from the community to the health facilities.** In this approach, the committees are given cash grants as a first responder group which is restricted to the facilitation of transport services. This approach was used by the spotlight initiative projects in Malawi where the cash was managed by a committee, which has designated signatories to help in facilitating the transfers to the community members. The cash is used to facilitate SGBV survivors to seek healthcare. The committee accounts to the GOAL office. The use of community committees is aimed at empowering the community as first responders to the community challenges.

Rationale: The referral system is an essential component of health systems. It provides a means for community members to access specialized services that are offered in higher levels of care. This is particularly important in low resource settings where hospitals may not be easily accessible due to long distances and financial challenges that come with that. This is made worse by the lack of efficient public transport systems, warranting the need for private systems like the use of taxis. This makes the cost of seeking care too expensive for vulnerable populations. In South Sudan for example, where community members often need to cross the border to seek care, it was reported that they often have to meet other related costs like accommodation and meals for themselves as well as the caregivers who may be accompanying them. This approach, therefore, covers indirect costs (transport and accommodation), which is a major financial barrier to seeking treatment.

100%
OF HEALTH & NUTRITION PROJECTS WERE GIVING SOME FORM OF FINANCIAL ASSISTANCE

Challenges: Key challenges encountered by GOAL project teams with this approach include:

i. **Logistical challenges:** These are challenges associated with making payments to community members in remote areas, especially where GOAL does not have an office. This often results in delays in disbursements which may mean delays in accessing care.

ii. **Difficult to plan:** Since the disbursement is dependent on the occurrence of an unpredictable event (need for an emergency referral), planning and forecasting is dificult.

iii. **Time-consuming and demanding to the financial and logistical teams:** This is because the transactions are individualized, unlike in the case of MPCA where the value of cash is based on a set basket of goods so payments can be standardised.

Lessons Learnt and Best Practices: Some of the best practices that should be considered in scale-up include:

i. **Consider the use of mobile money and other forms of electronic transfers /electronic vouchers** where **possible to reduce the delays.** However, the use of this approach may be limited to mobile network coverage. In countries like Sudan and South Sudan, this may limit appropriate options.

ii. **Maintain a cash float to ensure that there is always cash that can be disbursed at short notice:** The Sudan team reported this approach has helped in reducing the delays to some extent, especially in regions with a GOAL office.

iii. **Empower community structures:** These includes structures like community health committees to facilitate payment to community members especially in locations where GOAL does not have offices. This approach may enhance community engagement and ownership in response to health issues.

[2] Langendorf C., 2014. Preventing Acute Malnutrition among Young Children in Crises: A Prospective Intervention Study in Niger https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001714#references

AT LEAST 29% OF HEALTH & NUTRITION PROJECTS HAD FINANCIAL INTERVENTIONS THAT FIT THE STANDARD DEFINATION OF CVA.

2.2.2 Cash Transfers for improved nutrition outcomes:

This approach combines cash transfers for household assistance and individual feeding assistance to achieve improved nutritional outcomes among malnourished children. The approach targets households with children on Ready to Use Therapeutic Food (RUTF). The cash transfers are disbursed until the malnourished child successfully achieves the required nutritional outcomes. This approach is being used in Zimbabwe.

Rationale: The household assistance is based on the fact that a household with a child suffering from malnutrition means that the entire household is likely to be food insecure and thus other members of the household are also at risk of malnutrition. The household assistance is therefore given to purchase household food for other members. This reduces the risk of RUTF being consumed by the other household members as a food coping strategy.

Challenges:

Delays due to competing priorities: Diagnosis and enrolment of the cases require close collaboration with the health centers. This can result in delays especially due to competing priorities at the health facilities. For example, during the COVID-19 pandemic, the Zimbabwe team reports that the health facilities did not prioritize nutrition hence low enrolment.

Lessons Learnt and Best Practices

This approach which is a preventive food security-based strategy is effective in the prevention of acute malnutrition (Lngendorf et al. 2014)[2] however, UNICEF encourages further exploration and documentation of this approach to ascertain the best combination of modalities for effective results. The main lesson learnt was:

i. **Close collaboration with health sector:** According to the Zimbabwe team, the approach requires close collaboration with the health facilities to monitor the progress of the malnourished cases as well as close follow-up of children at the household level to ensure they are consuming RUTF as prescribed.

In terms of the results, the team expressed that the approach had significantly contributed to improved management of malnutrition among the community members. A more detailed analysis of the project data is however needed to ascertain the impact of this approach.

2.3 Financial assistance interventions that did not fit the standard definition of CVA

The mapping exercise findings show that all health and nutrition projects were implementing financial assistance interventions, however, some interventions did not meet the standard definition of CVA. This section discusses some of the financial approaches that are critical in increasing access to health services but are not necessarily considered CVA interventions, however some of them may be considered as social protection support. The interventions identified include:

2.3.1 Provider payment mechanisms

Some of the GOAL health and nutrition projects support provider payment mechanisms. This includes and are not limited to:

i. **Financial assistance to meet medical bills including consultations and medicines of referred clients:** This approach involved meeting costs incurred by community members in hospitals among 11 projects listed in Table 1- section B. The payment is based on an agreed price list for services offered. Upon offering services to community members e.g. caesarian section, the medical service providers send their invoices to GOAL for payment. This model is being implemented in Sudan and South Sudan. Though this approach falls under demand-side financing, it is generally not considered CVA as a third party pays (in this case GOAL) on behalf of the community members (Grundy et al 2009)[3].

ii. **Financial assistance to facilitate access to essential drugs:** This approach was reported in Sudan where GOAL was making payments to meet part of the cost of medications prescribed to community members (through reimbursement to NHIF). GOAL paid medication subsidies based on claims submitted by the National Medical Supply Fund (NMSF) and approved by the NHIF. This approach is not categorized as CVA since payments are made to state agencies on behalf of the community members, however, the approach can be categorized under social protection.

iii. **Reimbursement of cash to meet the fuel and maintenance costs for ambulances:** This approach was used in Niger where the GOAL office had agreements with health facilities and would reimburse fuel costs used to transfer community members to access specialized care e.g. in the referral of pregnant women and severely malnourished children. This approach is very similar to what is discussed in 2.2.1, however, in this case, the cash is paid directly to the Ministry of Health through the health district management teams and not directly to the community members.

iv. **Payment by GOAL directly to community-based transport service providers to facilitate transfers of patients to the hospitals.** This approach is used in Sierra Leone where the project team has agreements with boat owners to facilitate the transfer of pregnant women to hospitals to seek emergency care, upon GOAL's request; the hospitals are out of reach for many community member as they are only accessible via boat.

Rationale: Provider payment mechanisms are recognized as powerful tools for promoting the development of health systems towards the achievement of universal health coverage. Indeed, according to the Global Health Cluster and WHO (2018), the preferred option for supporting access to health care services, when these service are available with appropriate capacity and quality but when user fees are applied, is through provider payment mechanisms, with CVA complementing these. This is demonstrated in Sudan and South Sudan where projects are paying medical bills directly to the health service providers (based on an agreed price list) while at the same time providing the community members with cash to facilitate their transport to the health facilities. By paying the direct costs (medical bills, drugs) as well as the indirect costs (transport), this approach reduces the financial barriers towards accessing health services. In addition, co-payments to subsidize the costs of medication further protects vulnerable community members from catastrophic health expenditure.

Challenges

Delays in disbursement of funds: The main challenge encountered by GOAL project teams was delays in the disbursement of funds which may result in interrupted services. This was especially a challenge where the government was required to share specific documents before reimbursements were processed. Generally, the team reported the processes were long with many reporting requirements that often resulted in prolonged delays in the release of payments. Where agreements are with transport associations, reimbursements to individual service providers often take longer and may result in lethargy among the providers.

Lessons Learnt and Best Practices

i. **Complementing provider-based mechanisms with CVA interventions:** The main lesson learned is the significance of complementing provider-based mechanisms with CVA interventions targeting community members. In line with WHO recommendations, projects need to find an optimal mix of interventions that should be informed by assessments. As alluded to above, in the case of Sudan and South Sudan, the use of a provider-based mechanism, coupled with cash transfers to community members to facilitate referrals to health facilities increases access to quality services. The two approaches complement each other. The payment of bills directly to the hospitals based on a pre-agreed price list protects community members from possible exploitation by service providers.

ii. **Building the capacity of the health systems financial processes to meet the reporting requirements.** One approach that has been used is the seconding of staff to the government offices to support the processes and ensure adherence to donor requirements. In Niger, though informally, they reported that the finance team was working closely with government finance officers to streamline the processes.

iii. **Regular meetings with the transport service providers to address challenges and streamline the processes:** where the project has agreements with taxi providers, it's critical to keep in touch with the service providers to ensure a smooth process. The Sierra Leone office reported that through the meetings and engaging the transport service providers, they have been able to change their perspective to focus more on community service. As a result, despite delays in payments, many transport service providers have continued to serve their community by providing transport services. The project team reported that some of the service providers have taken lots of pride in that. However, the team is still working with the association of the service providers to streamline the processes.

2.3.2 Cash to facilitate implementation of health project activities

The mapping exercise identified three main approaches used to facilitate project activities:

i. **Payment to government authorities to implement specific project activities:** This approach was used in Niger (Table 1 section D) and involved the transfer of cash to Ministry of Health authorities to facilitate the implementation of certain agreed-upon project activities. For example, activities like training of government health care workers were conducted and managed by the Ministry of Health in coordination with the GOAL project teams. However, unlike in other countries, GOAL would make payments directly to the ministry which would then facilitate any payments related to the required activities. This approach is aimed at strengthening the capacity of existing MOH structures to carry out their mandate. The approach does not qualify as CVA as the cash is paid to a state agency to implement an array of activities.

ii. **Payment of medical and nutrition staff salaries and incentives**

This approach included payment of government staff on monthly basis an agreed-upon amount as a top-up to their salary to ensure that they remained in their duty stations and delivered the services. As shown in Table 1 section C, at least 22% (16) of the health projects were using this approach. This was reported mainly in Sudan (6) and South Sudan (9) where staff salaries were often delayed resulting in staff absconding duties. To ensure continuity of services, two types of payment approaches were identified:

   i. Payment made directly to the government staff by GOAL. For example in Honduras, the project supported the government to recruit staff and was meeting the salary costs of the medical brigades.

   ii. Payments were made to the government authorities who would then make the payments to the staff: this was an approach used by one project in Sudan.

iii. **Payment of monthly allowances to health and nutrition community volunteers.**

This included payment of community volunteers like NIPP and CLA facilitators, on monthly basis for services rendered. The

[3]Grundy J., et al 2009.Health system strengthening in Cambodia—A case study of health policy response to social transition,Health Policy, Volume 92, Issues 2–3,Pages 107-115, ISSN 0168-8510, https://www.sciencedirect.com/science/article/abs/pii/S01688510090013

approach was used in Sierra Leone, South Sudan, and Zimbabwe reported in 28% (16) of the health projects. This allowance was often pegged to submission of reports and project data although it was not necessarily a condition for receiving the monthly allowance. In Uganda and Sierra Leone, GOAL made submission of data and reports to the project a condition for receiving monthly allowances by the community volunteers. According to the project teams, this resulted in increased reporting rates.

The payment of salaries and allowances does not qualify as CVA since the payment is a fee given in exchange for services rendered to the project, by skilled personnel who are not considered direct project community members. The incentives are meant to motivate the staff to continue rendering their services to the community without disruption. This does not also fit to be referred to as cash for work since the volunteers are not necessarily primary project community members.

Rationale: Provision of funds to the government agencies to facilitate project implementation is an approach aimed at strengthening the capacity of health structures in health delivery. This approach provides an approach to the health system to take charge in planning and implementing health activities, thus increasing ownership and accountability to the community. In addition, salary incentives are critical in attracting, retaining, motivating, and improving the performance of health workforce, a key pillar in health system strengthening. The approach contributes towards addressing the growing gap between the supply of health care professionals and the demand for health services. GOAL reported that the approach motivates the health workers (who often go unpaid by their respective governments) to continue offering health services. The allowances to the various teams were also associated with improved reporting rates. For the GOAL team, it was easy to demand reports from the staff given the allowances, while for the government staff and community volunteers, the allowances motivated them and hence were more responsive to the needs of the projects. Allowances to government officials facilitated them to conduct field monitoring visits, supportive supervision, and submit reports whenever required.

Challenges: In addition to delay of disbursement of funds due to government processes other challenges included:

i. **Delays in implementation of project activities:** This was reported in Niger, where due to government long processes as well as busy schedules by government officers, implementation of activities at times delayed.

ii. **Inadequate infrastructure to facilitate effective mobile money transfers to the community teams/assistants resulting in delays making payments**. This was reported in countries including Sierra Leone and Uganda where there is low network coverage. In Sierra Leone the team reported that community members faced many challenges withdrawing cash from mobile money agents including having to travel to towns thus incurring extra costs.

iii. **Difficulties in determining the right level of incentives:** Country offices reported that they did not have country specific national guidelines to determine the right level of incentives for each cader.

Lessons Learnt and Best Practices:

i. **Provision of funds to government agencies to conduct activities should be guided by well documented guidelines outlining the financial processes and requirements**. This will be critical in addressing challenges including delays that were reported by the country offices.

ii. **Standardize Incentives:** There is need to work with MOH on specific countries to standardise incentives across the different cadres of health staff.

2.3.3 Subsistence allowances /cash for logistical support- transport, meals, accommodation to health care workers and volunteers

This was a common approach adopted by at least 98% of the health projects. This involves the provision of a cash payment to participants of different project activities including MOH officials, health care workers, and community volunteers whenever they are engaged by the project. The cash is intended to meet their costs to facilitate participation in certain activities e.g. transport and meals costs when attending training. It is also used to facilitate Ministry of Health officers to conduct

98%

OF HEALTH & NUTRITION PROJECTS WERE GIVING SUBSISTENCE ALLOWANCES

supportive supervision activities. For example in Uganda, the COVID 19 Social Mobilization Action Consortium (SMAC) approach project provided MOH staff with transport allowances to enable them to supervise activities at the community level.

Rationale: Subsistence allowances are usually given to meet costs of meals, lodging, gratuities and other such payments made for services rendered during official travel. GOAL was providing allowances to facilitate the teams to meet any costs related to their participation in the project activity.

Challenges

Lack of standardized guidelines in deciding the level of allowances. Almost all country offices reported that the community teams often complained the amounts were not adequate.

Lessons Learnt and Best Practices

i. **Develop country specific guidelines on volunteer allowances:** The daily subsistence rates for different cadres of health staff are country specific. Most countries have policies that guide the provision of allowances for public service employees, unfortunately, in many countries, community health workers are not covered under public service staff and thus there are often no policies to guide their remuneration. As a good practice, projects should work closely with the Ministry of Health staff to agree on an incentive package that is reasonable based on the amount of time, hours of engagement among others.

Two women hold cash

03

CVA FOR NON-HEALTH & NUTRITION SPECIFIC OUTCOMES WITH INTEGRATED COMPONENTS OF HEALTH AND NUTRITION IN THE PROJECT CYCLE

3.1 Introduction

Findings show that the non-health and nutrition-specific projects have adopted approaches that seek to integrate health and nutrition. This section discusses the key approaches under the different steps in the project cycle.

Table 4: Distribution of health and nutrition interventions among projects with non-health specific outcomes projects.

Financial Assistance Interventions	Number of Projects	% of CVA projects
Cash in response to COVID-19 pandemic[1]	4	7%
Provision of health and nutrition services e.g. vaccination during cash distribution, nutrition screening, health and nutrition education[2]	23	39%
Facilitate referrals to access health services[3]	10	18%
Selection Criteria took into consideration health and nutrition factors[4]	54	96%
MEAL frameworks had health or nutrition related indicators incorporated[5]	39	70%

1 South Sudan, Sudan, Honduras, Syria
2. Honduras, Syria, Malawi, Sudan, South Sudan, Ethiopia
3. Turkey, Ethiopia, Zimbabwe
4. Sudan, Colombia, Niger, Zimbabwe, Malawi, Syria, Honduras, Haiti, South Sudan, Turkey, Ethiopia, Malawi
5. Sudan, South Sudan, Niger, Zimbabwe, Malawi, Ethiopia, Haiti, Syria, Colombia

3.2 Integration Approaches

3.2.1 Project Design:

A review of project proposals showed that there were intentional efforts to coordinate with other players including health and nutrition stakeholders and integrate health in various ways through the project cycle.

3.2.2 Project Planning – Project Community Member Selection Criteria

Study findings show that most of the projects implementing CVA interventions took into consideration health related factors in their selection criteria as shown in Table 2. In terms of selection criteria, 96% of the non-health specific projects (with financial assistance modalities) considered factors like households with pregnant and lactating mothers, children under five years, households with a member who is living with a disability, households with malnourished children, and those at risk of malnutrition.

Rationale: Pregnant and Lactating Women (PLW), along with children, and People with Disabilities (PWDs) are often considered among the most vulnerable groups of the population, with heightened health and nutrition needs, therefore they require aid assistance and specific services essential for their survival, protection, and recovery.

96%

OF NON-HEALTH SPECIFIC PROJECTS INTEGRATED HEALTH & NUTRITION FACTORS IN THE SELECTION CRITERIA

Challenges:

Difficulties in beneficiary identification processes: The intended community members' risked being left-out due to poor coordination mechanisms. i.e. identification of PWDs for example requires close coordination with partners working with PWDs while identification of malnourished children requires close coordination with health and nutrition partners. The community leaders involved in the identification process may not be aware of some of the health and nutrition factors affecting a household, for example, a household with a child at risk of malnourishment may be missed out especially in cases where nutrition is not incorporated.

Lessons Learnt and Best Practices:

i. **Community Engagement:** All projects highlighted the importance of community engagement in the identification process to ensure that the right people including pregnant and lactating women, PWDS among others are identified as per the protocol. Project teams reported that they work hand in hand with community committees and community opinion leaders in the identification process.

ii. **Conducting MUAC assessments to identify malnourished children:** One best practice that should be scaled up is the screening of children using MUAC tapes to ascertain their nutrition status instead of depending on the community leaders to identify those at risk. This approach was used in Malawi where project teams worked in partnership with nutrition partners to identify households with children at risk of malnutrition.

3.2.3 Project Implementation:

At the project implementation level, there were efforts by various projects to integrate health and nutrition into non-health-specific projects. At least 39% (23 projects) from Honduras, Syria, Malawi, Sudan, South Sudan, and Ethiopia were implementing some of the actions discussed below:

i. **Sensitizations on COVID-19 key messages:** All 23 projects as shown in Table 2 section B had adopted this approach. The sensitizations were conducted during trade fairs and cash distribution events. The sensitizations were often conducted in collaboration with internal health and nutrition departments, for example in Sudan, nutrition officers worked with livelihood teams to conduct nutrition sensitizations. In Honduras GOAL officers partnered with the Ministry of Health (MOH) officials, while in Ethiopia, projects were using mass media like radio to sensitize the communities on COVID-19.

ii. **Facilitating provision of health and nutrition services:** This involved strong collaboration between the project and MOH authorities. An example was in Honduras where the MOH staff provided COVID-19 vaccines during the cash distribution events or fairs. In Malawi, in partnership with UNICEF, the project conducted nutrition screening for their community members at a household level.

iii. **Health and nutrition awareness:** All 23 projects reported that they offered education on appropriate nutrition practices on topics

such as nutritious diet, appropriate food preparation methods among others. Just like COVID-19 sensitizations, the projects worked with internal health and nutrition departments, the MOH, or with other implementing partners. For example in Malawi, the project partnered with UNICEF to conduct sensitizations on nutrition to farmers during trade fairs, including training farmers to adopt nutrition-sensitive approaches[4], while in Turkey they offered education on the importance of vaccination in addition to giving community members value vouchers.

iv. **Facilitating transport to health facilities:** Among the projects with non-health and nutrition-specific outcomes, 10 projects were supporting community members to access health services. This was reported in Turkey, Ethiopia, and Zimbabwe. In Turkey under the GREEN project, community members are supported to access health-related assistance like medical consultations and vaccinations for COVID-19 and child immunizations. The project organizes taxis to transport community members to hospitals or to access GBV services. For Ethiopia and Zimbabwe, the intervention was discussed above (under health-specific projects.

Challenges:

The main challenge faced by the project teams in integrating health and nutrition activities in their program design and implementation included:

Limited time: Most projects incorporated health education and sensitizations during other project events like cash/voucher distributions. Being that the focus of the events was not to offer health education, the amount of time allocated was very limited and not always adequate to address many issues.

Need to collaborate with other partners: For offices without health and nutrition departments, integration of services meant that they needed to collaborate with other partners to offer the services. This could result in delays in planning and delivery of project activities.

Lessons Learnt and Best Practices

Multi-stakeholder engagement in all stages of project cycle: Implementation of multi-sectoral projects provides an opportunity for integrating different aspects to ensure access to comprehensive services by the community members. To ensure success of the project, it is important that the various stakeholders including communities, government and other partners are engaged in all stages of project cycle, right from project design to implementation as well as in monitoring and evaluation. This active project participation promotes ownership and accountability and encourages support by other partners.

3.2.4 Monitoring and Evaluation:

As part of monitoring and evaluation processes, 70% of the non-health and nutrition-specific projects were tracking health and nutrition-related indicators. The most common indicators being tracked include:

i. **The proportion of cash utilized to meet health and nutrition needs at the household level:** As part of Post Distribution Monitoring (PDM), many projects reported that they were tracking the proportion of cash utilized to meet health and nutrition needs at the household level. Some of the PDM reports reviewed showed that a significant amount of the cash was used to meet medical bills, and pay for transport to health facilities.

IN SYRIA, PDM FINDINGS SHOW THAT UP TO 50% OF THE CASH WAS USED TO MEET MEDICAL EXPENSES AT HOUSEHOLD LEVEL

ii. **Food Consumption Scores:** To measure the household's food security status, projects were using this indicator which puts into account not only dietary diversity and food frequency but also the relative nutritional importance of different food groups consumed by the households.

iii. **Coping strategies:** Many projects such as food security projects and basic needs projects reported that they were also measuring the different coping strategies including those that would cause negative impacts on a household nutrition and health status such as skipping meals and shifting to less preferred/ cheaper foods.

[4] Agricultural interventions that not only focus on addressing under-nutrition, but also have nutrition specific outcomes

Challenges:

Some of the indicators may not be appropriate for short-duration programs: This is the case, especially in short emergency response programs (like those less than 6 months) where it may not make sense to track some of the outcome indicators. For example it maybe difficult to measure particular negative coping strategies which might occur once in someone's lifetime like selling their organs.

Inadequate staff capacity in the measurement of some indicators: While most MEAL coordinators expressed confidence in measuring processes, some of the project staff expressed challenges in data collection and measurement of the indicator, especially in regards to the interpretation of the food consumption score.

Lesson Learnt and Best Practices

i. **Allocation of cash in minimum expenditure basket:** The continuous monitoring of health and nutrition expenditure through post-distribution monitoring revealed that a significant proportion of cash is used to meet health and nutrition needs. This brings into focus the need for country offices/cash working groups to allocate cash for health needs when coming up with the Minimum Expenditure Basket (MEB). Some country offices like Ethiopia reported that in many cases the MEB was dependent on donor guidelines. Some donors currently do not support the inclusion of health related expenses in the MEB despite it being one of the main categories of expenditure, as determined by households.

3.2.5 Referrals of community members to access CVA services or health and nutrition services

The findings show that the health-specific projects had established referral mechanisms to facilitate community members to access CVA interventions.In addition, the non-health specific projects were also making referrals for health and nutrition services.

For example in Uganda, the project had a strong partnership with a nearby hospital run by a Faith-Based Organisation (FBO) that was offering commodity food vouchers to community members. GOAL has established a relationship with the hospital although they do not have an Memorandum

South Sudan, cash transfer in Ulang

of Understanding. This allowed GOAL to identify cases of malnutrition and refer them to the FBO for further assessment and possible enrolment into the partner's food voucher program. According to the GOAL team, this approach was especially beneficial for pregnant and lactating women as well as HIV-positive community members.

For GOAL delivered projects with CVA, this approach involved facilitating referrals for clients to access health and nutrition services as discussed under section 4.2.3.

Rationale: A referral mechanism is an essential component of any health project as no single project can meet all the needs of its community members. Such a system aims to ensure that the community members receive a comprehensive package of care. GOAL Uganda in partnership with a local FBO is working hand in hand to ensure that the community members access a comprehensive package that includes food assistance for pregnant and HIV-positive patients.

Challenges:

Difficulty in following up with community members once they are referred for the food vouchers: Since there was no official working agreement, GOAL did not keep track of the services offered to the Community members.

Lessons Learnt and Best Practices

i. **Establishment of formal referral systems:** A good referral system requires a mapping exercise to establish the services available that may be beneficial to the project target group. Following this, it is critical to establish a formal referral system with agreements with the various stakeholders. While the Uganda team did not have an agreement in place, they recognize that this would be beneficial to both the organizations as it would clarify terms of engagement, agree on reporting requirements if need be, and provide a platform to explore other opportunities.

3.2.6 CVA in response to a health crisis

To mitigate the impact of COVID-19 on beneficiaries, four projects from South Sudan, Sudan, Syria, and Honduras provided unconditional cash transfers to help their beneficiaries meet their basic needs. The selection criteria included people most vulnerable to contracting COVID -19 like the older persons, people, with co-morbidities, and those with disabilities.

Rationale: The COVID-19 pandemic resulted in increased expenditures related to its management e.g. purchase of masks and sanitizers. This coupled with the general trend of income loss due to lockdown measures leads to increased economic hardships. Cash assistance was therefore meant to cushion the beneficiaries from economic shock following the loss of income during the quarantine period (for COVID-19 survivors) and other economic challenges as a result of COVID-19 restrictions. The cash transfers helped the households meet its basic needs as well as improve their ability to access health services.

Challenges:

Close monitoring of cases: The approach required close monitoring of the quarantined cases to establish their COVID-19 status and at times this was not possible due to limited testing kits in the health facilities.

According to the team in Syria, while the approach resulted in increased testing, it also had the potential to negate efforts to curb the spread of the disease. This is because for some very vulnerable households, getting infected meant they would at least get some financial assistance. However, there has not been any evidence that demonstrates this was happening in practice. Unfortunately due to pressure from the health actors (due to limited resources), the project discontinued this activity.

Lessons Learnt and Best Practices

i. **Integration of COVID-19 prevention interventions:** Provision of MPCA to meet basic needs for vulnerable households (including older people, persons with disabilities) that have lost income due to lock-down measures, or because they are quarantined and/or otherwise caring for a sick household member is considered effective in improving health outcomes.[5] The cash provides households with the ability to access health services. The approach should go hand in hand with other COVID 19 prevention interventions including ensuring that markets and health facilities meet basic risk mitigation protocols so that community members can access items safely and are not put at risk.

[5]Global Health Cluster and WHO, 2020. Guidance note on the role of Cash and Voucher Assistance to reduce financial barriers in the response to the COVID-19 pandemic, in countries targeted by the Global Humanitarian Response Plan COVID-19

04

CATEGORIZATION OF THE INTERVENTIONS (AS CVA OR NON-CVA)

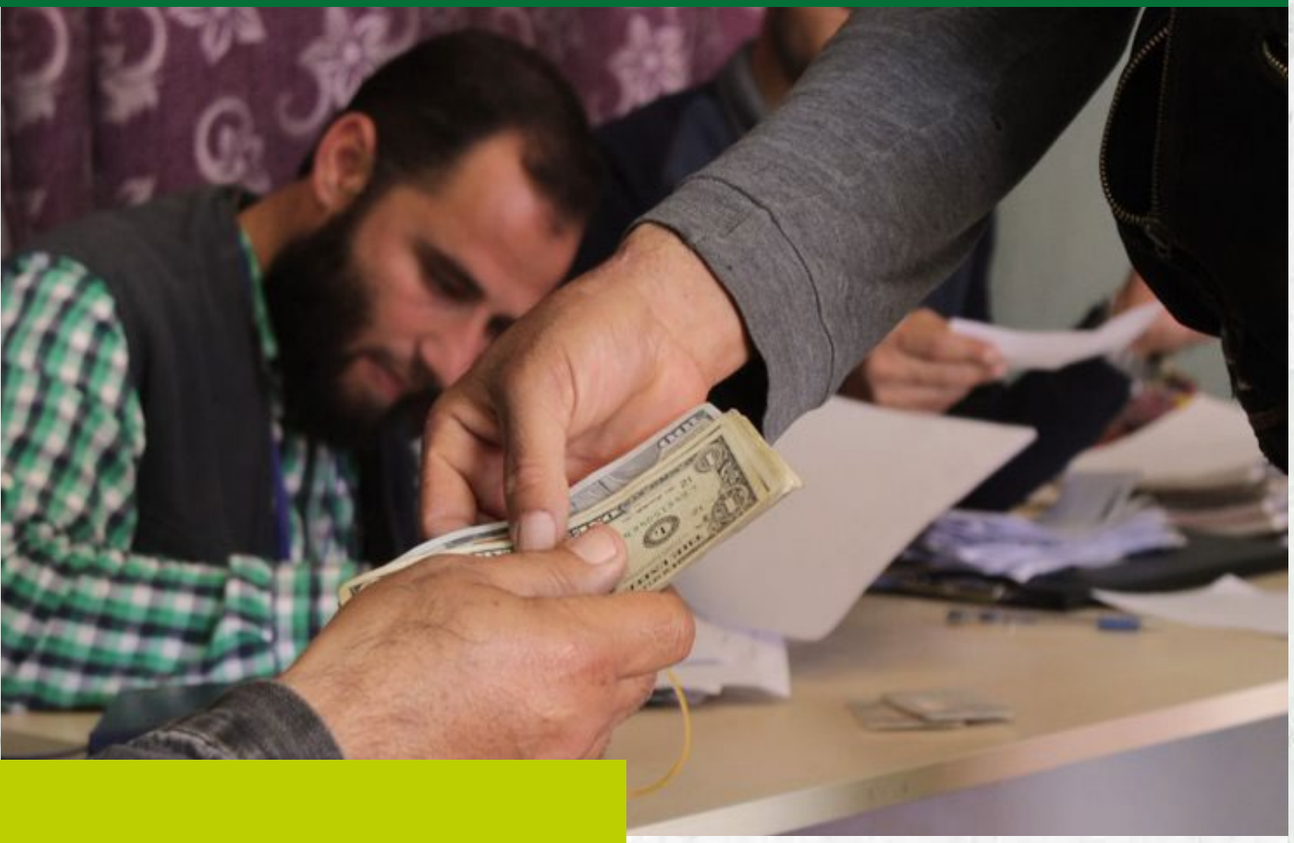
CASH FOR WORK

Cash payments provided on the condition of undertaking designated work. This is generally paid according to time worked (e.g. number of days, daily rate), but may also be quantified in terms of outputs (e.g. number of items produced, cubic metres dug). CFW interventions are usually in public or community work programmes but can also include home-based and other forms of work

The CVA definition stipulates that the grants given to governments or other state actors do not qualify to be referred to as CVA. Subsequently, medication subsidies and staff incentives being paid by GOAL to government agencies to facilitate community members access to health services does not qualify to be considered CVA. In addition, the definition excludes any provider payment mechanisms which includes payment for services to the providers either directly by the project or through state agencies.

Allowances (e.g. stipends) to facilitate community volunteers to participate in or facilitate project activities may not qualify as CVA if the recipients are not the targeted direct project beneficiaries and selected in accordance to their levels of needs/vulnerability. However, when cash/vouchers is given directly to community members who are the targeted project participants and the CVA is provided on the basis of supporting them to overcome financial barriers which might limit their engagement in project activities or accessing project related goods and services, this is considered as CVA. For example cash given to pregnant women to facilitate them to attend and participate in a training on the importance of hospital delivery. This can be considered cash transfers conditioned on the attendance of free priority preventative health service (health education) aimed at improving the uptake of a specific service (hospital delivery).

Likewise, on other occasions, payment of allowances to community volunteers could be considered as Cash for Work, which is also a form of cash assistance. It can be considered as Cash for Work when the community volunteers are also part of the targeted project population and they are partly selected due to their own/household needs or vulnerability. These community volunteers are paid for carrying out certain work e.g. mobilizing community members to engage in Community Led Action. However, this allowance is commonly referred to as a transport allowance whose aim is to facilitate the volunteers to participate in a certain activity. In practice, cash for work is used to help community members meet their essential needs while at the same time undertaking activities which will benefit the wider community.



05
CONCLUSION & RECOMMENDATIONS

Conclusion and Recommendations

CVA is particularly effective on the demand side by providing households or individuals with the financial means to address economic barriers to compensate for a loss or lack of income (UNICEF 2020)[6]. However, the ability of CVA to address demand-side barriers to health services and commodities depends on a sufficiently functioning supply.

Key findings of this exercise were that GOAL had adopted various strategies that were offering financial assistance to increase access to health and nutrition services/ commodities, however many (71%) of these interventions do not fit the standard definition of CVA. This is perhaps due to the limiting definition of CVA which has been shaped over time by lessons drawn from the food security sector with minimal, if any, contribution by the health sector.

GOAL remains committed to delivering CVA in diverse ways for a range of needs including MPCA for basic needs. Recognizing the intersectionality of needs, GOAL wishes to apply a health lens to its CVA irrespective of its sector.

[6]UNICEF and Global Nutrition Cluster. 2020. Evidence and Guidance Note on the Use of Cash and Voucher Assistance for Nutrition Outcomes in Emergencies. https://www.nutritioncluster.net/resource_Evidence%20and%20Guidance

In its financial assistance interventions that are aimed to meet its health related needs, the study noted that with some slight adaptations to the approaches, some of the interventions could be more CVA oriented, for example:

i. For projects that are paying service providers directly to meet the transport costs of the community members and to facilitate referrals to the hospitals, the project could design vouchers to be issued by community committees or GOAL (and partners) to program participants. The vouchers would then be exchanged by the community member for transport services and GOAL would reimburse the transport service provider.

ii. For projects that are paying hospital bills directly to the health service providers on behalf of the community members, GOAL could consider designing service vouchers for accessing specific priority services e.g. maternity services to improve access to skilled delivery. However, it is recommended that the service should be accessed from pre-selected providers that meet minimum standards. Projects could also design commodity vouchers for accessing specific medications that may be too costly for community members e.g. a project targeting hypertensive patients could consider issuing them with a commodity voucher that will enable them access anti-hypertensive drugs on a monthly basis from specific pre-qualified service providers. Another example is the provision of cash or food vouchers to caregivers of children admitted in stabilization centers instead of providing in-kind food support.

iii. In view of the need to ensure that the community members access quality services, GOAL could consider use of a combination of approaches e.g. use of provider payment-based mechanisms (to reduce the user fees) with CVA targeting the specific needs of a patient such as transportation and incidental costs related to accessing services. This could include direct payment of medical bills to service providers while at the same time using vouchers to facilitate transport to hospitals.

iv. Community facilitators (i.e. volunteers) who are paid a stipend for their work in facilitating health or nutrition community social behaviour change activities are often program participants themselves. There can be a more deliberate selection of community facilitators based not only on their interest in being part of the project and their ability to influence fellow community members, but also on their own levels of vulnerability. Thus, these interventions could be re-framed as 'cash for work', whereby someone is paid cash assistance on the condition of undertaking certain work.

For non-health specific projects utilizing CVA, the findings show that health and nutrition aspects were integrated within the project cycle. To further enhance the integration with health, and strengthen CVA for health, GOAL should consider the following:

i. Allocating cash for health needs when coming up with the Minimum Expenditure Basket (MEB). The MEB is often developed through an inter-agency collaborative process, coordinated by a Cash Working Group or else aligned to a government social protection system. Thus, inclusion of re-occurring or seasonal health related needs into a MEB is often dependent on inter-agency agreement and donor endorsement. While WHO (2018) recommends that the amount should not be more than 15%[7] this study found that in some instances, community members were using up to 50% of the MPCA to meet health needs. This presents an area for further study to inform appropriate proportions and should be context specific.

Lastly, it is recommended to study in more detail the effectiveness and the impact of the mapped out interventions. This was not covered exhaustively by this exercise due to the large number of projects that were under review and the limited data readily available in relation to the effectiveness/ impact of specific interventions, but it remains an important aspect in informing GOAL's CVA strategic approach. Moving forward, GOAL could consider conducting a deeper analysis of specific interventions mapped out by this exercise, to better understand the quality of such interventions and their impact.

[7]Global Health Cluster and WHO (2018). Working paper for considering cash transfer programming for health in humanitarian contexts ; cash task team https://www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf

ANNEXES

ANNEX 1: KII GUIDE

CASH VOUCHER ASSISTANCE AND HEALTH & NUTRITION MAPPING

Key Informant Interview Guide

INTRODUCTION

GOAL is currently developing a global CVA strategy. As part of this strategy, GOAL will carve out organizational competence in linking CVA and health.

Objective: to document some of the formal and informal ways that GOAL has been linking social protection, cash, and vouchers assistance with health and nutrition.

To achieve this, we will review the projects into 2 main categories:

1. Health and Nutrition Programs
2. Cash and Voucher Assistance/Social Protection projects

Definitions

Health and Nutrition Programs

Health and nutrition programs will include any project that supports any of the six core components or "building blocks "of health including:

(i) service delivery e.g. provision of health or nutrition services – HIV, MNCH, therapeutic feeding, nutrition screening, etc..
(ii) health workforce e.g. capacity building of health care workers- Nursing offices, medical officers, Lab Technicians, etc..
(iii) health information systems- DHIS, health data reporting, data for decision making, etc..
(iv) access to essential medicines- e.g. provision of essential drugs
(v) financing- strengthening health financial systems of local authorities, budgeting systems, etc..
(vi) leadership/governance- e.g. building capacities of community health or nutrition committees, local governance structures

For purpose of this exercise, health will be defined broadly to include Nutrition projects e.g. CMAM, TSFP, etc..

Cash and Voucher Assistance: includes the provision of cash transfers and vouchers to targeted Community members.

- Cash transfers include the provision of money (physical currency or electronic cash) to targeted recipients (individuals, households, or communities)

For example

1. Provision of money to PLW to access a nutritious diet
2. Providing Community members with transportation fees to access health services.
3. Payment of fees to enable Community members to access specific services like ANC profile, Contraceptives, Delivery services, etc..

- Vouchers can be provided in paper or electronically and can be exchanged for a set quantity or value of goods or services, denominated either as
    a. value voucher (e.g. US$ 15),
    b. commodity voucher (e.g. A litre of cooking oil, 5kg or rice)
    c. service voucher (e.g. to access maternity services)

NB: for purpose of this exercise, kindly include any financial assistance that might not fall within the CVA definition e.g. Out of pocket allowances for CHVs

Methodology

1. Mapping of Social Protection, Cash and Vouchers Assistance for Health/nutrition Specific Outcomes.

Guiding Questions

i. Where has GOAL (and partners) delivered CVA/ supported cash-based social protection activities for health/nutrition-specific outcomes, in the past two years?
ii. How were these interventions designed?
iii. What worked well, what were the challenges. Consider intervention design, implementation, staff capacities, financial resources, stakeholder support, etc..
iv. What impact did the interventions have on health/nutrition-related outcomes?

2. Mapping of cash or voucher assistance in GOAL for non-health or non-nutrition outcomes which has health/nutrition-related components integrated into the project cycle.

This can include (but is not limited to) considerations on targeting criteria and approach, cash transfer value, cash distribution approach, monitoring of health or nutrition-related indicators, referrals to health and nutrition actors.

i. The rationale for linking with health/nutrition.
ii. What worked well, what were the challenges.
iii. What sort of contexts could such an approach be replicated and recommendations on best practices to replicate?
iv. Did it enhance the effectiveness of the project and make a difference in its impact?

Basic Information

Name of the Country_____

Number of Projects: _____

From the list of the projects, identify classify them as either:
a) Health and Nutrition Program
b) CVA /SP Project
c) Other

For each of the projects, in category, a or b, use the questions below to guide the discussions:

HEALTH /NUTRITION PROGRAMS

1. Kindly share a brief overview of the project- overall objectives and main implementation approach.

2. Does the project provide any financial assistance to the Ministry of Health authorities and /agencies e.g. Payments to NHIF? Purchase of medical drugs and supplies?
    i. If yes, explain how this is done?
    ii. What is the rationale?
    iii. Do you think this approach is successful? What is working well? What has facilitated its success?
    iv. Are you facing any challenges with this approach? Please explain? What is not working well? Explore staff capacities, adequacy of the financial support to meet the intended needs, challenges with tracking funds utilization?
    v. How is this approach contributing to the success of the project? How is it impacting on the beneficiaries?
    vi. Is this approach supported by stakeholders? Government/Local authorities? donors? Partners? the community? Is there any resistance?
    vii. Do you think the approach can be replicated in other regions? What aspects? Are there any pre-conditions for it to work?
    viii. Has the approach enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence, and can you share it with me?

3. Does the project make any direct or indirect payments to health service providers/Health institutions e.g. pharmacies, health clinics, hospitals, etc. to meet health and nutrition-related services on behalf of the beneficiaries e.g. payment for consultations and other user fees? For medical drugs? Nutrition supplementation? ANC, Maternity, FP, PNC services?
    i. If yes, explain how this is done?
    ii. What is the rationale?
    iii. Do you think this approach is successful? What is working well?
    iv. Are you facing any challenges with this approach? Please explain? What is not working well? Explore staff capacities, adequacy of the financial support to meet the intended needs, integrity of the service providers etc.
    v. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?
    vi. Is this approach supported by stakeholders? Government/Local authorities? donors? Partners? the community? Are you facing any resistance?
    vii. Do you think the approach can be replicated in other regions? Are there any pre-conditions for it to work?
    viii. Has the approach it enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?

4. Does the project provide any cash/voucher/stipends or other financial assistance to the individual beneficiaries or households to enable them to access health and/or nutrition services? For example, Payment for consultation fees, transport, referrals, out of pocket expenses for in-patient treatment like accommodation and food, cash to incentivize attendance to priority health services,?
    i. If yes, explain how this is done?
    ii. What is the rationale?
    iii. Do you think this approach is successful? What is working well?
    iv. Are you facing any challenges with this approach? Please explain? What is not working well? Explore staff capacities, adequacy of the financial support to meet the intended needs, M&E capacity
    v. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?

vi. Is this approach supported by stakeholders? Government/Local authorities? donors? Partners? the community? Is there any resistance?
vii. Do you think the approach can be replicated in other regions? Are there any pre-conditions for it to work?
viii. Has the approach it enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?

5. Does the project provide any cash/voucher assistance to the individual beneficiaries or households to improve their health or nutrition status by accessing health/nutrition related commodities like food? For example, payments for caregivers of children with SAM, CVA to support dietary diversity, fresh food vouchers, CVA for medicines?
   i. If yes, explain how this is done?
   ii. What is the rationale?
   iii. Do you think this approach is successful? What is working well?
   iv. Are you facing any challenges with this approach? Please explain? What is not working well? Explore staff capacities, adequacy of the financial support to meet the intended needs, M&E capacity
   v. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?
   vi. Is this approach supported by stakeholders? Government/Local authorities? donors? Partners? the community? Is there any resistance?
   vii. Do you think the approach can be replicated in other regions? Are there any pre-conditions for it to work?
   viii. Has the approach it enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?

6. Does the project provide any financial assistance to Community Health Committees? Community Health workers? CLA facilitators? Cash, Social Protection and Health Mapping facilitators?
   i. If yes, which groups? explain how this is done?
   ii. What is the rationale?
   iii. Do you think this approach is successful? What is working well?
   iv. Are you facing any challenges with this approach? Please explain? What is not working well? Explore staff capacities, adequacy of the financial support to meet the intended needs, M&E capacity
   v. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?
   vi. Is this approach supported by stakeholders? Government/Local authorities? donors? Partners? the community? Is there any resistance?
   vii. Do you think the approach can be replicated in other regions/contexts? What components? Are there any pre-conditions for it to work?
   viii. Has the approach it enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?

7. Do you link your health/nutrition project with other projects (internal/external) that are providing cash or voucher support?
   i. If yes, explain how this is done?
   ii. What is working well?
   iii. Are you facing any challenges with this approach? Please explain? What is not working well?
   iv. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?
   v. Do you think the approach can be replicated in other regions? Are there any pre-conditions for it to work?

vi. What else do you think can be done to strengthen the linkages?
vii. Has the approach it enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?

CVA/SOCIAL PROTECTION PROGRAMS

1. From the list of the Cash/SP projects, identify those that have connections to health and nutrition?

2. Kindly share a brief overview of the project- overall objectives and main implementation approach.

3. During beneficiary selection, do you have any criteria related to health or nutrition such as pregnant and lactating women, HIV positive, Malnourished children?
   If Yes,
   i. What is the rationale?
   ii. What challenges (If any) are you facing in relation to this criteria? Explain
   iii. How is this contributing to the success of the project?
   iv. How is it impacting the beneficiaries?

4. Do you offer any health or nutrition education or social behavior change activities to your CVA beneficiaries e.g. SRH education, Nutrition-related education or sensitizations, Community Led Action (CLA)? This could be during support group meetings? During distribution events, during HH visit? etc.
   i. If yes, explain how this is done?
   ii. What is the rationale?
   iii. Are you facing any challenges with this approach? Please explain? What is not working well?
   iv. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?
   v. Is this approach supported by stakeholders? Government/Local authorities? donors? Partners? the community? Is there any resistance?
   vi. Do you think the approach can be replicated in other regions? Are there any pre-conditions for it to work?
   vii. What else do you think can be done to strengthen the project design (In relation to Health and Nutrition)?
   viii. Has this approach enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?

5. Is the project being implemented to respond to a health crisis? e.g. COVID-19 pandemic, Ebola, Cholera outbreaks?
   If yes,
   i. Explain how the assistance is offered?
   ii. What is the rationale?
   iii. Are you facing any challenges with this approach? Please explain? What is not working well?
   iv. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?
   v. Do you think the approach can be replicated in other regions? Are there any pre-conditions for it to work?
   vi. What else do you think can be done to strengthen the project design?
   vii. Has this approach enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?

6. 6. Do you support referrals to health and/or nutrition services?
   If Yes,
   i. How? (information provision, payment of transportation, payment of services, etc.)
   ii. What is the rationale?
   iii. Are you facing any challenges with the coordination of referrals? Please explain? What is not

working well?

iv. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?

v. Do you think the approach can be replicated in other regions? Are there any pre-conditions for it to work?

vi. What else do you think can be done to strengthen the referral system (In relation to Health and Nutrition)?

vii. Has this approach enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?

7. Do you monitor nutrition or health status in your MEAL processes for example? MAM, SAM, health-seeking behavior among beneficiaries, etc. Do you monitor health related commodities in your market monitoring for example medicines, face masks etc.
   i. What indicators are you tracking? e.g. Minimum Acceptable Diet, Meal frequency for Children, Dietary Diversity, use of negative coping strategies related to health/nutrition?
   ii. What is the rationale?
   iii. What Challenges (If any) are you facing in monitoring Health and Nutrition components? Explore lack of data tools, staff capacity,
   iv. What else do you think can be done to improve the MEAL processes? (In relation to Health and Nutrition)

8. How else do you link your services with other health & nutrition programs? Within and outside the organization?
   i. What is the rationale? (In terms of linkages with Health and Nutrition services)
   ii. What are the main challenges that you are facing/ faced in relation to strengthening linkages between CVA with Health & Nutrition services (both internally and externally)?
   iii. How is this approach contributing to the success of the project? How is it impacting the beneficiaries?
   iv. hat else do you think can be done to strengthen the linkages?
   v. Has this approach enhanced the effectiveness and impact of the programme and if so, how? Do you have any evidence that demonstrates its impact? If so, what evidence and can you share it with me?
9. For projects giving unrestricted Cash assistance, is there evidence to show that the cash is also used to cover health and nutrition-related costs for individuals or households?

10. Apart from the projects discussed, have you in the past implemented a project that had strong components of CVA with linkages with health & nutrition that you feel could inform this process significantly? If yes, review the project.


GOAL