Regional Expert Meeting on Cash & Voucher Assistance in Health Emergencies

25-26 September 2019
Beirut

Meeting Report

NORWEGIAN CAPACITY | CASHCAP

HEALTH CLUSTER

World Health Organization

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List of acronyms

BNA: Basic Needs Analysis tool
CALP: Cash Learning Partnership
CCF: Common Cash Facility
CCT: Conditional Cash Transfer
C4H: Cash and voucher assistance for Health
CTT: Cash Task Team
CSI: Coping Strategy Index
CVA: Cash and Voucher Assistance
CWG: Cash Working Group
EMRO: Eastern Mediterranean Regional Office
ESSN: Emergency Social Safety Net
FGD: Focus Group Discussion
FSP: Financial Service Provider
GHC: Global Health Cluster
GNC: Global Nutrition Cluster
HCC: Health Cluster Coordinators
HDN: Humanitarian Development Nexus
HH: Households
HERAMS: Health Resources and Services Availability Monitoring System
KII: Key Informant Interview
MCH: Mother and Child Health
MEB: Minimum Expenditure Basket
MENA: Middle East and North Africa
MIS: Management Information System
MPC/ MPG: Multipurpose Cash Assistance/ Multipurpose Cash Grant
NCD: Non-Communicable Diseases
ODK: Open Data Kit
OOP: Out-Of-pocket Payment
PDM: Post Distribution Monitoring
WHO: World Health Organization

Acknowledgments

The two co-lead facilitators would like to thank the Global Health Cluster, CashCap, the U.S Office of Foreign Disaster Assistance and the World Health Organization-EMRO office for making this regional expert meeting possible.

This event would not have been a success without the leadership of Dr Alaa AbouZeid (EMRO-WHO) and technical guidance of Dr Andre Griekspoor (WHO).

We would also like to express our gratitude to Sandra Nessim (EMRO-WHO) for her support in organizing the event and to Lurdes Soares for her help with writing this report.

And last but not least, we would like to thank all the participants for sharing their experiences and expertise with the group and for all their invaluable contributions during the discussions and group activities.

This report was written by Elodie Ho (Cashcap-GHC) and Lurdes Soares (EMRO-WHO). October 2019.

Executive summary

Rationale for the meeting
Due to the particularly significant volume of Cash and Voucher Assistance in the Middle East and North African region, the WHO-EMRO office organized a two-day regional meeting to take stock of the evidence on CVA & Health, facilitate experience sharing and discuss the actions needed to better support humanitarian actors in using CVA for health outcomes.

Participants selection process
For this expert meeting, a high priority was given to humanitarian actors based in the MENA and who had recently or are currently using CVA to achieve health outcomes. Whenever possible, staff directly involved in the design, implementation or evaluation of the program were invited to the meeting.

Attendance and facilitation
Attendees: 30 participants with a CVA or Health expertise working for UN agencies, INGOs or academic institutions based in the MENA.
Lead facilitators: Elodie Ho (CashCap-GHC), Thomas Byrnes (CashCap)

Objectives of the meeting
1. Present the evidence and share experiences on the use of CVA for specific health services (e.g. cash for referrals, cash for formal delivery / C-sections, cash for medicine)
2. Introduce the Response Option Analysis methodology to determine the most appropriate intervention (including CVA and other health financing options)
3. Discuss the operational implications of using CVA for health (e.g. risk management, logistics, monitoring) with specific examples
4. Present guiding documents on the use of CVA for specific health services in emergency contexts
5. Agree on the next steps to improve health cluster partners' capacity in the EMRO region to conduct CVA for health outcomes in emergency contexts

Action Plan
Participants identified activities they could lead within their organizations to improve the uptake of CVA in health programs.

At the regional and global levels, an action plan for 2019 (Q4) and 2020 was agreed upon.
Priorities were divided into four categories:

a) Enable Cash and Vouchers to be routinely considered, alongside other tools
b) Build enough capacity for Cash and Voucher Programs
c) Develop an evidence base and standard procedures for cash for health
d) Ensure the quality of Cash and Voucher programming and monitoring

For each category, participants identified key activities, the leading actor/agency and the expected deliverables (Annex 3).

Meeting sessions

Day 1

Opening remarks

Dr Alaa AbouZeid (WHO-EMRO)

Due to the particularly significant volume of CVA in the European-Mediterranean region, health cluster partners in the region have expressed high needs for technical guidance and support. The WHO-EMRO office has been committed to provide this support and plans to build its own capacity to respond to those needs. With experts in Cash or Health in the room, we hope that the discussions, learnings, and networking will be valuable for both the participants and the EMRO office.

Objectives of the meeting and core concepts

Elodie Ho (CashCap /Global Health Cluster) – Thomas Byrnes (CashCap)

"Universal health Coverage means that all people have access to the health services they need, when and where they need them, **without financial hardship**"[1]. (WHO, 2019)

Despite international efforts to provide affordable and equitable access to healthcare, millions of people in the world are still being pushed into extreme poverty because they have to pay for their health care[2]. In emergency contexts, household surveys showed that out-of-pocket payments can surpass 90% of household's health expenses[3].

To protect people from catastrophic expenditures, various health financing modalities exist, whether they focus on the supply-side (e.g. health insurances, user-fee waivers, co-payments) or on the demand-side (e.g. cash and voucher assistance). Both aspects should be considered when designing a health emergency response.

The purpose of this expert meeting was not to debate if CVA can be used in health emergency interventions but to discuss when, for what and how it can be used.

The specific objectives of the meeting were:

1. Review Evidence - present the evidence and share experiences on the use of CVA for specific health services
2. Decision making tools - introduce and discuss tools to determine the most appropriate intervention (including CVA and other health financing options)
3. Operational implications - discuss the operational implications of using CVA for health with specific examples
4. Guidelines - present guiding documents on the use of CVA for specific health services in emergency context
5. Action Plan - agree on the next steps to improve health cluster partners' preparedness and capacity in the EMRO region to conduct CVA for health outcomes in emergency contexts

[1] https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
[2] https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
[3] See session 3 and PUI's experience in Afghanistan

Session 1: What do we still need to know?

Evidence of Cash and Voucher Assistance and other innovative financing approaches for Sexual Reproductive Health and Rights (SRHR) in humanitarian emergencies

Fernando Maldonado (KIT – Royal Tropical Institute)

Despite a growing investment in research on the effects of CVA on health, critical gaps persist. The GHC/CTT hired the Royal Tropical Institute (KIT) to lead an operational study project on the use of CVA in SRHR programs in emergency contexts. The study protocol was presented to the group to collect feedback before the project starts at the end of October.

Research questions:

1. What is the operational feasibility and the comparative advantages/disadvantages of CVA within or complementary to other SRHR interventions in humanitarian settings?
2. What are the effects of CVA on SRHR in humanitarian settings?
3. What are good practices and operational recommendations for future CVA for SRHR programming?

The four main deliverables for this project are:

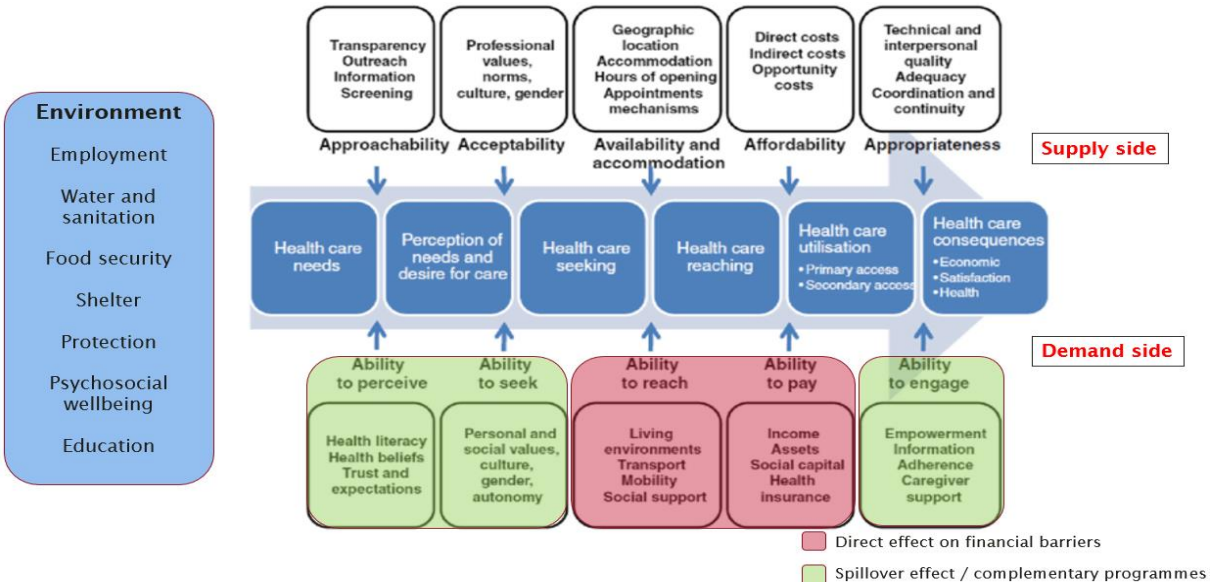
1. Conduct a review of evidence on feasibility and effectiveness of CVA to reduce financial barriers and/or increase utilisation for SRHR services in development programmes, and current evidence of its applicability in humanitarian emergencies.
2. Document learning and develop 3 case studies based on actual experiences of implementing CVA for SRHR programmes in Cox's Bazar, Yemen and DRC or in any other relevant emergency contexts
3. Develop/adapt tools to assess the feasibility and assist the implementation of CVA interventions for SRHR in humanitarian emergencies
4. Present the results to key partners implementing CVA for SRHR interventions to discuss initial findings and proposed tools.

Study timeline:

- Phase 1 (mid-October/Nov): Creation of a technical advisory group to oversee the study project; Methodology development and validation.
- Phase 2 (Nov/Dec): Data collection and analysis
- Phase 3: Consultative meetings and review of the study deliverables; Synthesis report

Potential challenges: Most of the evidence about CVA for SRHR is likely to come from development programmes, not humanitarian responses. Information about context and other influencing factors is limited, and the review will rely on possibly limited evidence about effect/attribution. Regarding the case studies, the main challenge is that the work will be done remotely (document review and Key Informant Interviews), with no field visits.

Adaptation of the patient-centred conceptual framework on access to health care of Levesque et al[4]:



Discussion

Conceptual framework:

- Delivery mechanisms are important to consider, as they can influence effects on gender, behaviors, data protection…
- Consider interactions with other factors beyond health and indirect effects on other sectors too (environment, livelihoods etc.)
- Social cohesion should also be added as a factor influencing the ability to reach and pay for health care
- On the demand-side, how elements like corruption, inflation are incorporated into the conceptual framework

Study design:

- Clarification: Contexts for the case studies are not limited to Bangladesh, DRC and Yemen. Any organization who used CVA in SRHR are encouraged to participate in the study and contact KIT (suggestion of Jordan and Lebanon)
- Identify if there are significant differences on the use and effects of CVA at different stages of an humanitarian crisis (rapid onset, protracted, post-emergency, development)?
- Consider including seasonality in the possible influencing factors.
- In the selection of Key Informants, also include other sectors are they may have been involved in the intervention too (e.g. protection, nutrition, food security, basic needs)
- Also look if the CVA intervention created harm (e.g. unsustainable behavior change) and how to prevent it, and conditions to make the effects of CVA sustainable
- What's the effect/impact on those who receive cash vs those who don't receive and the host community?

Next steps:

1. GHC creates the Technical Advisory Group (by end of October).
2 The GHC will contact participants to identify other relevant contexts/programs and key informants for the study (by end of October).
3. KIT will share the study methodology and tools for the TAG's review (November)

[4] Levesque et al.: Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. International Journal for Equity in Health 2013 12:18

CVA for nutrition outcomes

Andre Dürr (CashCap-Global Nutrition Cluster)

Similar to what the health sector experiences, research on the CVA impacts on child nutrition comes predominantly from development contexts but evidence from humanitarian contexts is growing (Niger, DRC, Somalia, Yemen, Pakistan).

The existing literature reviews show that CVA can impact nutritional status through different pathways.

- Strong evidence that it can lead to increased expenditure on food; investment in assets; debt reduction as well as of negative coping.
- Potential effect (but weaker evidence) that CVA can be used to increase the resources for care for mothers and children, leading to: more time available for care; improved caregivers' control over resources, while promoting autonomy and empowerment; improvement in the physical and mental health status of the caregiver; and reduced stress levels at the household.

Overall, CVA positive effects observed rarely extend after the CVA distribution ends.

Growing recognition that:

i. cash alone is insufficient to impact child nutrition status and does not resolve any of the supply side constraints;
ii. cash needs to be combined with appropriate nutrition sensitive and specific interventions to maximize impact.
iii. "Size matters": Timing and duration of the CVA influences the outcome, as well as who receives the transfer.

Discussion

- "Cash Plus" or "Plus Cash"? "Plus Cash" conveys the idea that cash is the main component of the intervention whereas it should be the opposite. Cash is one tool that supports other activities to achieve the desired outcome. Maybe distinguish "nutrition sensitive cash" and "nutrition specific cash" instead.
- Nutrition sensitive cash = cash (unrestricted cash) by nature is not sector-specific but it can include in its design nutrition elements to improve/better complement the effectiveness of nutrition programs.
- The impact of CVA on diet diversity can vary between contexts & projects. For one participant, PDMs show significant positive impacts on food consumption but little on diet diversity. In Somalia, a Concern and UCL study showed that CVA improved the child diet diversity score but not the risk of MAM[5].
- What are the unintended consequences of financial incentives on people's behaviors?

Next steps:

Strong collaboration between the GNC and GHC to invest in research and map evidence and share technical documents (and avoid duplication).

GNC is now part of the GHC-CTT and the GHC will join the GNC reference group for the review and consolidation of evidence on CVA & nutrition

[5] Grijalva-Eternod CS, Jelle M, Haghparast-Bidgoli H, Colbourn T, Golden K, King S, et al.(2018) A cash-based intervention and the risk of acute malnutrition in children aged 6–59 months living in internally displaced persons camps in Mogadishu, Somalia: A non-randomised cluster trial. PLoS Med 15(10): e1002684. https://doi.org/10.1371/journal.pmed.1002684

Session 2: Response Option Analysis

Elodie Ho (CashCap-GHC), Thomas Byrnes (CashCap)

There are many existing response option analysis tools[6], but few consider both CVA and supply-side health financing options. Health Cluster coordinators have been asking for a simple decision tool to help them decide when CVA can be an adequate option or not. A first version of the Decision Tree was introduced in 2016 but with limited uptake in the field. The revised version was introduced to the group for testing and feedback.

Discussion

- In the decision tree, what should be considered "good enough quality and availability"? What should be considered essential health services? Because in some contexts, the levels are quite low and if we follow the decision tree, CVA would never be an option. Consensus that Health Clusters will help define the standards and essential health package in their contexts.
- Size and level of complexity of the tool: hard to find a balance between the need for a comprehensive tool and the need to keep things simple and generic enough to be used in various contexts. Consensus that the tool should stay simple and focus on decisions at the macro level but with reference to more comprehensive tools.

Feedback:

- Briefly describe or emphasize the required steps before moving to the decision tree (target group, problem analysis, pre-conditions for CVA feasibility, objective of the intervention)
- Clarify whether the service availability mapping refers to public, private or both;
- Important to add operational/coordination aspects;
- link interventions suggested in the boxes with tools on how to do it or on how/where to find the information;
- Reinforce the behavioral aspect and link it with CVA
- Include decisions on the choice of CVA modalities and transfer mechanisms
- Reinforce the need for integrated programming
- Reinforce the message for complementarity of CVA and supply-side interventions
- Format: have an electronic and off-line format that includes links to other resources

Next steps:
With the feedback collected, the GHC/CTT will revise the Decision Tree Tool and share it with participants for their feedback (activity included in the Action Plan, Annex 3).

Session 3: Improving access and referrals to health services- PUI in Afghanistan

Dr Abdul Baqi (Première Urgence International)

In Afghanistan,10 million people have limited or no access to essential healthcare, despite significant progress to improve health coverage. 54% of the population lives below the poverty line and Out-of-Pocket-Payments (93%) represent a major barrier to access health services[7]. PUI supports both the provision of qualitative health services (mobile clinics, rehabilitation, construction, training, medical supply, staff incentives) and the financial access to services (vouchers and multipurpose cash).

[6] See the GHC/CTT 2018 workshop report, with presentations of the Basic Needs Analysis (BNA) and Response Options Analysis& Planning (ROAP) tools: https://www.who.int/health-cluster/about/work/task-teams/cash-workshop-nov2018.pdf?ua=1

[7] Central Statistics Organization, Ministry of Public Health, 2017

PUI distributed “Cash for referrals” to ensure patients will reach the appropriate specialized services (MNCH, MHPSS and Malnutrition services). 12.5 USD were given in two instalments to cover transportation costs (see presentation).
Multi-purpose cash assistance was also disbursed ($350 for 1 or 2 months) to enable recently displaced families to pay for their immediate basic needs.

Challenges: improve availability and quality of the referral facilities, increase community participation in the design of community-based modality of distribution, absence of guidelines for cash distribution in the MHPSS Working Group.

Recommendations: evaluating the use of cash and impact on patients who received cash for referral; evaluating the possibility to create revolving emergency community funds to improve sustainability; advocating at cluster level to harmonize the approach and advocating at country level for increase service availability.

Discussion
- Discussion whether or not medical staff should be involved in the cash distribution. Concerns that it may create conflict of interests or situations of power abuse.

Session 4: Identifying and managing risks

UNICEF’s experience in Yemen
Dr Sherin Varkey, Cecilia Chawatama (UNICEF)

The Project Management Unit (PMU) is a multidisciplinary and multiagency unit (including private sector) that provides technical support on CVA in various sectors. Motto: “*No logos no egos*”.

In Yemen, UNICEF has been distributing Emergency Cash Transfer (ECT) to 1.5 million Yemenis using the national social welfare system. The transfer amount is aligned with the social welfare benefit (5,000 YER a month/person or 15,000 YER per quarter/person) and represents 40% of the food basket. The money is transferred via two private banks who then sub-contract to hawalas. For people in hard-to-reach areas and with specific needs, mobile teams will distribute the cash assistance. UNICEF also provides staff incentives to teachers.

How did UNICEF deliver cash in such high-risk environment?
UNICEF adopted a risk mitigation approach based on the following elements:

a) ***Risk Informed model*:** risk analysis embodied at every step of the program activities.
b) ***Innovation**:* use of the Management Information System (MIS) that connects with different software and applications (e.g. Kobo, RapidPro) to collect and analyse data and provide feedback. Can be used offline and online.
c) ***Contract management and administration:*** clear SOPs and Long-Term Arrangements with service providers, monitoring of invoices
d) ***Live risk library**:* dynamic risk matrix that monitors 50 risks and is informed by multiple data sources. There are monthly updates with new risks added as needed. The red lines are defined by a consultative committee. The library is shared with donors but can also be shared with other organizations
e) ***Multiple levels of monitoring:*** field monitoring by the PMU and by a 3rd party, media monitoring, data dashboard
f) ***Fraud surveillance**:* call center, SMS, field monitoring etc. Transfer of the risk of financial loss to the service providers: by contract, the banks have to reimburse the cost of any lost money. In exchange, UNICEF pays higher fees.

g) ***Grievance redressal****:* call center, mobile applications, case management

Challenges:

- exchange rate and devaluation of the YER. UNICEF negotiated with banks a better exchange rate
- partnering with large service providers has created monopolies
- Beneficiary data protection: UNICEF decided to not go with biometrics because there are not enough safeguards to protect beneficiaries' data
- Low risk appetite from donors to use CVA in Yemen. Higher pressure to mitigate risks than on other health interventions (vaccination etc.). A robust risk management and monitoring system was necessary to address concerns, and donors and implementers are learning as they go.
- Data harmonization, cross-checking and avoiding duplications: many agencies have been pushing for their own data management system, which makes data harmonization difficult. Ex: both UNICEF and WHO provides incentives to medical staff but hard to know if there are duplications or not.

Lessons learned:

1. important to adopt a risk-mindset throughout the project cycle: challenge assumptions, monitor risks and find mitigation measures.
2. a robust risk management system has been critical
3. dynamic tools are required in rapidly changing contexts
4. be mindful of the resources available when choosing the risk mitigation measures.

Upcoming project:

UNICEF is designing a project with vouchers for transportation to pregnant women, mothers and children under 5.

Characteristics: Conditional vouchers given only after enrolment of people at pre-identified facilities and after certification of the health condition by a medical doctor. Three colored vouchers will be provided, one per type of service: delivery, postnatal care and referral/admission at a pre-identified health facility. Vouchers have a limited date validity and are redeemable at contracted payment sites. The amount will cover the transportation costs and incidentals.

Discussion

Emergency Cash Transfer

- Why did the transfer amount only cover 40% of the food basket? This amount is aligned with the social welfare assistance. Concern that if we give too much, the government won't be able to sustain the same assistance after the crisis.
- What does risk-sharing with donors mean? It means making donors acknowledge the risk-matrix, making them co-own the risks. But at the end of the day, the liability is still on UNICEF.Are teacher incentives a cash assistance? It was externally reported as cash assistance (many teachers have fallen into poverty) but internally at UNICEF, it is considered as staff incentives.
- How does the third-party monitoring work for this project? Donors contract a third-party organization to monitor each project activity.
- What did people use their cash for? 1. Food, 2. Health, 3. Debts (mostly contracted to pay for food or health).
- Was health included in the list of negative coping mechanisms? No, the CSI was food-focused.

Voucher for transportation:

- Why UNICFE chose to go for vouchers instead of contracting a transport company directly? A service provider assessment was done and it was not possible to contract a company to transport all beneficiaries
- Has UNICEF considered a cash top-up to the ECT instead of vouchers? The objectives of the vouchers are very health/nutrition-specific and may not be attained with a cash top-up.
- Question if referring people to pre-identified specialized facilities won't create perverse effects. The majority of the population seeks health services at primary health care facilities.
- Is UNICEF risk system in Yemen replicable to smaller size organizations? The system in Yemen requires a lot of resources (HR, financial, expertise) but the live risk library for instance can be shared with other organizations.

Risks in Cash and Voucher Assistance: a reflection on gender-sensitivity

Holly Welcome Radice (CARE)

Gender sensitive CVA means it is designed to respond to the unique needs and capacities of women, men, boys, girls, and those of other genders; is developed in a manner that avoids exposing recipients to harm; and is built on social norms. Some key risk and protection-based findings of a Care-led research in Malawi, Jordan, Haiti, the Philippines, and Niger were presented. At the community level, participants identified concerns over physical collection of transfers (e.g. distance from place of distribution and long queueing for women, who worry about the children left alone at home) and fear of harassment/being called names in the community (both for women and men). CVA can also impact the household dynamics and power dynamics and the impact is not the same in all countries (e.g. in Jordan there were reports of tensions in financial decision-making, but not in Niger).
Care highlighted the need to involve the affected population to improve protection, since participation was linked to improved satisfaction and reduction of protection-related concerns.
In female crisis affected populations, there are systematic issues that cannot be disregard, such as limited knowledge of technology, levels of literacy, language barriers, and lack of documentation. Selection of the financial service provider (FSP) must be carefully considered. CVA must also be linked to feedback mechanisms, and it is important to have female-friendly communication mechanisms and that giving feedback/making complaints does not expose individuals to reprisal.

Under Care's commission, a Cash & Voucher Assistance and Gender-Based Violence Compendium: Practical Guidance for Humanitarian Practitioners was recently published. This compendium addresses the gap on CVA guidance in GBV Guidelines, consolidates and summarises multiple evidence reviews of CVA and GBV that practitioners can apply. It also includes two new tools: a modality Decision Tree and GBV Risk Analysis Tool for CVA, and an analytical Tool - GBV Risks, Economic drivers and potential CVA.

Discussion

The discussion that ensued touched upon the following points:

- achieving balance between household dynamics and power dynamics;
- engaging with/involving adolescents in cash for SRH;
- involving women in project management to reduce some risks - according to UNICEF's experience, irregularities in project implementation are lower in women managed teams.

Day 2

Session 5: Effects of multipurpose cash on health

Evaluating the effect of the Emergency Social Safety Net (ESSN) programme on access to health care for refugees in Turkey

Ilgi Bozdag (World Food Programme)

With 3.9 million refugees and asylum seekers, Turkey is hosting the largest refugee population in the world, most of whom are Syrians. Since 2014, registered Syrian refugees have benefited from a Temporary Protection status which grants them legal stay, access to public services including free medical care and education and the ability to apply for work permits and social assistance.

The Emergency Social Safety Net (ESSN) programme is funded by ECHO (€6 billion) and is led by the Turkish Ministry of Family Labour and Social Services and the Turkish Red Crescent, with technical support from WFP. The ESSN uses the existing national social assistance system and aims at enabling refugees to cover their basic needs (rent, food, water etc.) with multipurpose cash assistance (transfer mechanism: debit cards). The targeting is based on socio-economic criteria but also includes the health vulnerabilities: families with one or more disabled people (>40% incapacity certificated delivered by authorised state hospitals). Out of the 3 million applicants, 1.7 million were eligible for MPC.

The presentation described the methodology and findings of a recent program evaluation conducted by the Johns Hopkins University.

Methodology: The analysis included data collected by WFP between 2017 and 2019 on refugees in Turkey. Two independent data sources were used. The first, the Comprehensive Vulnerability Monitoring Exercise (CVME), is a cross-sectional survey of refugees that was implemented four times over the two-year period. The CVME collects data from ESSN applicant households (both eligible and ineligible households) as well as non-applicant households.
The second data source was longitudinal data from ESSN applicant households collected during the Pre-Assistance Baseline (PAB) and six subsequent rounds of Post-Distribution Monitoring (PDM). The PAB and PDM include data from a random sample of ESSN applicant households only.

Key findings:

- Because registered refugees have access to health services for free, only a minority of ESSN beneficiaries had high health expenditures.
- HH with pregnant women and people with disabilities spent more on health compared to other HH. Sociodemographic characteristics were significantly associated with higher or lower health expenditure, but differences were generally of small magnitude
- There was no particular impact on health seeking behaviors, the demand for health care was already high in both beneficiary and non-beneficiary HHs. However, the seeking care rate is lower for non-registered refugees
- 82% of registered refugees who sought care went to governmental hospitals
- Beneficiaries were often less likely to reduce essential expenditures or borrow compared to non-beneficiaries.
- Household health expenditures and the need to reduce essential expenditures to meet basic needs both decreased over time among beneficiaries and non-beneficiaries, which is suggestive of an improving situation.

Because ESSN beneficiaries did not have major financial barriers to access health care and care-seeking rates were already high, MPC did not have a significant effect on health service utilization and on household health expenditures.
However, MPC played a vital role in helping vulnerable (mainly Syrian) refugees to meet their basic needs in Turkey.

Discussion

- *Study design:* The sample size of the CVME was 1300 refugees and around 4000-5000 for the PDM surveys.
- *Social cohesion and perception:* To date, no surveys have been carried out to assess the perception of the Turkish people on the use by Syrian refugees of the national health services.
- *Quality of healthcare provided:* results from FGDs show that main complaints are about the language barrier, the waiting time and bullying. The language barrier can have substantial negative effects on the quality of services, as it makes it difficult for Syrians to explain their health problems and doctors may refuse to deliver the disability certificate.
- *The MEB calculation* included a health component, but it was small and mostly to cover expenses with medicines.
- *Collecting health expenditure data:* hard to collect and the study could be improved by disaggregating into specific types of health expenses or categorized by level of care. Could be helpful to investigate the types of health-related costs of those who spent money on health, and for those who had not, why. Suggestion to calculate health expenses per capita instead of per HH.
- Is WFP's experience in Turkey replicable to other contexts? Working closely with governments to include refugees in the national health system is possible and desirable in many contexts, but there were numerous factors that made it more possible in Turkey: good public health coverage and quality, significant foreign aid into the ESSN (6 billion), good coverage of the banking system. Also, in Jordan and Lebanon health care is not free for refugees so the conclusions of this evaluation cannot be applied to contexts with high OOP.

Multipurpose Cash for Health, MEDAIR's experience in Jordan

Dr Stephen Chua (Medair)

Around 755 000 refugees are living in Jordan, either in camp or non-camp (84%) areas. The majority of the non-camp refugees live below the poverty line and financial issues is the greatest barrier to access healthcare, with high OOP for health expenditures.
Medair's cash-for-health programme is integrated in a community health approach in the four governorates with the highest concentration of refugees. Cash assistance is given to highly or severely vulnerable refugees with the following health needs: deliveries for pregnant women; urgent conditions, such as hospital admissions and surgical intervention; and NCDs, particularly hypertension, diabetes and chronic respiratory diseases.

Most cash transfers are made using the common cash facility (CCF), primarily through ATM cards which are distributed at the bank, assisted by Medair's staff, and the amount is sufficient for accessing the service and indirect costs (transportation). Registered Syrian refugees are encouraged to access MoH facilities, while unregistered Syrians and non-Syrian refugees are referred to affiliated hospitals. So far, 10,924 refugees have been reached with cash-for-health assistance and about 94% spent the cash as intended (for health services).

Challenges:
The main challenges faced were related to:

- A lack of monitoring mechanisms and quality assurance measures on the supply side: observation of costlier and unnecessary procedures prescribed by health providers

- The limited scope of cash-for-health coverage: high focus on pregnant-related services and NCDs.
- The fact that the CCF and iris-scan identification system are still not fully viable for urgent, one-off transfers
- Difficulties in establishing a functional information system, with incompatibilities between ODK and financial reporting tools
- The lack of available evidence to inform decisions, but MEDAIR is currently conducting a study with Johns Hopkins to evaluate the impacts of MPC and CCT on health
- A general difficulty in exiting/pivoting to more sustainable modalities. The national health insurance system is available to Jordanians. Some initiatives where UNHCR or other NGOs cover insurance premiums for a limited number of refugees.

Discussion

- *How did you mitigate the risk of tensions between host and refugee community?* 30% of beneficiaries are required to be Jordanian according to the law. Also Jordanians have access to the national health insurance scheme.
- *Timing of the assistance, e.g. pregnant women?* Many complications are before 8/9 month. Medair reimburses women if they require assistance at earlier pregnancy stages.
- *Next steps, are you planning to expand and take in new beneficiaries?* Health volunteers are following-up after the child delivery for breastfeeding sensitization. Only one post-natal visit is included in the program, women are encouraged to visit the health center after that.
- *ATM cards – how do you manage risks (e.g. theft, loss)?* Beneficiaries can pick up the cards within a short period of time, staff support the delivery of the cards and train recipients on how to use it. Feedback and complaints mechanisms is in place to follow-up on issues with PIN codes, loss of cards, etc.
- *Is MEDAIR's cash intervention scalable?* Contrary to Turkey, OOP is a major barrier to access health care. Jordanian context is conducive to CVA, with good health coverage and quality, good banking system, existence of the CCF, good financial literacy amongst refugees.

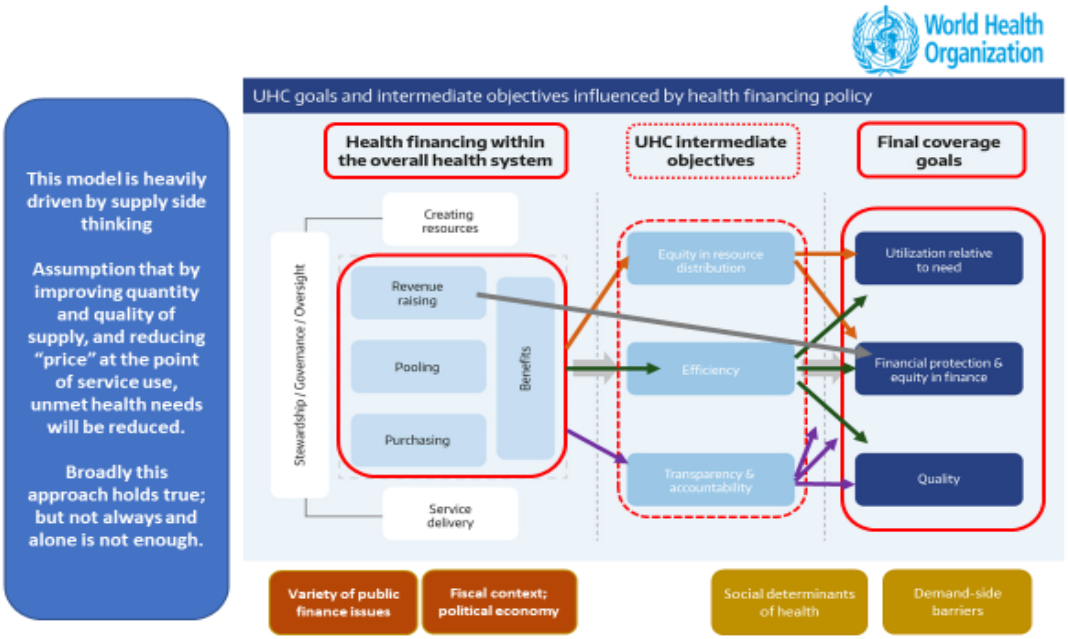
Session 6: Health Financing Policy and Implementation in Fragile and Conflict-Affected States (FCAS)

Dr Andre Griekspoor (WHO)

The WHO reference guide *Developing a National Health Financing Strategy*[8] and *the Health Financing Policy & Implementation in Fragile & conflict-Affected Settings*[9] were presented. Theses documents reflect the necessity to adapt health financing models for UHC to fragile and confllict affected contexts, but also to better take into account demand-side financial barriers and present the existing options (including CVA).

[8] WHO (2017), Developing a national health financing strategy: a reference guide. [https://www.who.int/health_financing/tools/developing-health-financing-strategy/en/]

[9] https://www.who.int/publications-detail/health-financing-policy-and-implementation-in-fragile-and-conflict-affected-settings



Key messages

- Humanitarian health interventions, especially in FCAS, could maximize gains in public health when they are designed: (i) with a longer-term view; and (ii) to link with existing mechanisms.
- Humanitarian actors need to get more familiar with health financing language, the role of government and public health policy and know the guiding principles of health financing when designing CVA interventions with health objectives.

Humanitarian-Development Nexus (HDN)

- HDN provides the space and scope for joint assessments, collective outcomes, and universal health coverage, but we need more evidence to learn how this could work operationally
- From the project design phase, it is crucial to have a reflection on longer-term consequences of any humanitarian interventions. For CVA, assess the risk of undermining the existing social welfare system in the short and longer-term (is it sustainable?). One approach adopted by some agencies was to tap into the existing social welfare system to distribute emergency cash (e.g. UNICEF in Yemen, WFP in Turkey).

Coordination and Cash and Voucher Assistance (CVA)

- The lack of coordination on the targeting, coverage, transfer value and transfer mechanisms can lead to a variation in the health package covered and to inequities.
- Collaboration and coordination between the health cluster/sector, cash working groups and other actors (private, government etc.) is paramount to pool resources (e.g. purchase of medicine) or harmonize practices (e.g. health package, MEB).
- CVA can play a critical role in protecting human welfare in fragile and conflict-affected states (FCAS) by supporting vulnerable HH to meet both health and non-health needs. But CVA should not undermine UHC; it should not contribute to a fee-charging culture for priority services.
- This can be achieved by ensuring that CVA modalities are viewed as complementary to the investment in the systems required to deliver common goods and essential health services.

Discussion

- Acknowledgment from the group that we need to find a better balance between demand side and supply side financing.
- Self-care: how does the public financing support health care?
- What does the nexus look like in practice?

Humanitarian actors are filling gaps in the provision of basic public services and in certain contexts, it can take a long time for governments to be able to take over. So how do we apply the nexus in practice and better involve governments in these situations?

- Development actors are more and more engaging with humanitarian actors. It can open up new opportunities of funding and more effective programming.
- Are humanitarian and development donors ready to link their separate envelopes? Are there hybrid emergency-development projects we could design that could make the case for stronger HDN funding streams?

Cash to access essential health services (CAEHS) in Jordan

Ahmad Alshibi (UNHCR, Jordan)

Jordan hosts over 755 000 refugees, the majority of which are Syrian. 84% of the Syrian refugees live in urban areas and 16% live in three camps (Azraq, EJ and Zaatari).
The health policy for Syrian refugees in Jordan has changed over the years:

- In 2011, when the crisis broke, there was a free access policy and health services were free of charge for refugees;
- In November 2014, a user fee for refugees was introduced, at the non-insured Jordanian rate, to receive care from the MoH facilities (but some services, such as ANC, PNC, HIV, remained exempted);
- In February 2018, all the waivers granted before were cancelled and the user fee was set at 80% of the foreigner rate, reducing the level of access to all refugees;
- In April 2019, the government rolled back on its decision and re-instated the non-insured Jordanian rate for Syrian refugees.

It was observed that NGO-supported referrals to MoH were charged at a much higher rate than the non-insured rate charged to refugees who paid for services themselves. Hence, direct provision of cash assistance to refugees was considered a more efficient way to access certain essential health services.

The CAEHS is a conditional, unrestricted CVA project to support Syrian refugees in urban areas who are eligible to access MoH facilities at the non-insured Jordanian rate.
Cash is provided for the following cases: deliveries (normal; complicated; C-section); high-risk pregnancies; emergency life/organ saving; elective cold cases, and thalassemia/blood transfusion.

The assistance process is the following: 1) eligibility check; 2) file is sent to referral hub and UNHCR; 3) money is sent to the bank; 4) the beneficiary receives a SMS to collect the money at the bank branch; 5) the beneficiary pays the service at the health facility.

There were several **challenges**, among which:

- coordination;
- cost variation among MoH facilities;
- charging foreigner rate for expired Asylum Seeker Certificate or invalid Ministry of interior Card;
- inflation rate and high gross medical cost trends in Jordan;
- donor fatigue and decrease fund on the one hand and increased demand on the other.

Some of the **lessons learned** from the CAEHS project were that:

i. CVA can increase health services utilization efficiently where the type and level of services needed and the costs are predictable;
ii. CVA most useful when a major barrier to accessing health care is financial.
iii. Counselling and health messages at the enrolment phase is important to ensure that the cash will be used for the intended purpose;

iv. Targeting of beneficiaries should be as simple as possible, preferably using an existing system of identification;
v. Close monitoring is needed to identify and address problems early.

Discussion

- Both Medair and UNHCR targeted their cash assistance to help pregnant women with delivery cost. Could this have been better coordinated at the design phase? There was coordination between UNHCR and MEDAIR. Now, linkages between the Basic Needs Working Group that coordinates MPC and the Health Cluster that manages sector-specific CVA should be reinforced.
- We now have a number of case studies using CVA within emergency health; how can we continue to monitor such interventions and the impact of CVA on health outcomes?

Session 7: Including health in the Minimum Expenditure Basket (MEB)

Elodie Ho (CashCap-GHC), Thomas Byrnes (CashCap)

During the first part of this session, a reminder of the key concepts was provided to the group.

The MEB refers to what a household needs – on a regular or seasonal basis – and its average cost over time. It can be a critical component in the design of interventions including MPC, with transfer amounts calculated to contribute to meeting part of the MEB.

It is important to stress that the MEB is not the only method to calculate a CVA transfer value. Another approach is to use the value of the social welfare assistance provided by the government (e.g. UNICEF in Yemen, ESSN in Turkey). The poverty line can also be used as a reference. In other situations, the CVA transfer value is more dictated by political and budget considerations.

The MEB should not be confused with the **transfer value** (either Multipurpose cash or sector-specific cash transfer). Households usually have some resources and free assistance to cover their needs and the transfer value is based on what the household cannot pay for. For health, this means that any services provided for free should not be included in the calculation of a cash transfer value. Indirect costs to seeking care (transportation, food and accommodation during treatment or for the caregiver, etc.) should however be considered as they are rarely included in the free health service package.

For essential health services that are not free, the solution should not systematically be a cash transfer. Other interventions could also be considered, such as advocacy for a user fee policy, inclusion into a health insurance scheme, etc.

The MEB is not an exact science and there is often a discrepancy between the planned expenditures and what people actually spend their cash assistance on.
However, the MEB exercise can generate helpful information to analyze households' needs and how they prioritize expenses across sectors and inform decisions on the most appropriate intervention.

During the second part of the session, the draft of the *Working paper on including health needs in the MEB, and how to interpret this for adding a component for health in the MPC* was presented.

To draft this document, the GHC/CTT reviewed multiple MEB methods from different contexts.
A major challenge was the very high heterogeneity of MEB approaches, with also different understandings on how health expenditures should be included.

Three approaches were listed:
- One approach is to reflect an essential set of services and commodities and estimate their costs.
- A second approach is quite similar to the first one but factors in unpredictable health expenses.
- The third approach looks into the amount of out-of-pocket payments for health per household. If OOPs surpass the catastrophic expenditure threshold (threshold to be agreed by health actors in the context), the cash transfer value could be equal to a percentage of the amount necessary to bring back the household under the catastrophic expenditure threshold.

Next step:
The MEB Working Paper will be revised and incorporate the feedback collected during this session. A second version will be finalized by the end of December 2019 and circulated to the group and Global Cash Task Team for review.

Session 8: Monitoring the effect of CVA on health

Alessandro Bini (Somali Cash Consortium)

The mandate of the Somali Cash Consortium is to provide Humanitarian MPC through mobile money to vulnerable households, alongside contribute to building the Somali Shock Responsive Safety Net. Unconditional MPC are given to vulnerable households to support multiple basic needs. The modality used is mobile money (great market penetration of mobile money and more protection for beneficiaries – no need to collect the transfer at a designated point). In terms of accountability, the population is informed about the selection process and entitlements to avoid conflicts and there are also safe and accessible channels to report complaints (Bulk SMS; Bulk Voice messages; PDM; several channels for the customer relationship management (CRM)).

There are expenditure differences between IDP and non IDPs but both groups have about the same level of expenditure on health (the MEB includes health but only to about 1% - 1.5% of the total basket cost). It is thus necessary to revise the MEB to include more realistic costs for health.

Concerning the Somali Shock Responsive Safety Net, the Cash Consortium has worked on harmonising procedures and tools of humanitarian agencies doing cash, and gives technical advice to the Donor Working Group.

Session 9: Improving CVA preparedness for health actors. What needs to be done to be "cash ready?

Elodie Ho (WHO/CashCap) – Thomas Byrnes (CashCap)

In the last session, the participants were divided in four groups to work on the following activity:

- In your group please identify an activity
    - That the global health cluster could hires a consultant to work on, to be completed by the end of the year.
    - That health agencies could in the next 6 to 12 months complete that could support the global health cluster could use or publicise.
    - That the global health cluster could work on to be completed in the next six to 12 months.
- Please outline for each activity
    - What it is? What would be desired outcome? Who will lead (agency/global) When it could be delivered?

Each group had to work on one of the categories:

1. Enable Cash and Vouchers to be routinely considered, alongside other tools

2. Build enough capacity for Cash and Voucher Programs
3. Develop an evidence base and standard procedures for cash for health.
4. Ensure the quality of Cash and Voucher programming and monitoring

The full Action Plan is in Annex 3.

Annex 1: Agenda

Wednesday, 25th of September

	Day 1	Objectives and expected outcomes
8:30-9:00	Registration	
9:00	Introduction- Objectives of the workshop	• The meeting's objectives are clear for all participants
9:30	**Session 1**: What do we still need to know?	• Progress report on the Health Cluster research agenda • Conceptual frameworks on the impact of CVA for different health outcomes • Presentation of future research projects
10:30	**Break: 30 mins**	
11:00	**Session 2:** Response option analysis	• A draft tip sheet for the response analysis for cash and health is developed.
12:30 LUNCH (1h)		
13:30	**Session 3: Improving access and referrals to health services** Lessons from the field: PUI Afghanistan	• Use of CVA to improve physical and economic access to health services is illustrated with field case studies • Use of CVA to improve referrals between health services is illustrated with field case studies
14:30	**Break : 30 mins**	
15:00	**Session 4.1 :** Identifying and managing risks – UNICEF's experience in Yemen	• UNICEF's experience on risk analysis and mitigation is shared
16:00	**Break 15 mins**	
16:15	**Session 4.2 :** Identifying and managing risks- CVA and gender	• The GBV and CVA compendium is introduced • Gender based risks and mitigation measures are discussed

Thursday 26th of September

	Day 2	Objectives and expected outcomes
9:00	Laying out the foundations of a collective action plan	
9:30	**Session 5:** Effects of multipurpose cash on health	• Use of CVA for health is illustrated with field case studies
11:00	**Break 30 min**	
11:30	**Session 6:** Linking emergency cash to health system strengthening interventions	• The Health Financing Policy and Implementation in Fragile and Conflict-Affected States (FCAS) guidance document is presented
12:00	Cash and Voucher to access essential services	• UNHCR's experience in Jordan is shared
12:30	**LUNCH : 1H**	
13:30	**Session 7:** Including health in the Minimum Expenditure Basket	• Concepts and methodologies are introduced and discussed • The MEB and Health guidance document is introduced and discussed
14:30	**Break 15 mins**	
14:45	**Session 8:** Monitoring the effect of CVA on health	• Monitoring of CVA is illustrated with a case study • Tip sheet on the minimum indicators is presented and feedback is collected • A list of minimum monitoring requirements is agreed upon
16:00	**Session 9:** Improving CVA preparedness for health actors What needs to be done to be "cash ready"?	• A plan on the next steps to improve health cluster partners' preparedness and capacity in the region is agreed upon
5:00	**Conclusion and next steps**	

Annex 2: List of participants

	Name	Position	Organization	Email
1	Kate Golden	Nutrition and health Coordinator	Action Contre La Faim	kgolden@lb.acfspain.org
2	Alexandra Irani	Project Manager	American University of Beirut	alexandra.irani@gmail.com
3	Zeina Jamaluddine	Public Health Proffessional	American University of Beirut	zj14@aub.edu.lb
4	Nick Nichol	CaLP regional focal point	CALP	nnichol@cashlearning.org
5	Holly Radice	Cash and Market Techncial Advisor	CARE	Holly.Radice@care.org
6	Fe Kagahastian	Cash coordinator for Whole of Syria	CashCap	Farhan.Bashir@savethechildren.org
7	Thomas Byrnes	Cash & Market expert	CashCap	thomas.byrnes@nrc.no
8	Elodie Ho	Cash & Market expert	CashCap/Global Health Cluster	hoelodie@who.int
9	Alessandro Bini	Somali Cash Consortium Director	Concern	alessandro.bini@concern.net
10	Andre Durr	CashCap expert for nutrition	Global Nutrition Cluster	aduerr@gmail.com
11	Carla Zmeter	PHC Assistant Program Manager	ICRC	czmeter@icrc.org
12	Reem Al Shami	Head of health programs	IRC	Reem.AlShami@rescue.org
13	Bianca Tolboom	Sexual and reproductive health specialist	Kit	B.Tolboom@kit.nl
14	Fernando Maldonado	Researcher	Kit	F.Maldonado@kit.nl
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16	Stephen Chua	Project Manager	Medair	ha-mer@medair.org
17	Jerry Masudi	Cash & Health Officer	Norcap/WHO-AFRO	jmasudik@gmail.com
18	Claire Allard	Cash advisor	Première Urgence International	callard@premiere-urgence.org
19	Abdul Baqi Ghafori (presented remotely)	Deputy Health Coordinator	Première Urgence International-Afghanistan	afg.dephealthco@pu-ami.org
20	Shihab Ibrahim	Regional health advisor	Save the Children Regional office	Shihab.Ibraheem@savethechildren.org
21	Jamal Fares	Cash Advisor	Save the Children UK	Jamal.Fares@savethechildren.org
22	Julien Morel	Cash Programme Officer	UNHCR-Lebanon	morelj@unhcr.org
23	Ahmad Alshibi	Public Health Associate	UNHCR Jordan	alshibi@unhcr.org

	(presented remotely)			
24	Cecilia Shawatama	Cash Transfer Specialist	UNICEF	cchawatama@unicef.org
25	Sherin Varkey	Team Leader-Project Management Unit	UNICEF-Yemen	svarkey@unicef.org
26	Hanane Chreki	Administrative Officer	WHO/EMRO	chrekih@who.int
27	Tonia Rifaey	Technical Officer	WHO/EMRO	rifaeyt@who.int
28	Alaa Abouzeid	Regional Team lead, operational partnerships	WHO/EMRO	abouzeida@who.int
29	Sandra Michael	secretariat	WHO/EMRO	nessims@who.int
30	Lurdes Soares	UNV/Partnerships	WHO/EMRO	soaresl@who.int
31	André Griekspoor	Senior Humanitarian Policy adviser	WHO/HQ	griekspoora@who.int
32	Ilgi Bozdag (presented remotely)	VAM associate	WFP Turkey	ilgi.bozdag@wfp.org

Annex 3 : Action plan

Categories	Activity	Lead	Contributors	Expected output	Timeframe
1. Enable Cash and Vouchers to be routinely considered, alongside other tools	1.1 Do a mapping of the existing response option analysis tools used in the region	EMRO Consultant	Health clusters Cash Working Groups CALP MENA	Synthesis report Case studies	in the next 3 months
	1.2 Technical oversight and support to disseminate the learning from the synthesis report and case studies produced by the consultant.	GHC	CALP	Learning synthesis with lessons learned, best practice from variety of contexts. A follow-up workshop on response option analysis	6-12 months
	1.3 Revise the decision tree tool and disseminate the improved version	GHC	Workshop's participants GHC-Cahs Task Team Health Clusters	Decision tree tool	6-12 months
2. Build sufficient capacity for Cash and Voucher Programs	2.1 Identify key lead agency for developing and providing capacity building training and funding to undertake these activities	GHC	CALP UNICEF WHO	Donor mapping Training agency mapping	In the next 6 months
	2.2 Undertake a training needs assessment and develop training plan for different profiles (managers, operations, MoH)	GHC	CALP Health Clusters CWGs	Training plan	
	2.3 Develop training materials and pilot them (fundamentals, TOT, online)	GHC	CALP Health Clusters CWGs	Training package developed, which is replicable and adaptable	6-12 months

3. Develop an evidence base and standard procedures for cash for health.	3.1 Collect evidence and tools on CVA for health and on other sectors if there are cross-cutting lessons (CVA for nutrition, for Wash, etc.)	EMRO consultant	GHC GNC CALP Health agencies Cash agencies	Repository of tools, evidence map and synthesis report to consolidate the findings	Next 3 months (but will likely require more time)
	3.2 Develop operational tools for the implementation of CVA for health outcomes	GHC	CALP	Decision tree tool Concise guide on the potential use of CVA for health SOPs per CVA modality	6-12 months
4. Ensure the quality of Cash and Voucher programming and monitoring	4.1 Desk review & mapping of currently used indicators for C4H	EMRO consultant	Health clusters CWGs Donors	Synthesis report	Next 3 months
	4.2 Testing & validation of C4H indicators through - Ongoing/new data collection - Statistical Analysis - Consultation & peer review	EMRO office	Health Clusters CWGs CALP	Indicator mapping Synthesis report	6-12 months
	4.3 Global technical workshops and consultations to come up with a consolidated list of final indicators	GHC	CALP Donors	Workshop report List of recommended indicators	6-12 months
	4.4 Development of a technical guidance on C4H indicators, and M&E methods and tools	GHC	Health Clusters CWGs CALP Donors	Guidance document on monitoring & evaluating	6-12 months

Annex 4: List of key technical resources

Research and program evaluations

- Research Agenda on CVA for health and nutrition outcomes: https://www.who.int/health-cluster/about/work/task-teams/research-agenda.pdf?ua=1

GHC-CTT activities, reports and guidelines

- GHC-CTT page: https://www.who.int/health-cluster/about/work/task-teams/cash/en/
- Global Health Cluster Knowledge Bank: https://www.who.int/health-cluster/resources/publications/filter/en/

Technical repositories and toolkits

- Cash Learning Partnership Sector-Specific page: http://www.cashlearning.org/sector-specific-cash-transfer-programming/sector-specific-ctp
- CALP technical library: http://www.cashlearning.org/resources/library
- Program Quality Toolbox: http://pqtoolbox.cashlearning.org/

CVA and Gender

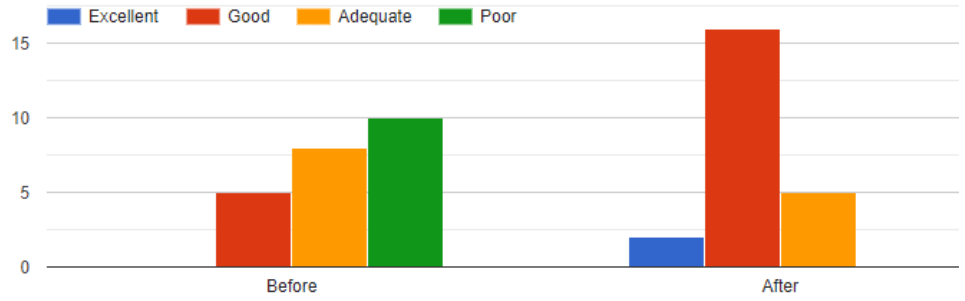
- CALP. “Gender and CVA”: http://www.cashlearning.org/thematic-area/gender-and-CVA
- CARE. 2019. “Cash & Voucher Assistance and Gender- Based Violence Compendium”
- http://www.cashlearning.org/resources/library/1343-cash--voucher-assistance-and-gender--based-violence-compendium
- IASC. 2018. “The Gender Handbook for Humanitarian Action.” pp 94-117. https://interagencystandingcommittee.org/system/files/2018-iasc_gender_handbook_for_humanitarian_action_eng_0.pdf
- Women’s Refugee Commission, Mercy Corps, IRC. 2018. “Mainstreaming GBV Considerations in CBIs and Utilizing Cash in GBV Response”, https://www.womensrefugeecommission.org/issues/livelihoods/research-and-resources/1549-mainstreaming-gbv-considerations-in-cbis-and-utilizing-cash-in-gbv-response

Annex 5: Participants' feedback

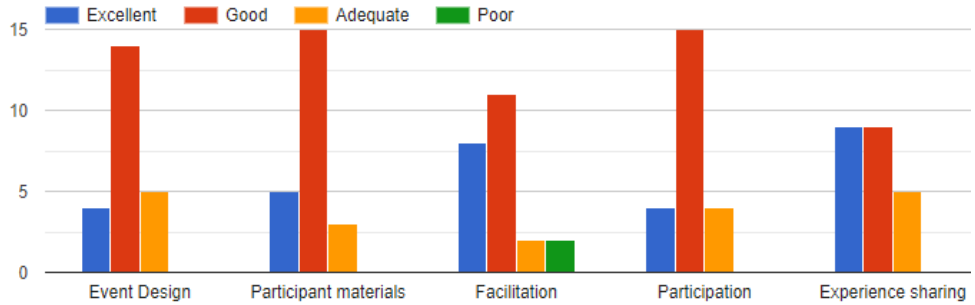
« Thanks for the great workshop! it had a good balance between setting a foundation of concepts, exposing participants to resources and sharing experiences. It is evident that there is a long way to go until there is a common view about how to use CVA for health. Pursuing the plans/activities proposed by the different groups seems much needed. Once more, thanks". One participant

N=23

Self Assessment - How would you rate your understanding of the issues around Cash and Health before and after the expert event?



How would you rate the Workshop elements?



Questions