Role of Cash & Voucher Assistance for health outcomes:

Using the Health Barriers Framework to determine the appropriate response

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HEALTH CLUSTER

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Contents

1.0 Purpose and target audience

The purpose of this guidance note is to support cash and health practitioners in considering Cash and Voucher Assistance (CVA) options systematically to address supply and demand side barriers to health, as part of the Humanitarian Programme Cycle and the Humanitarian Needs Overview, as well as for project design.

In line with the WHO and Global Health Cluster's (GHC) Working Paper for Considering Cash Transfers for Health in Humanitarian Context, CVA can help to improve access to and utilization of health services, by reducing financial barriers to access health care, including indirect costs (e.g. transport or accommodation costs), and direct costs (e.g. charges for consultation, diagnostic tests and/or medicines, or for preventive commodities as bed-nets), and incentivising the use of specific health services and/or improve adherence to long term treatment.

This document is complementary and aligned to the GHC guidance: People in Need (PIN) and Severity Guidance, that describes three major considerations for identifying health needs, and thus the number of people in need of health assistance: Health resources, that includes barrier analysis, health status and contextual factors.

Furthermore, WHO is finalizing a Handbook for Conducting Assessments of Barriers to Health Services in support of Equity-oriented Reforms towards Universal Health Coverage, that includes adaptation in humanitarian settings. Further harmonisation of this technical note will be done after its publication.

The target audience for this document are both health and cash practitioners. We note in different sections who we think should take the lead, for instance, during an assessment method or design, but the analysis, decision making, and implementation should be a collaborative effort between both.

2.0 Scope of the guidance

Below is an overview of the main sections in this technical guidance:

Overview of the guidance

1. **Barriers Framework** – Introducing the Tanahashi model
2. **Health Expenditures** – Understanding health expenditures and financial barriers
3. **Response Option Analysis** – Response option analysis including CVA to address supply and demand barriers to health
4. **Assessment and monitoring of barriers**
5. **Monitoring CVA**

The Tanahashi framework is used to describe different barriers to achieve effective coverage of health services: that people can use a quality health service when needed, without suffering financial hardship. The guidance provides a general resource to promote common understanding of barriers related to health services provision and use, and based on a response options analysis, how these can be addressed by different demand and supply side interventions, including but not limited to CVA within the response analysis.

Using the Tanahashi framework for analysis of demand and supply side barriers helps to understand that in most contexts a mix of interventions is required. Financial barriers are almost always a significant factor in such barrier analysis, with even small fees or co-payments leading to delays or not seeking care by the most vulnerable. Within the options to address financial barriers, CVA for health is complementary to, and not meant to replace, supply side financing.[1] This means that the optimal response to reducing user fees and out of pocket payment is through provider payments mechanisms. Cash and vouchers can then be used to address costs that are or cannot (yet) be addressed by such supply side solutions, and/or to address costs that are not covered by supply side financing, such as indirect costs for transport and costs for caretakers. Together (supply side financing and CVA), these types of interventions can reduce out of pocket payments, and subsequent risks of delays in or not seeking essential services, as well as catastrophic health expenditures, and thus contribute to the health outcome for universal health coverage with financial protection.

The guidance will explain what typical health expenditures are, and the basic characteristics of illness and subsequent health needs that need to be considered when assessing financial barriers and related response options.

The guidance will make reference to assessment methods and tools that are available to assess which barriers exist in a given context and making subsequent decisions whether or not CVA has the potential to be effective in reducing these barriers, and if so, which CVA modality would have the best characteristics to do so.

The note will also advise on indicators that can be used for assessment, during the design, implementation, and monitoring of CVA projects for health outcomes.

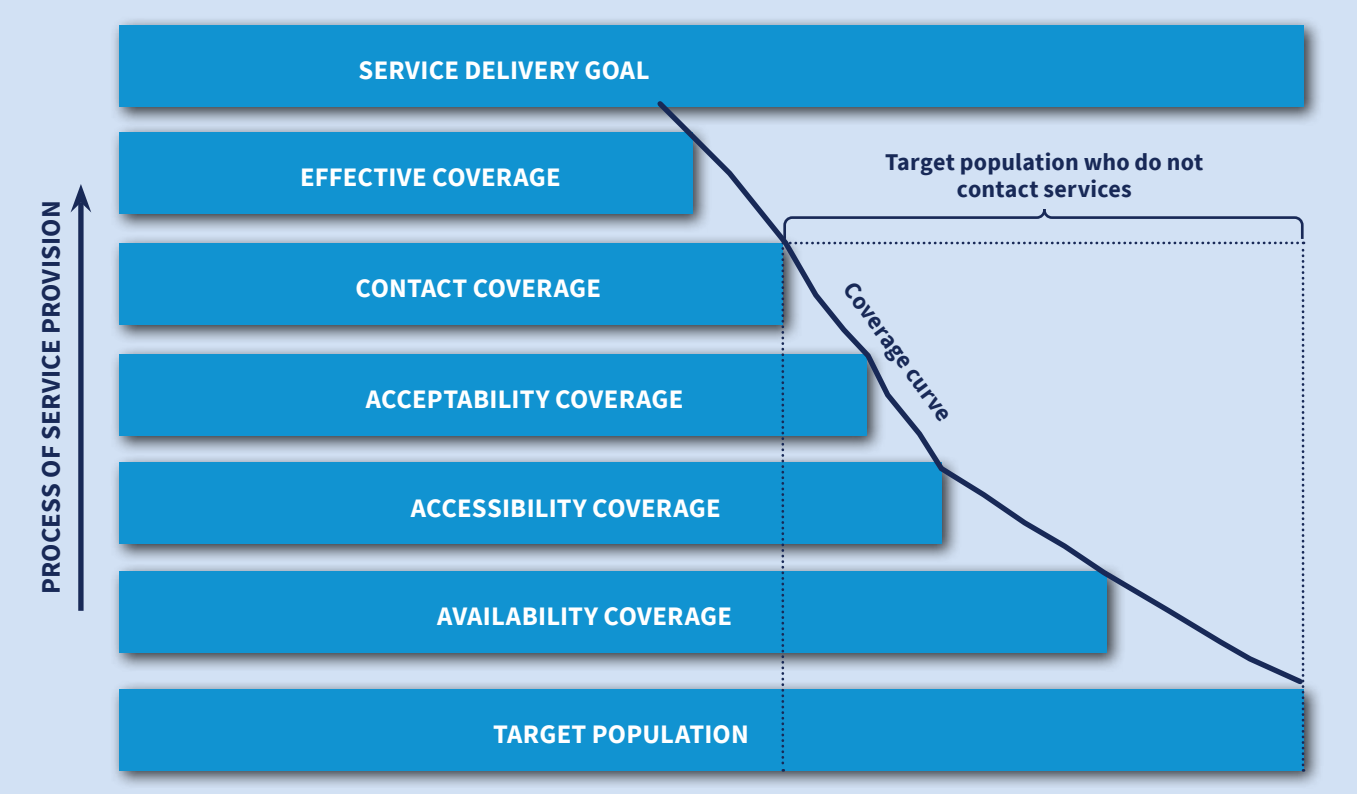
[1] See Global Health Cluster Working Paper for Considering Cash Transfer Programming For Health in Humanitarian Contexts – 2018

3.0 Using the Tanahashi barriers framework

The Tanahashi framework is an analysis tool that can be used to identify bottlenecks to effective coverage within the health system. It includes barriers related to coverage of availability, accessibility, acceptability, contact/utilization and effective coverage.[2]

Tanahashi for effective coverage is what is achieved when someone seeking care has overcome the barriers described in the framework and has received an affordable health service that meets quality standards. The service delivery goal we use for this guidance is the ability for people to use a quality health service when needed, without suffering financial hardship. The extent to which this service delivery goal is achieved is determined by the effective coverage.

Figure 1: Tanahashi framework



Why are we using this framework?

This framework allows health and cash practitioners to understand how and where CVA for health can be effective in addressing certain barriers to achieving health outcomes. Specifically, CVA can be effective in directly addressing barriers related to financial accessibility and utilisation, but evidence indicate that it also has indirect effects on availability and quality of services. This framework also demonstrates how CVA can be integrated within broader supply side interventions, such as availability of health services.

It also allows cash practitioners to understand how health service delivery and access to quality services is different from access to goods rooted in market-based programming approaches.

[2] Tanahashi, T. (1978). Health service coverage and its evaluation. Bulletin of the World Health Organization, 56 (2), 295 - 303.

Figure 2: Tanahashi framework for effective coverage

Figure 2 uses the categories of barriers from the Tanahashi framework toward effective coverage by adding examples of such barriers, including supply and demand side perspectives. As financial barriers, being part of accessibility coverage, are a main focus of this document, we made affordability a separate barrier.

The framework is to be used by health practitioners as part of the Humanitarian Needs Overview to design health strategies for the Humanitarian Response Plans. Tackling the barriers to effective coverage contributes to the following health and humanitarian outcomes:

- Improving access to a package of high priority quality health services
- Improving over-arching health system performance
- Improving health equities,
- Addressing discrimination and exclusion, and fostering social cohesion
- Contributing to improved security and protection of health care workers and patients
- Improving financial protection
- Enhancing responsiveness to non-medical need and ensuring patient – centred care.
- Ensuring the right to health for all: leaving no-one behind

What do the components of the framework describe?

1. **Availability coverage.** This addresses whether physical health facilities are available in adequate numbers, distribution and mix of delivery platforms, and if the facilities meet agreed standards. This also includes whether health facilities have been damaged, destroyed or looted. Availability also includes capacity and scope of essential services available, and whether there are adequate numbers of skilled health workers. This coverage also includes whether there are shortages of medical supplies such as medicines and equipment. This could be caused by challenges to establish reliable supply chains, and in country logistic challenges, but also restrictive measures against the importation of essential health supplies/resources.

2. **Accessibility coverage.** Accessibility can be broken into four categories – physical barriers, security/protection barriers, discrimination/exclusion, and organizational barriers. Health facilities may be available, but households do not have a way of accessing them because of a bridge being destroyed, or they may not have adaptations taking into account limitations for older people or people with disabilities. There may be security and/or protection related issues with accessing health facilities. This includes checkpoints, or roadblocks and people not feeling safe to travel to a health facility, or fear being in a health facility in contexts where these are deliberately attacked. In settings where the neutrality of health care has been compromised and/or where there is a close proximity to or even presence of military forces in health services, accessibility of health care may be compromised. Accessibility also includes issues related to the need for travel permits or travel permission to access health services. Organizational access barriers can be caused by limited opening hours, and insufficient information on where to find which service. Finally, there may be discrimination or exclusion issues that may prevent patients from accessing available services, such as discriminatory attitudes among providers based on ethnicity or other characteristics. Other gender norms, *e.g.* women requiring male permission or needing to be accompanied by a male relative, can further impede access. Finally, there may also be administrative requirements for care and receiving assistance (such as refugee registration), or the presence of policies that impede the ability of a specific population to utilize health services such as IDP's if they are not formally registered.

3. **Affordability (financial accessibility).** Financial barriers include both indirect costs, such as transportation costs, and direct costs, such as out-of-pocket fees for consultation, diagnostic testing, and/or medicines as well as costs for health commodities such as bed nets. Even when health services are available and provided free at the point of service, households continue to report health related expenditures. On the supply side, barriers are caused by health service providers charging fees, and/or the absence of financial protection (as part of broader social protection) for the poor and most vulnerable. Households may also have limited knowledge of how and where to access financial support for health services or subsidized care that is often available to them. Households may also be seeking private service providers because of poor perception of public services that are being offered.

   Additionally, high poverty levels present the challenge of competing needs when viewing health-seeking behaviors whereby households must prioritize other needs when spending demands exceed what they can afford. Health can be perceived as less of a priority than food or rent in many cases, leading to postponed or forgo treatment completely.

4. **Acceptability coverage** include socio-cultural barriers, and barriers caused by perceived lack of quality. Barriers such as language; perceptions of service quality; and inadequate culturally acceptable can create fundamental barriers to initial care-seeking and follow-up care. For example, there may be an insufficient number of female health workers to provide culturally appropriate care in contexts where female patients are prohibited from being treated by male health providers. Patients may also prefer seeking traditional healers and/or medicines. Furthermore, patients may prefer traditional medicines and to seek services from traditional healers.

5. **Contact coverage,** also service utilization. When all the above barriers are removed – health facilities are available, households have access to them and they are affordable and acceptable, we still see that some people still don't use the services. They may not perceive the benefit of the service. In other cases, fear of discovering a serious illness

or having to undergo treatment may lead to delays or people not using a service.

6. **Effective Coverage.** When having overcome all previous barriers and patients now have contact with a health worker, barriers at this level are focused on factors that contribute to or impede individuals from obtaining needed care in time and with a level of quality necessary for the desired health outcome, such as poor referral systems, treatments not according to protocols, treatment and health promotion not sufficiently explained to patients, or patients and staff exposed to risks while receiving a service. On the patient side, this includes for example inadequate treatment adherence.

4.0 Understanding health expenditures and financial barriers

While every sector is different, quantifying, averaging and costing health expenditures presents particular challenges. Unlike kilo calories, which the food security cluster uses to quantify average household food needs, it is not possible to quantify and/or predict average illness and related health service needs among household members. Subsequently, the approach of bottom-up costing of needs in other sectors as typically done when calculating a minimum expenditure basket, it is not possible to define average service needs or commonly used medicines at household or individual level. Furthermore, health services and medicines should meet regulated quality standards. While it is possible to estimate average costs for health services at population level, given that there is wide variation in illness and its severity, and subsequent variation in types of services needed, and that associated costs range from very low to extremely high, its interpretation in response options needs to consider these characteristics of illness and subsequent health needs. Therefore, addressing household health expenditures to access quality health services is not as simple as including items within the MEB and translating the amount in an equal multi-purpose cash proportion.[3]

When assessing whether CVA for health outcomes can be effective, it is important to understand what the health-related expenditures are, and if these pose barriers for access. CVA for health can directly addresses barriers related to financial accessibility (affordability), but also utilization. Indirectly, CVA has demonstrated to have effects also on availability, socio-cultural barriers, and quality of care for effective coverage. This is particularly relevant when discussing response options related to reducing user fees and reducing financial barriers, or when CVA can incentive the use of and adherence to services.

To define appropriate response options, one of the things to consider around health expenditures is where they are being incurred. It makes a difference if people pay for services from private provider rather than seeking services from public providers and those supported by humanitarian partners, that provide subsidized or even free services.

Equally important is to understand whether or not the service or medicines obtained after payments were of adequate quality, to avoid that CVA options do not inadvertently provide incentives for patients to seek services or buy medicines from unqualified providers, such as unregulated drug outlets on markets.

Even when health services are provided free at the point of delivery, household surveys indicate that people always have health expenditures. Thresholds that indicate low financial protection and already having expenditures classified as catastrophic are when health expenditures are more than 10% or 25% of the overall household expenditures.[4] But even small co-payments that are sometimes introduced in health policies for community participation, or making people feel more responsible when seeking services, lead to delays and barriers in seeking care for the poor and most vulnerable.[5]

In some contexts that have more advanced financial protection systems for health based on risk sharing and pooling, access to health services is financed through pre-payments for example in the form of a health insurance premium or from public funds raised through taxation complemented with donor support into a pooled health fund.

Household expenditure surveys and post-distribution monitoring (PDM) reports consistently reflect that household expenditures for health are frequently the third or sometimes even the second highest expenditure category, even when policies are in place for priority services to be provided free of charge in public facilities. Patients still have to pay for services not included in a benefit package, there may be informal fees charged by public providers, or patients seek services from private providers.

Expenditures for health services can be classified as direct and indirect, and related to obtaining health commodities.

Direct costs

Direct costs include fees to access primary or secondary care, for the consultation, fees for laboratory and other diagnostic tests as X-rays, medicines and medical supplies, costs for admission and surgical interventions. These costs can also be incurred when seeking services from public as well as from private health providers, including traditional healers. People may also purchase non-prescription drugs as self-medication for common illnesses. Furthermore, in many situations patients report having to buy medication from private pharmacies, as

[3] See Global Health Cluster (GHC) Technical Note on the Inclusion of Health Expenditures in the MEB and Subsequent Multi-purpose Cash Transfer September 2020.

[4] Ibid; WHO Health Financing

[5] See GHC Position Paper – Removing User Fees for Primary Health Care Services During Humanitarian Crisis March 2010. 1

public providers that should have provided the medication for free may have stockouts, often due to inadequate budgets allocated for this.

Paying monthly premiums for a health insurance is also a direct cost. Even when people have financial protection for health services, as part of broader social protection, and have free access to an essential health package[6] either from the government, or a humanitarian actor, not all services may be covered in the package, such as secondary care or care for non-communicable disease. In that case, people are still paying user fees to utilize such health services.

Indirect costs

Indirect costs are related to paying for transportation to access a health facility, or accommodation to accompany a family member in need of a health service. Finally, there is also the opportunity cost when using a health service, due to lost income, not being able to work on the land, etc.

Economically speaking, high poverty levels present the challenge of competing needs whereby households must prioritize between needs. Health can be perceived as less of a priority than food or rent in many cases, leading to postponed or forgone care. For example, even prevention services provided for free, such as vaccinations or antenatal care (ANC), may be deprioritized by affected populations because transportation for such activities may be too costly for them.

Costs for health commodities/goods

Health commodities include all commodities or goods that people need for either prevention or health promotion, or that are part of their treatment or rehabilitation, – such as long lasting insecticide treated bed-nets (LLITN), or medical assisted devices for people with disabilities, baby kits, female hygiene kit, or goods that may be required to implement health promotion (soap, condoms) or support treatment (additional food needs for patients on TB and HIV treatment, dietary diversity for children recovering from SAM with medical complications).

Table 1 Provides examples of the most common services, and characteristics for when and for whom they may lead to costs, often a mix of direct and indirect.

Table 1: Common health services and examples of related expenditures

Common health services	Frequency	Timing of expenditure	Type of costs and examples
Consultations and medicines at primary care level for uncomplicated and common illnesses	Often planned at population level for 1-4 visits average per person per year	When ill and seeking care	**Direct costs:** Usually relatively low costs, formal co-payments, user fees Per diagnostic test and treatment specific to the illness **Indirect costs:** usually low, average per consultation based on <5-10 km travel
Consultations and medicines for chronic illness	Recurrent (e.g.) monthly for patients with chronic illness	When seeing the provider for regular check-up and new prescriptions	**Direct costs:** Formal co-payments, user fees Per diagnostic test and treatment specific to the illness Services and medicines for HIV and TB should be for free **Indirect costs:** for transport **Commodity:** special dietary requirements, supplementary food
Antenatal and post-natal care	Agreed # and timing of visits during and after pregnancy	When visiting the ANC/ PNC program	**No direct costs** (service free for the patient) **Indirect costs:** transport, **Commodity:** LLITN, female hygiene kit
Normal delivery	Based on population fertility rate	When giving birth, or during the 2 months prior to the expected delivery date	**Direct costs:** Average fee per normal uncomplicated delivery **Indirect costs:** transport, stay in maternity home, costs for caretaker **Commodity:** baby kit, female hygiene kit

[6] Financial protection for health can range from obligatory pre-payment in a type of social health insurance fund, but also payment exemption and/or reimbursement schemes for the poor and most vulnerable. This would be complementary to a social cash transfer under a broader social protection program.

Common health services	Frequency	Timing of expenditure	Type of costs and examples
Routine immunisation and child growth monitoring	Several visits sequenced over 1 year, for children	At appropriate age	**No direct costs** (service free for patients) **Indirect costs:** transport, average per visit, for child and caretaker
Hospitalisation and hospital services	Based on number of admissions per population per year	When admitted for severe illness or requiring specialised services	**Direct costs:** High costs, rates agreed with provider, against quality standards and diagnostic treatment protocols. Can be selective for only diagnostics, medicines and supplies **Indirect costs:** Agreed daily admission rate for non-medical costs, cost for caretaker, transport
Treatment of severe malnutrition with medical complication	Based on GAM/SAM prevalence	When under treatment for SAM with medical complication	**No direct costs** (admission in nutrition rehabilitation unit free for patients) **Indirect costs:** for caretaker per visit or for duration of admission in NRU **Commodities:** LLITN, food items after discharge, diverse diet
Rehabilitation services for trauma and other illnesses that lead to disabilities or impaired functionality	Based on incidence of patients requiring these services	Linked to other services for patients requiring rehabilitation	**Commodities:** prosthesis, wheelchair, crutches

5.0 Response Option Analysis: interventions to address the barriers – including CVA

5.1 Overview of Response Options, including CVA for health

Using the barriers framework as in figure 2, different response options for CVA alongside other health interventions can be considered. In most contexts there will be a need for integrated programming to address different barriers as identified from the assessments. Options for CVA should be considered complementary to supply side health financing, and not aim to replace this. Together, they are complementary to non-financial demand and supply side interventions to develop integrated health response strategies.

Note that the response option analysis is only one component of a wider CVA feasibility analysis that we have not detailed here but would be standard procedure in any design of CVA program.

Figure 3 provides common examples of response options when considering interventions to address both supply and demand side barriers. It is important to consider all options against the identified barriers, as there are often different options to address the same barrier. As previously noted, CVA is just one component that addresses financial and utilization barriers. The description of response options on both and demand side is not meant to be comprehensive. It is meant to indicate for which barriers CVA for health can be effective when implemented correctly, directly and indirectly:

Direct effects:
- Reduce financial barriers/financial protection, caused by direct and indirect costs
- Ensure services and medicines are obtained from qualified providers
- Support access to health commodities and goods
- Incentivize utilization and adherence to services
- Accompanying the CVA with intensive health promotion activities at community level to link People of Concern (PoC) to health services and explain the importance of accessing care

Indirect effects when linked to provider performance:
- Increase availability and capacity of services
- Ensuring quality and effectiveness of treatment
- When CVA is given as MPC it can also contribute to better health outcomes because MPC contributes to meeting other basic needs that are determinants of health

Figure 3: Response Options Analysis

Availability response options:

Following the process flow as in the diagram, addressing barriers related to availability of services includes direct support to existing health facilities, restoring functionality or in some fragile settings strengthening health services that may otherwise be overwhelmed

This includes also demand side interventions such as information campaigns, so people are aware which services are available and where to receive them. Interventions related to accessibility include protection of health care on the supply side (including ensuring exemption of essential health resources from importation limitations) and addressing physical barriers on the demand side.

CVA can have indirect effect on supply side availability. When linked to performance of service providers, they have an incentive to meet increasing demand that results from CVA for health.

Accessibility response options:

Addressing the different accessibility barriers include interventions to improve security and protection, reduce discrimination, negotiate travel permissions, exempt health transports from military/police interventions, ensuring adequate protection for health facilities, and physical and organisational improvements to allow access for patients with disabilities and addressing opening hours.

CVA can improve accessibility by paying for transport.

Affordability response options:

When households are unable to afford health services, the optimal response is to consider contracting and purchasing of services – supply side financing.

CVA options can then address remaining direct and indirect costs, such as for transportation, and/or the need for health commodities.

Socio-cultural response options:

Socio-cultural interventions can include training of health workers on culturally appropriate behaviour and ensuring the health workers are well versed in the language of the population. On the demand side setting up health committees within the population can address the health seeking behaviours.

When financial barriers are removed, CVA also has the potential to indirectly impact socio-cultural and gender barriers.

Utilisation response options:

Using community health programs and health promotion campaigns to influence knowledge, attitudes and practices related to illness and health seeking can improve utilisation. Setting up health committees can further improve utilization of services as well as informational campaigns.

CVA, through (soft) conditionalities has proven to have positive effect on utilisation of free preventive health services, and/or improve adherence to longer term services and reduce defaulting.

Response options for effective services:

Finally, on the effectiveness and quality of care, these mostly require interventions addressing the supply side barriers, by improving the quality and safety of services, and for example timely referral mechanisms. On the demand side health promotion and people centred care can improve understanding of the illness and treatment, and thus compliance.

CVA for health can also be seen as a form of performance-based financing. By linking the CVA to pre-selected qualified providers, contracts can require adherence to treatment protocols and quality standards.

5.2 Selecting the appropriate CVA modality: which modality is best to address a specific barrier?

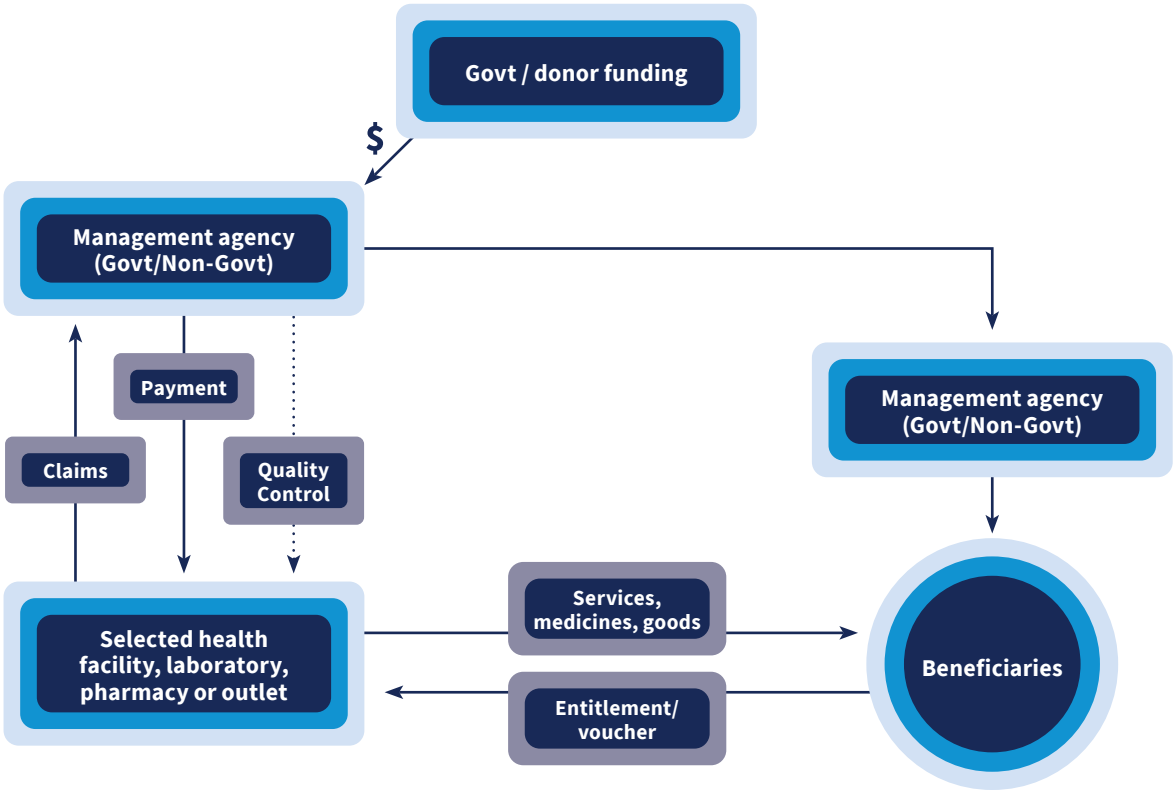
Each CVA modality has different characteristics, making them more or less appropriate to address specific direct and indirect costs as described above.

Below are descriptions of the different modalities, vouchers, conditionalities, and cash, with examples of how the different modalities of CVA can contribute to addressing the different barriers. It also describes what the basic mechanisms are for the transfer of the money between the implementing partner, the patient or beneficiaries, and the providers.

Vouchers

Vouchers for services or goods, value vouchers and health equity funds, reduce financial barriers and strengthen the supply of services by channelling funds to pre-selected contracted qualified health service providers to pay for user fees **(Figure 4)**. Vouchers also have the positive effect of controlling the quality of care provided to targeted beneficiaries, either through the selection process of the providers, requiring adherence to treatment protocols, and/or through regular quality checks.

Figure 4: Vouchers and health equity funds



Vouchers may be used in exchange for either a specific service (i.e., institutional delivery or a journey in the case of transport) or a sub-package of services (i.e. sexual and reproductive health care services and family planning), or they may represent a value (a value voucher) for services up to a fixed ceiling (i.e. for a package of essential services, or for receiving medicines). But it is important to note, like other voucher intentions, vouchers can restrict a household's ability to choose their own service provider, treatment and scheme.

Similarly, a Health Equity Fund subsidies in general all the user fees or co-payments charged in a health facility by reimbursing them to the facility for its target population. Depending on their design, they can also cover transport costs and commodities.

They all have in common that the transfer of money is directly to the health service provider, that can include public/Ministry of Health, as well as private and faith-based service providers, while the target group receives a voucher that is linked with that person, with pre-defined entitlements, and information where to receive these.

Pros:

- The strength of this modality and its variations is that they all control the quality of care received by the beneficiary, and as these don't have to pay anymore for these specified services, the financial barrier is significantly removed, or when used for deliveries and their complications, women no longer have the risk for catastrophic expenditures caused by delivery.
- When performance components are integrated in the contract, this generally has a positive effect on the capacity of services, and adherence to quality improvement processes.
- As vouchers use existing health providers, public or private, they build on and strengthen the existing health system. The approach to reimbursement through contracts can also be seen as pre-cursor for strategic purchasing through a pooled social health (insurance) fund and 'contracting out'.[7] As such, they can be used as entry points for the Humanitarian Development Nexus.

Cons:

- They take more time to set up, largely due to the process required to pre-select qualified providers, and to negotiate the contract with them for the selected services or goods, the quality standards, and their price. It may be difficult to really judge the quality of the provider, especially for pharmacies.
- The voucher needs to have a strong protection, so it can't be used by other people, and ensures confidentiality of the medical data.
- Vouchers can create perverse incentives to providers to increase their 'production', e.g., lowering medical threshold criteria for doing Caesarean Sections, or prescribing unnecessary tests or medicines, so they earn more money.

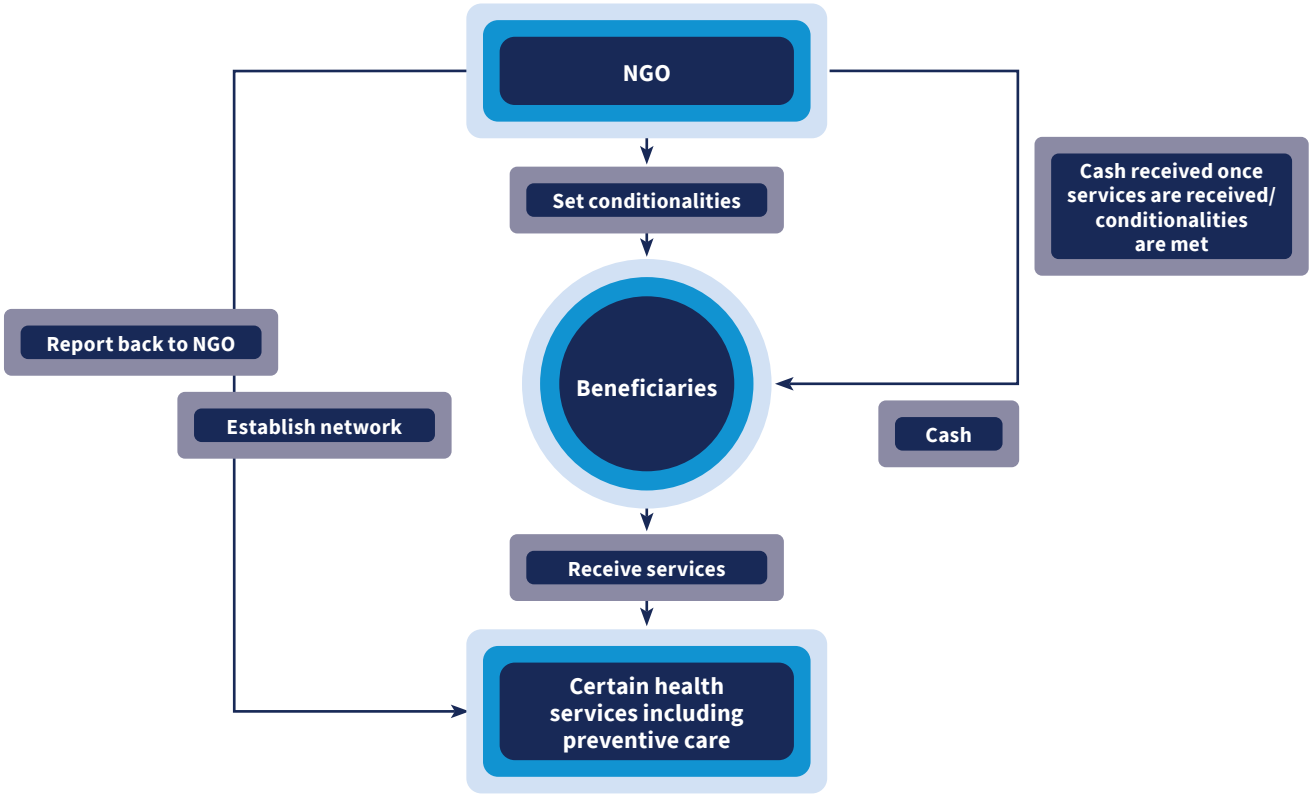
Conditional Cash Transfers

Conditional cash transfers (CCTs) are paid to a beneficiary *after* a certain action is taken, and often linked with services that are themselves provided for free **(Figure 5)**. Based on the evidence

[7] Contracting out usually targets the entire population and covers a full package of essential health services.

for what works to improve health outcomes (i.e., antenatal and postnatal care attendance and institutional delivery) they incentivize positive behavioural change. Conditional cash can also address **financial barriers** – where the condition is linked to participation in a health promotion activity that does have costs implications for the patient, including transport.

Figure 5: Conditional Cash Transfers



Pros:

- The evidence on the effectiveness of CCT to increase coverage of and/or adherence to the programs in which they are used is strong (provided a proper assessment was done to understand all the barriers people may have for the specific services for which the CCT is considered, as other barriers may be more important, and if cash is indeed an incentive for the specific target group and how high it needs to be to change behavior).
- A cost efficiency analysis can be done to demonstrate value for money (i.e., coverage increases by 20% for while reducing total average costs per service received).

Cons:

- Monitoring adherence to the conditionality adds an administrative time-consuming process.
- In some cases, the cause for not meeting a condition can be beyond the patient, and as such 'double punished'.
- Both cons above can be mitigated by having 'soft' conditionalities.
- Some argue that imposing conditions undermines the self-determination of the people receiving them.
- Health service providers can complain that demand increases so they have to work harder and are held accountable to meet quality standards, but they get nothing in return. This can be mitigated by vouchers that reimburse the provider for the services for which the CCT in introduced.

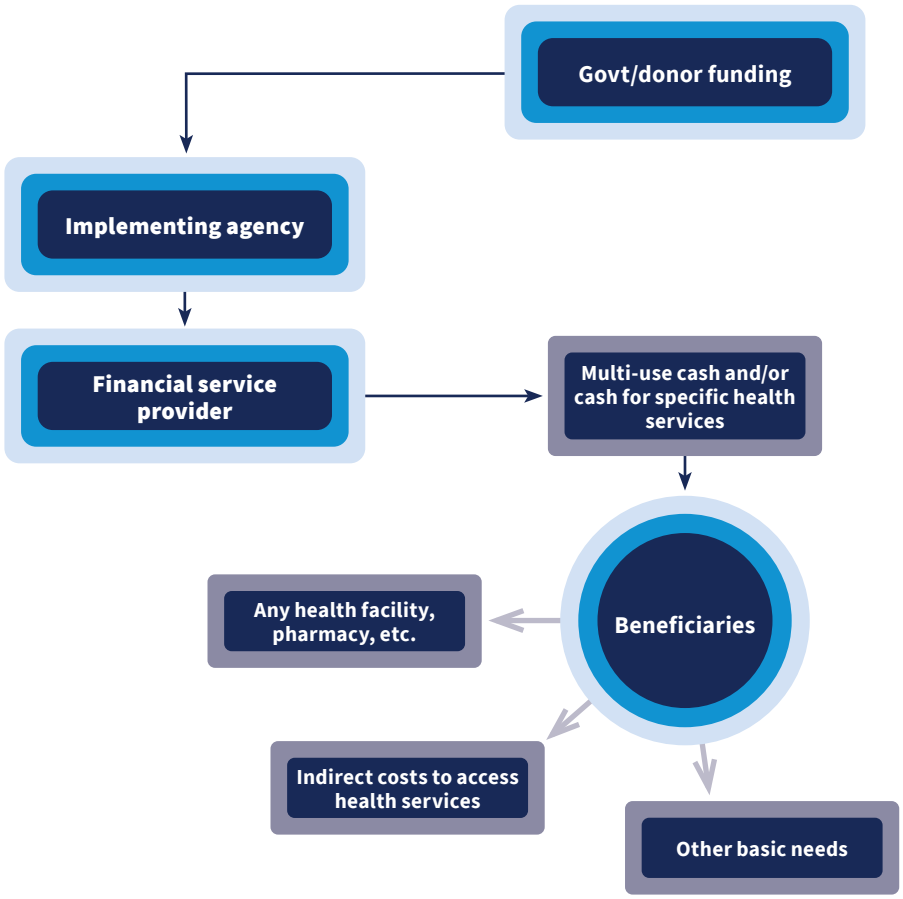
Cash for a specific health need

Finally, **Figure 6** illustrates two types of unconditional cash transfers, targeted to patients with a specific increased cost or a specific expenditure for medical goods, such as assisted devises, and/or cash for a specific health services they need to use. In this case, the cash can be used to address financial barriers to accessing health services, including paying for health services of their choice, covering indirect costs and/or costs for treatment or health promotion related commodities. The transfer and amount are linked to identified health related needs of individuals. It may also include covering other basic needs when patients have reduced ability to generate income or higher dependency rates or compensate opportunity cost. Because the cash is unconditional and is not restricted in where to use the money, as with a voucher, there is no guarantee it will be used for its specified health outcome and with a provider that meets quality standards.[8] However, with proper targeting, health promotion and sensitization, households are likely to

[8] It requires monitoring to see how cash has been spent and if it's not spent on health, what are the other needs and how beneficiaries have prioritized their needs

use it for its intended purpose and promote positive health outcomes. There is usually also a 'pre-commitment' to seek services from recommended health facilities where the quality of services and/or medicines meet national standards.

Figure 6: Unconditional Cash Transfers



Pros:

- Cash linked to specific health needs of patients adds value by filling gaps that can't be addressed by other modalities.
- For some financial barriers, such as indirect costs for transport, costs for caretakers, it is likely to be easier to implement compared to vouchers.

Cons:

- When using cash for specific health services, the quality cannot be ensured as with vouchers, but evidence indicates that most people do seek the service from the provider recommended by the agency providing the cash, when part of appropriate health promotion and dialogue with the patient.

6.0 Assessments and indicators

In this section we outline the different tools available to assess those barriers including tools used by the health community as well as the CVA community. We also include the related indicators for each barrier, which should be included at the assessment and at the monitoring stage of the design and implementation of a health intervention.

The following points can be used to guide decision-making processes to select project indicators.

1. The project context will have a large influence on the relevance and applicability of the indicators selected. It is essential to select the most useful indicators and then refine them to ensure they reflect the local context, and are SMART (specific, measurable, achievable, relevant and time-bound).
2. The indicators should be defined during the assessment and design phase of the project – to ensure the baseline is captured and to be able to measure the impact of the CVA and health intervention.
3. Indicators need to be defined for the barriers as well as for the desired health outcome on which the response interventions including CVA is addressing.
4. Health and cash actors should work together to refine the indicators and ensure they are mainstreamed into the different monitoring tools including household surveys and post distribution monitoring.

6.1 Assessing barriers to health services

Table 2 below outlines the tools used to assess the different barriers to receiving health services. These assessments will take place alongside other assessments and does not exclude the CVA related feasibility assessments. Within an emergency context, the Health Cluster would complete these assessments, and have the information related to availability, accessibility, affordability, utilization and effectiveness of health services.[9]

a. Availability. The Health Resources and Services Availability Monitoring Systems (HeRAMS) assesses the availability of health facilities, providers and services, as well as their functionality. The Surveillance System for Attacks on Health Care (SSA) is a reporting tool for attacks on health resources (including facilities, health workers, or patients), which provides an indication on the safety of service delivery points in a given context. These attacks have effects on the delivery of services, affecting their functionality, but also their accessibility by being a cause for security and protection barriers. Finally, the Public Health Situation Analysis (PHSA) provides an overview of the health status of the population, basic capacities of the health system, as well as response efforts and information gaps. More in-depth health system assessments or sector reviews provide deeper understanding of health system bottlenecks and causes.

b. Accessibility. Some of the same tools used to assess availability barriers will also be used to assess whether households have access to health services, including distance and security (HeRAMS), and the SSA can also be used to highlight barriers to access related to security constrains in certain context (e.g. violent searches, obstructions at checkpoints, etc.) Finally, KII and FGD will provide more detailed information on protection related issues such as gender and cultural norms, and possible barriers related to information or discrimination. Multi-cluster Interagency Rapid Assessments and Multi-Sectoral Needs Assessment provide further understanding on where people go to seek health services, and the proportion of people that delayed or not sought a health services and the reasons why. The latter includes possible barriers related not only to accessibility, but also availability, affordability and acceptability.

c. Affordability. Household surveys will provide information on health-related expenditures, the out-of-pocket payments, including where their expenditures were incurred and for which purpose. These should include indirect costs to access health services and costs for health-related commodities. Household surveys will also indicate priority needs and where health fits into the needs, and whether households are forgoing treatment to cover other basic needs. An income vs. expenditure survey can also be done using a national poverty line to determine the vulnerability of the household or community.

d. Acceptability. The Health Access and Utilization Surveys (HAUS) can be done at the household level. This survey is to

[9] Further guidance on assessment methods can be found in the Public Health Information Services Toolkit

monitor refugee access to and utilization of available health services. It could also include information on expenditures, care seeking behaviors, perception of quality of care, and reasons for deprioritizing treatment. Knowledge, Attitudes and Practices (KAP) surveys can also be used to identify knowledge gaps, cultural beliefs, and behavioral patterns that help understand needs, problems, and barriers to accessing health services. They help to understand information, attitudes, and factors that influence behavior. Socio-cultural barriers are often difficult to identify through household surveys, as respondents may not feel free to answer, or are part of the problem. KIIs and other methods are more suited to understand for example barriers related to gender, cultural and religious beliefs.

e. **Contact/utilization.** Because service utilization is also an outcome dependent on over-coming the barriers discussed above, the assessments related to availability, accessibility and acceptability, such as the KAP surveys and KIIs will also inform what the reasons may be for households not to use the service even when there are no others significant barriers. Health Information Management System data will indicate if and for which service utilization coverage falls below target thresholds.

f. **Effective coverage.** Tools for assessment of the effectiveness and quality of the services are mostly health facility based, or by tracing and interviewing patients that default and/or exit interviews following service provision. Health facility quality assessments can be used to also access the quality of health facilities, including testing mechanisms for timely referral. HMIS information will provide information on proportion of patients defaulting and/or lost to follow up.

6.2 Health & CVA indicators, linked with the assessment/ monitoring tools

Table 3 below outlines the different health indicators related to each barrier. The table also indicates which indicators can be influenced by CVA.[10]

Table 2: Barriers and assessment tools

Barrier	Health assessment tool/data source	CVA related assessment tools
Availability Coverage	• Public Health Situation Analysis (PHSA) • Health Resources Availability Monitoring System (HeRAMS) (including mapping of private/NNGO/FBO providers) • 4W (plus development partner support) • Surveillance System for Attackjs on Health care (SSA)[11] • Health system assessment	
Accessibility Coverage	• SSA • HeRAMS • Multi-Cluster/Sector Initial Rapid Assessment (MIRA) • Multi Sectoral Needs Assessment • Health needs in Negative Coping Index • Health facility quality assessment	• Basic Needs Assessment Surveys – this can identify the cause of barriers (triangulated with FGD and KII) • Household expenditure survey – with detailed questions for health – including health related expenditures and health seeking behavior • Negative coping index • Post distribution monitoring (PDM)– with specific questions on health • UN Feasibility Assessment Framework and Tool-kit – when considering CVA • Red Cross Movement Cash in Emergencies Tool-kit
Affordability	• Analyze health financing, assess what type of services people have to pay for in private/public providers, costs of health commodities, etc. • Household expenditure surveys • National Health Accounts • Multi Sectoral Needs Assessment	

[10] Further guidance on indicators can be found in the Public Health Information Services Toolkit

[11] Please be aware that the SSA may not function as an assessment tool in this sense – the SSA reports on incidents of attacks and will provide an indication of the volume and severity of attacks on health care in a given setting, and as such of the overall safety of health care services in the context. However, it does not report on the availability or functionality of specific facilities after an attack – it only captures the incident and its immediate consequences on HCW (deaths and injuries)

Barrier	Health assessment tool/data source	CVA related assessment tools
Acceptability Coverage	• Health Access and Utilization Survey (HAUS) • Health facility quality assessment • KAP surveys • FGD, KII • Multi Sectoral Needs Assessment	• Basic Needs Assessment Surveys – this can identify health seeking behavior (triangulated with FGD and KII) • UN Feasibility Assessment Framework and Tool-kit – when considering CVA
Contact/ Utilization Coverage	• HeRAMS • KAP surveys • FDG, KII • HMIS	• Post-distribution monitoring of cash and vouchers • Household expenditure survey[12]
Effective Coverage	• Patient exit interviews • Health facility quality assessment • HMIS • Default/LFU tracing and interviewing	• Post-distribution Monitoring – on the effectiveness of CVA to reduce the financial barriers

Table 3: Health and CVA indicators

Barrier	Examples of health indicators	Can these indicators be influenced by CVA?
Availability Are there health services available and of adequate capacity including equipment, materials and physical infrastructure.	• Average population per functioning health facility (HF), by type of HF and by administrative unit • % of population that can access primary healthcare within one hour's walk from dwellings • % of healthcare facilities that deliver essential package of health services • Proportion of health facilities with no stock-outs of essential medicines and supplies • Number of consultations per person per year • Proportion of health facilities that report capacity to provide bellwether procedures (caesarian delivery, laparotomy and treatment of open fracture) • Number of skilled birth attendant personnel (doctors, nurses, certified midwives) per 10,000 people • Number of community health workers per 500 people in rural and hard-to-reach locations	CVA can have indirect effect on supply side availability. When linked to performance of service providers, they have an incentive to meet increasing demand that results from CVA for health.
Accessibility Are services accessible - physical access - and safe and secure? This also includes gender, age, disability, and other relevant/ sensitive indicators that may be related to individuals and not necessarily households.	• Distance and/or travel time between the community and the health facilities • % of households that reported having been able to seek a health service when they needed to do so • % of patients seeking these services from qualified public providers (and/or supported by humanitarian partners) • % of households that reported seeking these services from private providers, drug-outlets, FBO, and/or traditional healers • % of households that reported that they did not use a health service when they needed to • % of households that report physical access as an obstacle to accessing health services (including transportation) • % of households that report lack of security and/or protection as an obstacle to accessing health services • % of households that report excessive security measures as an obstacle to accessing health services • % of households that report discrimination and/or exclusion as an obstacle to accessing health services • % of households that reported limited opening hours as an obstacle to accessing health services	CVA can improve accessibility by paying for transport. Multi-purpose cash can also cover the lost opportunity costs related to accessibility.

[12] Sample household expenditure survey from Somalia: https://www.calpnetwork.org/publication/somalia-household-expenditure-study/

Barrier	Examples of health indicators	Can these indicators be influenced by CVA?
Affordability Are services affordable	• % of households that report costs as an obstacle to accessing health services • % of income spent on health – disaggregated between direct and indirect costs, and health related commodities. • Percentage of HH expenditures on health[13] • % of HH with health expenditure that are more than 10% or 25% of total household expenditures (or more than 40% of non-food HH expenditures) • % of out-of-pocket payment for health of total health expenditure • Proportion of household that make obligatory pre-payment to health insurance • Proportion of households enrolled in a social protection program that includes health care coverage. • % of HH that had to sell assets, borrow money from family or take loans to pay for a health service • % households that prioritized other needs over health (delay or not seeking care when in need of a service).	CVA options can then address remaining direct and indirect costs, such as for transportation, and/ or the need for health commodities.
Acceptability Are services socio-culturally acceptable	• Proportion of households that report socio- cultural barriers to accessing health services • Proportion of households that report poor quality of services as reason not to seek services from Ministry of Health or NGO supported facilities. • Proportion of HH that report seeking services from other providers than Ministry of Health or those supported by humanitarian partners	When financial barriers are removed, CVA also has the potential to indirectly impact socio-cultural and gender barriers.
Contact coverage/ utilization Are services being used	• Percentage of deliveries assisted by a skilled birth attendant • Coverage of ANC and PNC • % of HH able to access a quality service when in need of such a service	CVA, through (soft) conditionalities has proven to have positive effect on utilisation of free preventive health services, and/or improve adherence to longer term services and reduce defaulting.
Effective Coverage Are people receiving services of adequate quality	• Proportion of HH that report having been able to use a health service when needed, from a qualified provider • Default rate/LFU for chronic treatment (malnutrition, NCD, HIV, TB) • Clinical record audit: % of consultations adhering to treatment protocols • Exit interview: proportion of patients able to tell correctly how to take treatment, and what health promotion activities were advised. • Referral testing: e.g. ability to refer to the next level of care within 1 hour.	These mostly require interventions addressing the supply side barriers, by improving the quality and safety of services, and for example timely referral mechanisms. On the demand side health promotion and people centred care can improve understanding of the illness and treatment, and thus compliance. CVA for health can also be seen as a form of performance-based financing. By linking the CVA to pre-selected qualified providers, contracts can require adherence to treatment protocols and quality standards.

[13] Disaggregated for level (primary vs secondary), type of provider (public, private, faith based or traditional), and direct or indirect (transport, accommodation and food for caretaker and patients, etc.), obligatory prepayment to health insurance (if this exists)

7.0 Monitoring indicators for implementing CVA modalities

The purpose of this section is to encourage health and cash practitioners alike to ensure the integration of both health-related indicators and CVA indicators for the respective project.

CaLP's Monitoring Guidance for CTP in Emergencies provides guidance and resources on CVA-specific monitoring requirements for CVA projects and how to incorporate these requirements in the respective monitoring framework. Among the resources within the guidance note are a range of tables which have compiled and categorised monitoring issues and indicators – for both outcome and outcome levels. In general, the cash community has agreed on a set of indicators when designing and implementing cash and or voucher programs.

During the design of any project – a monitoring plan would have to be designed as part of project management cycle – to measure different indicators. CVA for health projects are no different. The same monitoring frameworks should apply. But it is important that health indicators are incorporated into a CVA for health outcome activity – beyond the immediate output indicators but also whether or not health outcomes were improved. For this reason, cash and health actors will have to coordinate on the monitoring frameworks.

CaLP's Program Quality Toolbox, which has a set of common standards and actions for quality CVA, is a useful resource that has a section on CVA – related processes, activities and outputs. The tools within the toolbox are collected from humanitarian and non-humanitarian actors who have developed tools for the design and implementation of cash and voucher programs.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