Questions and Answers - Responses to posted questions raised in the CVA for Health themed Cash Hub Webinar held on the 21 October 2020 and those posted in the registration prior to the event.

Summary of question subjects:

Introduction to CVA for Health Outcomes & Health Costs

1) Cash programmes often give the same amount of assistance regardless of vulnerabilities such as age and disability, how should we make allowance for this in CVA and Health programmes?
2) What strategy and approach are you considering to reach an allowance for out-of-pocket payments in all contexts?
3) Regarding direct and indirect costs. How could we maintain a balance between the two, especially on the indirect cost which could at times exceed direct costs.
4) Based on your experience, how are costs and what kind are normally prioritized and covered in CVA Health Programs run within the Movement?
5) Could you give more information on the two key points about the supply side: 1) subsidized coverage 2) purchasing

Hellenic Red Cross – CVA for Health Programme

6) In terms selection criteria and people with disabilities, are you asking for an official disability health report provided by a registered hospital? If yes, are you looking for disability level like DHR percentage?
7) Any plans to assist the refugee population in camps in Greece [with CVA]?
8) What do we do if a beneficiary does not have any ID to get a medical report from the Public hospital?

DR Congo & Other ICRC Examples– CVA for Health

9) How long was cash assistance given, since some of the health care interventions described support to a range of people with differing health needs, such as combatant injuries or post-natal care?
10) Is the programme based on people already hospitalised or selected from communities or both?

General CVA questions

11) What are the monitoring tools available?
12) How to ensure the monitoring of CVA for quality assurance?
13) How to ensure the fair distribution of cash at household level in the context of gender inequality?
14) How can we support stateless people in conflict affected locations with CVA?
15) What are biometric systems in Cash assistance programming?
16) Have you encountered any localized inflation which is often associated with cash particularly in areas where markets are severely disrupted? If yes, any mitigation strategies that you would like to suggest?

Q	**Question (ed. for clarity)**	**Response**
	Introduction to CVA for Health Outcomes & Health Costs	
1	Cash programmes often give the same amount of assistance regardless of vulnerabilities such as age and disability, how should we make allowance for this in CVA and Health programmes?	**Mark James Johnson,** Health and Care Department, IFRC, Geneva Blanket targeting is often used, making CVA assistance a fast response option, especially in emergency situations. This is true also for other areas of work (such as in-kind assistance) in emergency settings. But as we move through the phases of an emergency, it is important that we are capturing an appropriate level of detail where we can identify those individuals with specific needs, allowing us to be more targeted and flexible in the support that we provide individuals. People living with disabilities is a good example as barriers to access to health services may not always be obvious and identifiable. Direct health care costs associated with living with a disability are perhaps easier to identify and assess if we're looking hard enough, but the question is whether we're also accounting for the indirect costs associated with their situation. For example, the main barrier to accessing health services for someone living with disabilities may in fact be due to the costs faced by the person's carer - costs associated with travel, accommodation and food which can be significant enough that the carer cannot afford to accompany that person and stay with them as they receive treatment, resulting in the person with disabilities not receiving care. So, whilst it's true cash can be fast, and that undoubtably remains a strength of CTP, cash can also bring flexibility when we combine it with assessment tools that are able to capture the varying levels of vulnerabilities that we find within communities. We can then, for example, provide top-ups to specific households which display certain vulnerabilities – such as those living with disabilities, or single mothers, the same as we would do with any other sector. However, over and above being more targeted with our cash interventions, using a combination of supply side interventions (such as service provision or targeted social care activities) and demand side support (in the form of CVA assistance), in most cases will remain as the most effective way to ensure the people we support - and especially those with specific needs - have access to sustained and quality health services.
2	What strategy and approach are you considering to reach an allowance for out-of-pocket payments in all contexts?	**Mark James Johnson,** Health and Care Department, IFRC, Geneva The default option in humanitarian contexts is that essential health services should be free at the point of delivery i.e. 'free of charge' in humanitarian settings. Undoubtedly this is a policy position we should continue to advocate for and work towards, but of course, the reality is that in many of the places where

		we work, 'free at the point of delivery' is not seen in practice. And in fact, in many situation, even if services are noted as 'free', at least on paper, we often still see from post-distribution monitoring that there are still both direct and indirect costs borne by the individual in the form of out-of-pocket payments. At the policy level, when WHO talk about a well-functioning health system and issues of equity and health financing, they always talk about reducing the reliance on out-of-pocket payments as a critical pre-requisite to reduce catastrophic health expenditures and households being pushed into various levels of poverty. Indeed, WHO recommends ensuring out-of-pocket payments make up less than 15% of total observed health expenditure to ensure an equitable health system for everyone. As presented within this webinar and shown in the introductory slides, the Health Cluster Cash Task Team's cash and health position paper offers a hierarchy of financing options which actors should use to reduce out-of-pocket payments and ensure everyone can access the health services they need. The paper proposes that the preferred way to achieve this outcome is to attempt to ensure universal coverage through supply-side interventions, for example, through pooling resources (through taxation) and/or having national health insurance schemes in place. If that is not (yet) possible, they propose that actors subsidise access to a package of services assured through contracts with service providers to ensure quality. These supply interventions are ideals to strive for and prioritise and certainly should be recognised in any overall strategy or approach that we take, but the reality is supply side interventions are not always available, or indeed where they are available, out-of-pocket payments can still persist, resulting in people not being able to access services. And so, as a result, the Health Cluster's paper recognises the role that CVA can play in combination with efforts to improve the coverage and equity of supply side interventions, as appropriate. Indeed, the evidence continues to develop on the role of CVA as a complimentary tool that can add value to help ensuring access to health services and promote equity, where gaps and inequalities persist. The Health Cluster's paper offers a useful strategy and approach to addressing out-of-pocket payments that we should look to adopt. **Jo Burton,** Cash and Markets Lead, ICRC Even if it is normal to pay for healthcare this is not something we are trying to encourage (as we don't necessarily want to propagate a poorly functioning system) and so reducing the reliance of health systems on out-of-pocket costs on the individual is important. Analysing how people spend money with PDMs is quite telling about the functioning of the healthcare system. For example, in Nigeria we analysed the expenditure of multipurpose cash given to cover basic

		needs and we noticed expenditure on immunization for children under 5, which we know in Nigeria it should be free. In this case, the PDMs results were telling us that people were spending money on something they shouldn't have to pay for so ICRC Health colleagues were able to follow up with the Ministry of Healthcare on this complex issue. Expenditure data can tell us something very interesting about the functioning of healthcare systems and people's priorities. For us to understand this in the first place we needed to have a detailed and nuanced understanding of what people spent money on.
3	Regarding direct and indirect costs. How could we maintain a balance between the two, especially on the indirect cost which could at times exceed direct costs.	Please see response above.
4	Based on your experience, how are costs and what kind are normally prioritized and covered in CVA Health Programs run within the Movement?	**Ansa Masaud Baloch Jørgensen,** Cash and Health Coordinator, Norwegian Red Cross Jo has already given some interesting discussion of this. Adding to this, whenever we support healthcare costs these should contribute to achieving health outcomes and remove financial barriers in this context. You can use CVA if this is this tool will support your programmatic objective. Within our interventions for example we use CVA to support healthcare, for example supporting indirect healthcare costs, which are often undertaken through unconditional cash transfers for expenditure such as transportation and accommodation related costs (if these pose a financial barrier to accessing health services). Another emerging theme within the Movement is supporting maternal healthcare costs such as the ones associated with consultations and visits, as well as with deliveries, through conditional grants to achieve specific health objectives. We are also witnessing nutrition related CVA support for example to support growth of children. You would often create categories and thresholds for supporting costs based on an in-country analysis of costs for healthcare systems.
5	Could you give more information on the two key points about the supply side: 1) subsidized coverage 2) purchasing	**Mark James Johnson,** Health and Care Department, IFRC, Geneva I would encourage you to consult the Health Cluster Cash Task Team's working paper on Cash Transfers Programming for Health in Humanitarian Contexts – it provides an excellent breakdown of both supply side and demand side interventions when we talk about using CTP to finance access to health services.
	Hellenic Red Cross – CVA for Health Programme	

6	In terms selection criteria and people with disabilities, are you asking for an official disability health report provided by a registered hospital? If yes, are you looking for disability level like DHR percentage?	**Sophia Peponi**, Director of Programmes Dept. Cash Transfer Programming (CTP) Coordinator at Hellenic Red Cross As part of the general practice, for each of the criteria HRC sets, we should receive a respective supporting document, which is evaluated during the selection process. A health condition is verified by a public hospital or a doctor of the public health system. As far as it concerns disabilities, the percentage should be above 65% and it comes from a special committee that evaluates the level of disability that a patient has. [Note: The "disability percentage" is an official tool intended to represent the extent of disability which also corresponds to different disability entitlements. The percentage is decided by statutory commissions within social security bodies on the basis of medical information for each individual case.]
7	Any plans to assist the refugee population in camps in Greece [with CVA]?	**Sophia Peponi**, Director of Programmes Dept. Cash Transfer Programming (CTP) Coordinator at Hellenic Red Cross Please find the Hellenic Red Cross (HRC) response to asylum seekers and refugees in camps and urban areas in the latest revision of the IFRC Population Movement Emergency Appeal here: https://www.ifrc.org/en/publications-and-reports/appeals/?ac=MDR65003&at=0&c=&co=&dt=1&f=&re=&t=&ti=&zo= appeal code: MDR65003, 8 Oct.2020. Cash assistance for asylum seekers and eligible refugees in Greece is part of the UNHCR "ESTIA" programme. IFRC Greece in cooperation with the HRC are implementing partners in North Greece. The programme is transiting to the Greek State in 2021.
8	What do we do if a beneficiary does not have any ID to get a medical report from the Public hospital?	**Sophia Peponi**, Director of Programmes Dept. Cash Transfer Programming (CTP) Coordinator at Hellenic Red Cross An identification document is necessary for the cash assistance. It is quite rare to see a beneficiary without an ID or another equivalent identification document (social security booklet or driving licence). However, as part of the general practice, in case the beneficiary has lost his/her documents and is eligible to receive the cash assistance, we provide the necessary information and support through the relevant HRC channels (social services, accompanied referrals, etc.) so that the person receives the necessary identification document through the Police (in case of a Greek citizen). Asylum seekers in particular, should also address to Police or the Reception and Identification Centers, however, this process is facilitated mainly by UNHCR only with provision of information on the process and the details of the respective Asylum Service offices.

		HRC also provides guidance on how the person can receive the necessary supporting documents to verify his/her health condition. Access to the public primary health care system is free for all vulnerable groups including asylum seekers, migrants and refugees, who do not have a National Insurance Number (AMKA), since 2007 by Greek Law (14 PD 220/2007). Until 2016, fully registered persons of concern needed an AMKA number to access secondary health care and also medicines, which if provided on prescription by a doctor working in a public health facility are free of charge (UNHCR, 2016c). In 2016, a new national law (Article 33 L 4368/2016) has extended free access to the public health system (primary and secondary) and pharmaceutical treatment to all persons of concern, regardless of whether they have an AMKA number (GCR, 2016)." See: Multi-purpose Cash and Sectoral Outcomes, Greece Case Study In addition to the above, the recent ministerial decision 717/2020, National Gazette 199/B/31-1-2020, introduces a unique number P.A.Y.P.A., and ensures access of applicants for international protection to health services, health care, social security and the labour market. The P.A.Y.P.A. number (Temporary Insurance, Health and Care Number of a Foreigner), is issued by the Asylum Service.
	DR Congo & Other ICRC Examples– CVA for Health	
9	How long was cash assistance given, since some of the health care interventions described support to a range of people with differing health needs, such as combatant injuries or post-natal care?	**Jan van Zoelen**, former Cash & Markets Specialist, DR Congo, ICRC The programme was designed to provide support for at least a month – the monthly Minimum Expenditure Basket for the average family was used. Nonetheless, dependent on the specific case, the assistance might last longer or a bit shorter. In case of the need for extra support, there are also longer-term programmes to which the beneficiaries could be referred, although their scope is not as wide, particularly in terms of geographical reach.
10	Is the programme based on people already hospitalised or selected from communities or both?	**Jan van Zoelen**, former Cash & Markets Specialist, DR Congo, ICRC The program is based on at-risk people already being supported by the ICRC in DRC. These persons could be weapon wounded patients being treated at ICRC-supported hospitals, beneficiaries from the ICRC-supported mental health programs, patients from the physical rehabilitation programme, as well as beneficiaries from Protection activities (e.g., restoring family links, detention, support to victims of sexual violence). The objective is to provide a more holistic support to existing ICRC beneficiaries, particularly to reduce risks trough short-term economic support.

	General CVA questions	
11	What are the monitoring tools available?	**Stefania Imperia**, Cash Hub, British Red Cross There are different tools that can be considered in monitoring a programme. For a full list of tools see the Cash in Emergency toolkit section:https://www.cash-hub.org/guidance-and-tools/cash-in-emergencies-toolkit/monitoring-and-evaluation
12	How to ensure the monitoring of CVA for quality assurance?	**Stefania Imperia**, Cash Hub, British Red Cross CVA "monitoring helps understand the community perception of the programme, and its effects on non-beneficiary groups. Cash transfers can affect and be affected by markets, or have multiplier effects on the local economy. Therefore market monitoring, particularly price monitoring, should happen regularly. Finally, CTP evaluation can take place at different stages of the programme, and can help understand whether the expected outputs, outcomes and objectives have been reached, so as to capitalize on learning". See: "Roadmap for CTP Monitoring and Evaluation" of the CiE Toolkit. For a full list of tools check the Cash in Emergency toolkit section: https://www.cash-hub.org/guidance-and-tools/cash-in-emergencies-toolkit/monitoring-and-evaluation
13	How to ensure the fair distribution of cash at household level in the context of gender inequality?	**Stefania Imperia**, Cash Hub, British Red Cross When designing cash assistance, it is important to take into account gender considerations at different levels: 1 Needs assessment and desk review, 2 Risk vulnerability and capacity analysis, 3 Eligibility criteria and targeting. For a list of detailed actions that can be taken read more on this UNHCR resource reporting on Key Considerations and Learning on Cash Assistance and Gender. Some other examples are reported in this resource of WFP on "The potential of cash-based interventions to promote gender equality and women's empowerment ": "i.e. The following observed actions supported equitable and empowering impacts: • undertaking comprehensive analyses and consultations on gender and related issues of protection, nutrition and livelihoods (Bangladesh); • piloting the CBI with a small caseload to identify impacts, such as related to control of and decision making on the CBT, transfer use, workload and time-use, mobility, saving, livelihoods etc. (Bangladesh, El Salvador, Jordan and Rwanda); and • collecting monitoring data at the individual level, and not solely household or institutional levels, and analysing it from a gender perspective (Bangladesh, El Salvador)."

14	How can we support stateless people in conflict affected locations with CVA?	**Jo Burton,** Cash and Markets Lead, ICRC The international legal definition of a stateless person is "a person who is not considered as a national by any State under the operation of its law". In simple terms, this means that a stateless person does not have a nationality of any country. Some people are born stateless, but others become stateless. Some stateless people are also refugees. However, not all refugees are stateless, and many people who are stateless have never crossed an international border. There are multiple challenges when working with these groups, but when it comes specifically to CVA, they key issue is that these people may be unable to access financial services in their location. To access many types of financial services, people require documentation to pass through the Know Your Customer (KYC) process, and this would be a barrier for many people without the requisite documents. Additionally, as soon as people cross borders – as refugees or migrants – documents that they do have may not be accepted with national financial service providers. However, this need not be a total barrier to using CVA. Firstly, whilst the (often digital) identities created by humanitarian organisations, enabling people to have access to their programmes, are not official legal identities, and as such may have limited use beyond their specified purpose, it may be possible to negotiate their use with the relevant authorities (such as in the case of UNHCR issued refugee ID cards which provide access to services beyond those provided by UNHCR, including sometimes financial services[1]). Secondly, humanitarian agencies could choose to provide direct cash or vouchers to recipients. [1] Available at: https://www.unhcr.org/registration-guidance/chapter5/documentation/ **Stefania Imperia**, Cash Hub, British Red Cross For a more detail on the ICRC Intervention Design Process see pag. 21 of the "Cash Transfer Programming in Armed Conflict: the ICRC's Experience". You can also consult the ICRC - Cash Transfer Programming (CTP) Standard Operating Procedures (SOPs) For more resources on Cash in Conflict visit this dedicate page on the Cash Hub platform: https://www.cash-hub.org/resources/cash-in-conflict For other programming tools visit the Guidance and Programming Tools page of the Cash Hub platform: https://www.cash-hub.org/guidance-and-tools/programme-guidance

15	What are biometric systems in Cash assistance programming?	**David Dalgado,** Cash Hub, British Red Cross For a number of years various humanitarian organisations have used biometrics (collecting data the individuals human characteristics such as finger prints, iris scans or photos) in registration processes to help ensure assistance is given to those selected for support. This can help reduce risks related to fraud, corruption and diversion of assistance. An interesting article on the issue can be found here: The Promise and Peril of Digital Identification for Aid Distribution
16	Have you encountered any localized inflation which is often associated with cash particularly in areas where markets are severely disrupted? If yes, any mitigation strategies that you would like to suggest?	**David Dalgado,** Cash Hub, British Red Cross Post-crisis there may often be a shortage of key commodities (and services) and this can lead to significant inflation of prices. The following is recommended: Market analysis and market mapping to understand why the price of a commodity or service has increased. Is it because there is very high demand or has there been disruption to the supply. For the mapping think about the steps the item takes to get from the producer (in the case of commodities) to the consumer to map out the chain. Where are the bottlenecks, is there something that the RCRC can do to support the recovery of the market. Using the Market Assessment, if it is clear that there is limited supply on the market for a particular item, it may not be appropriate to give CVA to support households to access that item until the market recovers. Can another modality be used in the short term and then switch to CVA once the market has recovered. Advocacy - I have seen RCRC national societies successfully advocate with local business chambers of commerce to ask them to not raise prices above pre-crisis levels (even when there is the potential to charge more because of demand). RCRC national societies have advocated with governments to remove import tariffs and taxes on items required post-crisis temporarily and this can also help reduce costs of essential items. Can the RCRC consider supporting vendors to come (perhaps through organising a market) to a particular affected area to try to increase supply. This can involve sometimes subsiding the vendors transport costs, but can also just involve organising a temporary market place on a particular day where a number of vendors will be present and advertising to the affected and local population. Can CVA be given to support affected people to travel further to other markets where supply is less impacted.

		Can households be encouraged to work together purchasing power so that they can better bargain with vendors for the same items and achieve a fairer price. There are a range of other mitigation measures that can be considered, however, it is recommended that a strong market assessment, analysis and mapping and a strong context analysis is undertaken to consider options.

All those interested in engaging with our work in the Movement Cash and Health Sub Working Group, and the upcoming workshop. Please contact David Dalgado on helpdesk@cash-hub.org who will connect you with the chair of the working group.