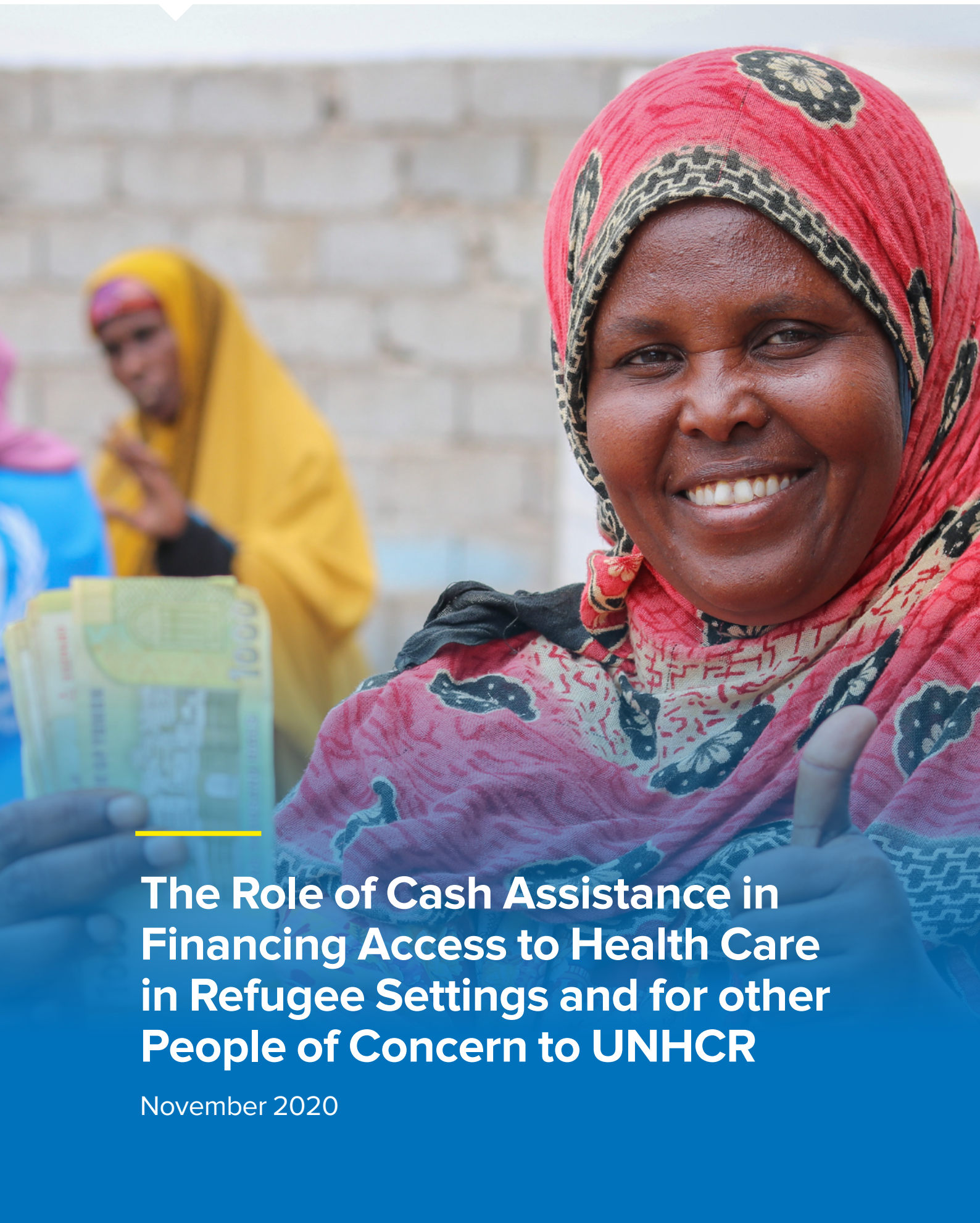




UNHCR
The UN Refugee Agency



The Role of Cash Assistance in Financing Access to Health Care in Refugee Settings and for other People of Concern to UNHCR

November 2020



This document provides guidance and key considerations on how cash assistance – along with in-kind and services - can be used to meet health needs in refugee settings and for other people of concern to UNHCR. It aims to facilitate discussions in UNHCR operations around the use of cash assistance to achieve health outcomes throughout the operations management cycle, from assessment and design to implementation and monitoring.

UNHCR promotes the goal of universal health coverage and facilitates access to health services to refugees and other people of concern (PoC) through a range of interventions and mechanisms.

UNHCR's policy on cash assistance¹ aims to expand and systematise the use of cash as a modality to support assistance and services when feasible.

1 UNHCR Policy on Cash-Based Interventions. 2016-2020. <https://www.unhcr.org/581363414>

KEY CONSIDERATIONS

- ▶ **Engage** public health officers in the multi-functional team when considering cash assistance to achieve health objectives.
- ▶ **Conduct** a health-specific assessment to identify dominant barriers to care including availability and acceptability of health services; access to services (including under what conditions); quality of services; and costs and payment conditions.
- ▶ **Consider** cash assistance as one of many complementary modalities to support access to health services. The selection of a modality must be based on solid analysis, understanding, and assessment of needs, context and operating environment, including a sound understanding of national health policies, the functioning of health services and the health seeking behaviour of the target population².
- ▶ **Apply** the following preconditions for the use of cash assistance in health programmes:
 1. Supply-side barriers (e.g. adequate quality and capacity of care) are addressed;
 2. A demand for the health service exists;
 3. Cost is a dominant barrier to access health care; and
 4. Other mechanisms to overcome cost barriers are not possible.
- ▶ **Refer** to standard cash feasibility assessment and response analysis for cash assistance and review the risks relating to services and protection.
- ▶ **Consider** the current level of welfare of households, their ability to meet basic needs and their expenditure patterns.
- ▶ **Be aware** that cash may increase access to, and utilization of, health services through reducing financial barriers and/or incentivising use of preventative services, but cannot remedy the lack of, or poorly functioning, health services.
- ▶ **Maximise** opportunities to integrate refugees/PoCs in the national public health systems in line with the Global Compact on Refugees.
- ▶ **Consider**, where possible, the enrolment of persons of concern in functioning national health insurance schemes.
- ▶ **Advocate** continuously with governments to eliminate and/ or lower user fees for vulnerable groups as essential health care should be free of charge or affordable.
- ▶ **Ensure** that any health providers pre-selected in a cash assistance intervention meet minimum standards of quality.
- ▶ **Be aware** that unconditional and unrestricted cash transfers are considered easier to set up with lower administrative costs than other cash assistance options, however for specific health needs, they may not be effective in ensuring equity and financial protection unless careful targeting of beneficiaries is done.
- ▶ **Conduct** careful targeting when using cash assistance for health outcomes, linking cash to a health need of an individual such as delivery or to households with predictable health care costs.
- ▶ **Establish** a structured monitoring plan, in addition to the regular post-distribution monitoring, to monitor the impact of cash assistance on health utilization and outcomes.

2 UNHCR Cash-Based Interventions for Health programmes in Refugee Setting – A Review. 2015 available at: <https://www.unhcr.org/568bce619.pdf>

-
- ▶ **Monitor** for any unintended consequences of the intervention, such as decreased capacity of health services due to over-demand or negative impacts on health.

BACKGROUND

UNHCR is mandated³ to enable refugees to maximize their health status by supporting them to achieve the same access to quality community, primary, and referral health services as nationals. The health sector is guided by the aims of universal health coverage as described by the World Health Organization:

All people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.

In line with the *Global Compact on Refugees*, integration of refugee health services into national public health systems, combined with sufficient support to those systems, is a priority wherever local capacity allows. However, the majority of refugees/PoCs live in low- and middle- income countries where national public health systems may be under-resourced and over-burdened, making the ambition of integration and universal health coverage challenging. Therefore, depending on both the context and where refugees/PoCs are located, ensuring access to health services may require multiple modalities of financing and service delivery support by UNHCR.

Cash assistance refers to the provision of cash to individuals, household or community recipients; not to governments or other state actors. Over the past years, cash assistance has gained increasing traction as a modality to assist people in need, since the beginning of its cash institutionalisation in 2016, UNHCR has delivered some USD 2.8 billion to 20 million people in more than 95 countries to help them meet basic needs, address protection needs and enhance opportunities for solutions.

Taking account of opportunities and challenges of cash assistance in the health sector, this document provides a general overview of health financing mechanisms and the specific role cash assistance can play in financing access to health services in refugee settings and for other PoC to UNHCR.

UNHCR country operations need to consult with their public health staff at country level and/or in the regional bureaux before initiating cash assistance to achieve health outcomes.

3 UNHCR Mandate of the High Commissioner of Refugees and his office - Executive Summary. Available at: <https://www.unhcr.org/5a1b53607.pdf>

UNHCR Support to Health Services

Ensuring access to essential health services for refugees/PoCs requires a range of interventions, with much of the focus on supporting **availability and quality of the respective health services and increasing demand for services** (see Table 1). **UNHCR sees in-kind, services and cash as complementary in delivering sectoral outcomes.**⁴

Table 1: Response options for improving access to, and quality of, health services

Context	Response
Absent or dysfunctional national health services in refugee/PoC sites (for example during emergency phase or in remote sites/camps).	<ul style="list-style-type: none"> ▶ Establishment of primary health services, through a project partnership agreement with an implementing (UNHCR-funded) or operational (self-funded) NGO, Red Cross/Red Crescent partner or government partner ▶ Improving access to health services through community health activities and other outreach modalities ▶ Support the Ministry of Health to improve the quality and expand coverage
Fragile national health services that are not able to fully meet the needs of the host population and refugees/PoCs.	<ul style="list-style-type: none"> ▶ Refugee/PoC health services should be linked and integrated into national health structures whenever feasible. ▶ Additional support is provided from project partnership agreements or other arrangements such as country-level letters of understanding through accredited national and/or international health NGOs, or the Red Cross/Red Crescent ▶ UNHCR may provide financial, material and/or technical support to improve the quality and capacity of MoH health facilities (infrastructure, medicines, medical supplies, equipment support, health workforce support including additional staff and staff training)
National health services of sufficient quality are available, but refugees/PoC cannot access them at all or in part due to legal, administrative, or financial barriers.	<ul style="list-style-type: none"> ▶ Facilitate access to existing national health services through negotiated agreements with the Ministry of Health, and/or subsidised care for relevant refugees/POCs through various financial mechanisms. ▶ Advocacy to reduce or waive user fees and/or include refugees/PoCs in national health insurance schemes ▶ Cash assistance to address identified and relevant financial barriers
Refugees/PoCs have access to the national health system, however only limited free services are offered (e.g. primary care, immunization, TB and HIV).	<ul style="list-style-type: none"> ▶ UNHCR and/or other partners support access to services not covered under the national health system such as: referral to secondary or tertiary health facilities; Mental Health and Psychosocial Support services (MHPSS); clinical management of rape and intimate partner violence; preventive health services such as contraception and cervical cancer screening; rehabilitative and palliative care services, etc. ▶ Cash assistance may be considered as one modality to facilitate access if other conditions are met

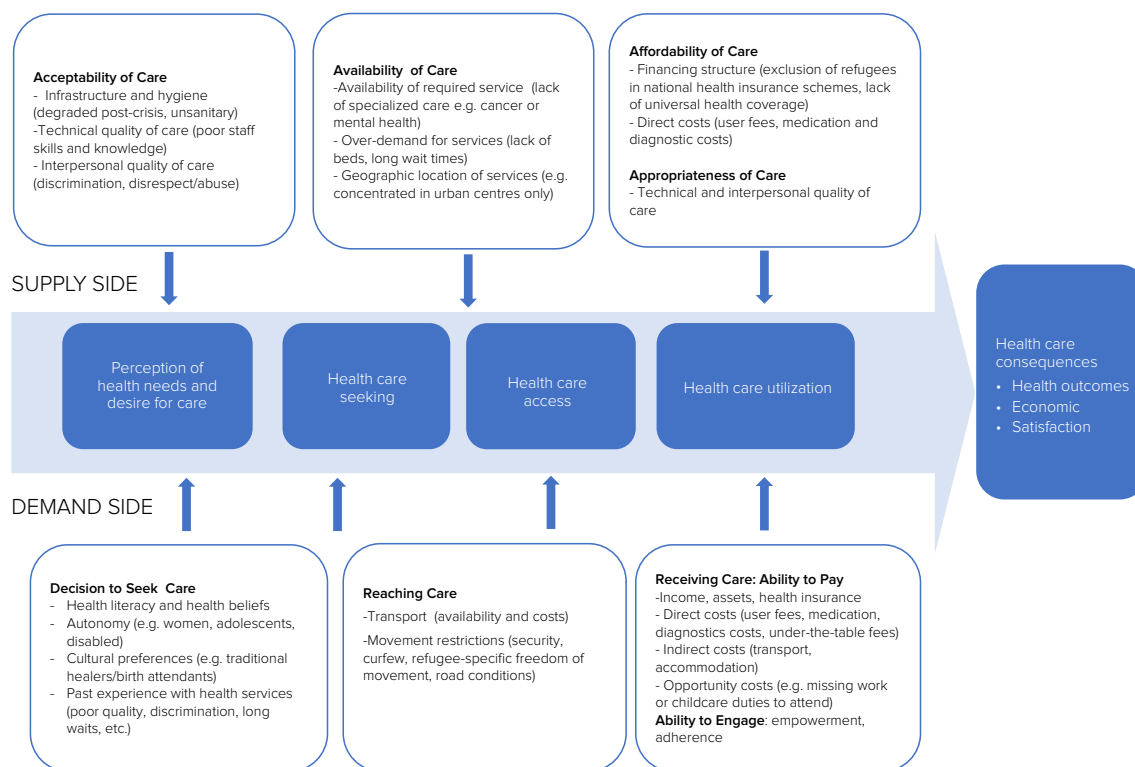
4 Harvey P and Pavenello S. 2018. Multipurpose Cash and Sectoral Outcomes: A review of Evidence and Learning. UNHCR. Available at <https://www.unhcr.org/5b28c4157.pdf>

Using cash assistance for health should be based on a sound understanding of national health policies and systems and the functioning of health services used by beneficiaries. In addition, understanding the health seeking behaviour of the target population is fundamental in defining whether cash assistance may present suitable options and how to ensure access and/or fostering health seeking behaviour.

A health-specific assessment, involving relevant public health expertise, is necessary, to identify dominant barriers to health care including availability of services; access to services (including under what conditions); quality of services available at health facilities; and costs and payment conditions. Secondary data should be used whenever available and reliable.

Figure 1 outlines factors that contribute to health care utilization and common barriers in refugee contexts and for other persons of concern to UNHCR.

Figure 1: Health service utilization and common barriers⁵



In determining whether cash assistance may present a suitable option for health programmes, a standard cash feasibility assessment ([Cash Feasibility and Response Analysis](#)) is required.

The following should be considered when assessing a role for cash assistance to meet health outcomes.

⁵ Figure 1 adapted from Levesque, Jean-Frederic & Harris, Mark & Russell, Grant. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International journal for equity in health*. 12. 18. 10.1186/1475-9276-12-18.

Supply-side considerations:

- ▶ The availability and scope of national health services, the extent of progress towards universal health coverage and the level of integration of refugees/PoCs into national health systems, including national health insurance schemes.
- ▶ The costs for essential services, including both direct (user fees) and indirect costs (e.g. transport), and national financing policies.
- ▶ The availability of essential health services of sufficient capacity and quality of care including respectful and non-discriminatory care. The capacity of existing services and their ability to absorb an increase in patient load that may result from initiatives to increase access for beneficiaries.
- ▶ The key health utilization and health outcome indicators. What specific services are under-utilised based on indicator data? What are leading causes of morbidity and mortality that need further resources to address?

Demand-side considerations:

- ▶ The health-seeking behaviours of the target population. The lower the demand for health services among a target group the less effective cash assistance alone is likely to be at achieving desired health seeking behaviour by recipients.
- ▶ Current levels of welfare. The more challenges persons of concern face in meeting their basic needs such as food and shelter, the higher the tension between meeting these and prioritising health needs.
- ▶ Intra-household patterns of expenditure and who in the household is responsible for decision-making on health expenditure. Low prioritisation of expenditure on women and children or people with disabilities/ people with chronic mental health conditions can negatively impact programme success when cash is not conditional to a specific health-related action or accompanied with measures related to behaviour change. This understanding can help inform the complementary activities (e.g. empowerment and advocacy, community mobilization, health promotion, etc.) that need to be conducted as part of the cash assistance.
- ▶ Other barriers to care such as cultural beliefs and practices (e.g. preference for traditional healers) and context-specific barriers such as refugee/PoC-specific movement restrictions or restrictions due to insecurity that will not be solved with cash assistance.

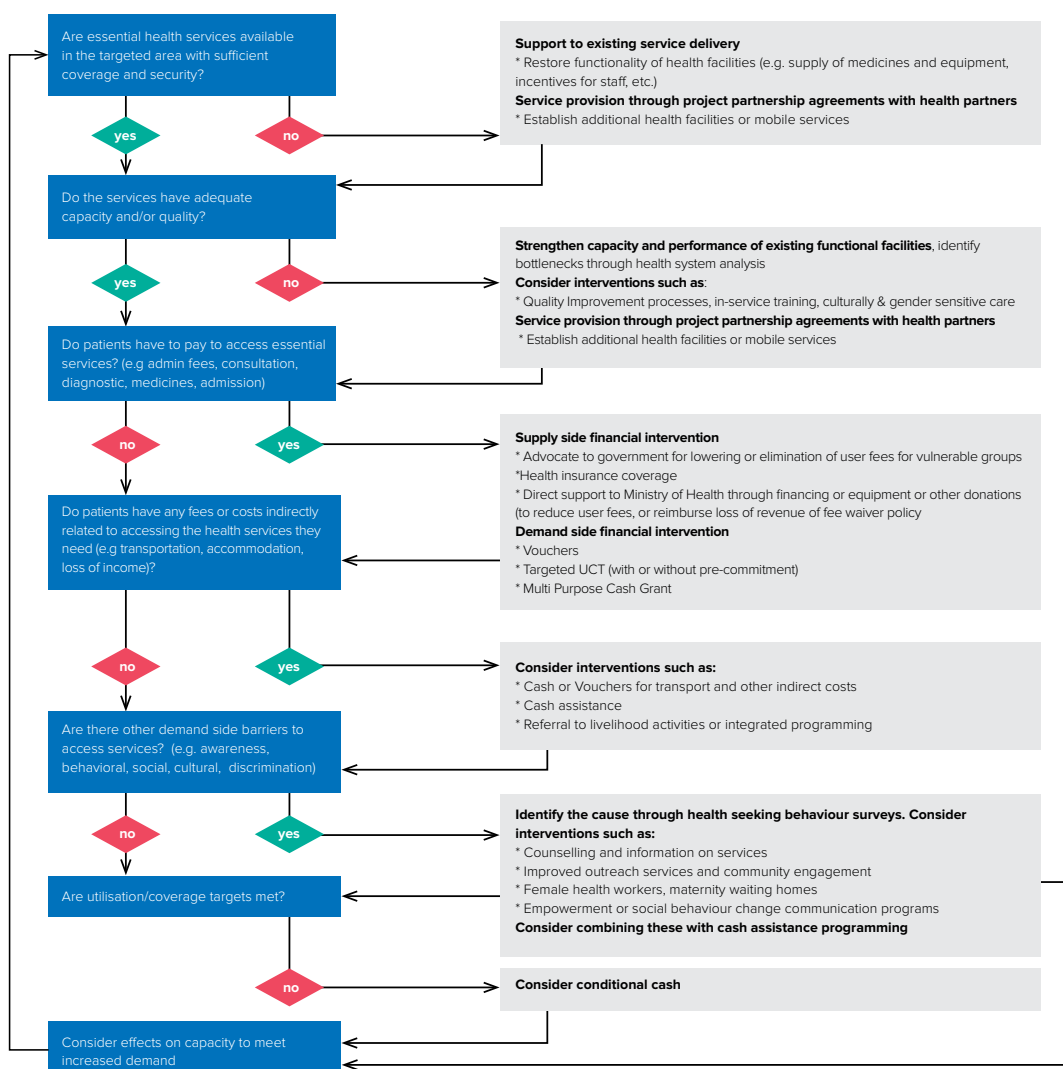
PLANNING AND DESIGN

If cash assistance is selected as modality, the type of cash assistance to use should be determined. Cash assistance for health may fall into two broad categories:

- ▶ As one component of a multisectoral **Multipurpose Cash Grant (MPG)**, which is dependent upon the calculation of the **Minimum Expenditure Basket (MEB)** (including health-specific considerations); and/or
- ▶ As part of a sector-specific response to meet specific health objectives. Health sector specific cash assistance strategies may take many forms (conditional/unconditional, restricted/unrestricted).

A flow chart on the appropriateness of cash for health based on contextual indicators may help guide decision-making (Figure 2).

Figure 2: Decision Algorithm for Use of Cash Assistance in Health⁶



6 Adapted from: Global Health Cluster and WHO Cash Task Team (2018). Working paper for considering cash transfer programming for health in humanitarian contexts. Available at <https://www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf>

Cash assistance to meet health outcomes should consider the following programme design factors:

- ▶ Amount of the cash transfer
- ▶ Design and enforcement of any conditions or restrictions (see below)
- ▶ Duration and sustainability of the programme
- ▶ Correct targeting of beneficiaries
- ▶ Method of providing cash (e.g. direct deposit)
- ▶ Monitoring and evaluation plan

Not all types of health services are appropriate for cash assistance.

Figure 3 (see end of document) provides a guide to which types of health services are best suited (based on available evidence) for a cash-based assistance approach.

UNHCR Resources:

- ▶ [Cash-based Interventions for Health Programmes in Refugee Settings. A Review.](#)
- ▶ [Cash for Health: Key learnings from a cash for health intervention in Jordan.](#)
- ▶ [Cash Based Interventions: Key Documents, Tools and Guidance.](#)

Supply- and Demand-Side Response Options

In low-income contexts if cash assistance is to be provided to achieve health outcomes it should be implemented along with other means of support to health services. Synergies between cash for health programmes, health insurance schemes and efforts to reduce or waive fees, as well as efforts to improve the acceptability of the services (both technical and interpersonal quality of care) should be considered as a key part of health initiatives and better integrating refugee/PoCs health care into national systems. These aspects are outlined further below.

Supply-side options

1. Addressing User Fees

In humanitarian settings, essential health services should be available free of charge at the point of delivery. Where health services are available at sufficient quality and quantity, but user fees are in place and represent a significant barrier to access, **provider payment methods**⁷ are preferred above cash assistance options. Options may include advocacy to government to lower or eliminate user fees for vulnerable groups, or if this is not successful, direct payment of user fees by UNHCR or via health partners.

2. Access to Health Insurance

To support universal health coverage goals of the 2030 Agenda, several governments are supporting access to an essential health package through health insurance. With health insurance the enrollees pay a set premium whether they use the services or not, thus pooling the risk. Access to national health insurance schemes may be linked to employment or premiums may be waived or highly subsidised for vulnerable individuals as part of social health protection.

UNHCR, in partnership with ILO explores related possibilities in different refugee contexts and with other forcibly displaced populations.⁸ Over the years UNHCR has developed experience in enabling refugees/PoCs to access national health insurance and to enrol in voluntary health insurance schemes. To ensure the payment of premiums, different options are being used or can be considered:

1. Refugees/PoCs contribute themselves directly
2. UNHCR or partner directly pays the health insurance scheme for the most socio-economically vulnerable or,
3. UNHCR or partner provides cash to socio-economically vulnerable refugees/PoCs to ensure that they can pay the premium (this can be included in the MPGs or can be provided as a sectoral top-up or sectoral cash transfer separate from an MPG)

For more information see: [Handbook on social health protection for refugees: Approaches, lessons learned and practical tools \(ILO/UNHCR\)](#)

3. Contracting Providers for Essential Health Services

Where priority health services cannot be fulfilled through national health systems in sufficient quantity or quality, UNHCR may choose to contract NGO or Red Cross/ Red Crescent service providers through project partnership agreements, to work within existing health structures, or as new stand-alone services. This increased capacity often contributes to improved quality of care.

7 See above definition. Additional information available at: Provider payment methods and UHC Technical brief strategic purchasing for UHC. 2017. https://apps.who.int/iris/bitstream/handle/10665/258894/provider_payment_methods_fr_uhc.pdf?sequence=1&isAllowed=y

8 ILO-UNHCR Partnership (2019). Joint Action for decent work and long term solutions for refugees and other forcibly displaced persons. Available at: https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/publication/wcms_732371.pdf

Definitions

Multipurpose Cash Grants (MPGs): MPGs refer to regular or one-off cash transfers to a household to cover, fully or partially, a set of basic and/or recovery needs that span across different sectors (for instance shelter, food, education and livelihoods) and support protection and solutions outcomes. MPGs are unrestricted cash transfers which place beneficiary choice and prioritisation of their own needs at the centre of programming. They are designed to offer refugees and other persons of concern the maximum degree of flexibility, dignity and efficiency commensurate with their diverse needs and capacities.

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

Sector-Specific Intervention refers to an intervention designed to achieve sector-specific objectives. Sector-specific assistance can be provided as in-kind, cash and/or vouchers. Assistance can be conditional or unconditional. Conditionalities might be used to limit expenditure to items and services contributing to achieve specific sectoral objectives. Cash assistance used to achieve sector specific objectives may be labelled and designed to influence how recipients spend them.

Conditionality: Conditionality refers to prerequisite activities or obligations that a recipient must fulfil in order to receive assistance. Conditions can in principle be used with any kind of transfer (cash, vouchers, in-kind, service delivery) depending on the intervention design and objectives. Some interventions might require recipients to achieve agreed outputs as a condition of receiving subsequent tranches.

Restrictions (restricted/unrestricted cash transfers) refers to what a transfer can be spent on after the beneficiary receives it.

Provider payment methods: Refer to the way in which purchasers transfer funds to health provider institutions to deliver agreed services

See **Cash Learning Partnership** for further definitions.

Demand-Side Options

Unconditional and Unrestricted Cash Assistance

Ninety-five percent of UNHCR cash assistance is provided as unconditional and unrestricted cash to provide refugees and others of concern with the choice on how to take care of their own needs.

Two main options are used:

1. Multipurpose cash grants

MPGs are unrestricted and unconditional transfers (either periodic or one-off) corresponding to the amount of money required to cover, fully or partially, a household's basic and/or recovery needs. MPG transfer values are often indexed to expenditure gaps based on a Minimum Expenditure Basket. Evidence collected through post-distribution monitoring and research shows that a significant part of MPGs for basic needs is spent on health care related costs, such as transport to and from health facilities, over-the counter medicines and user fees, etc. This reality should be taken into account in the calculation of the Minimum Expenditure Basket (MEB) and corresponding grant size calculation; a public health officer should be involved to identify expenses that can be considered relevant to achieving positive health outcomes and to advise on alternative interventions to reduce such out of pocket household expenditures for health, particularly if more than 10% of total expenses.

Of forms of cash assistance MPGs are considered the easiest to set up with lower administrative costs. However, used alone they are not sufficient to achieve health outcomes or in promoting health equity, nor for protecting from catastrophic expenditures. If post-distribution monitoring shows significant money was spent on health (>10%), this may indicate that the MPG supported access to health services, but does not mean that this is the optimal modality to meet health needs. Instead, a sound response analysis will determine *why people are needing to pay for health services and subsequently design interventions to address this*.⁹ This may or may not include cash assistance, along with other measures such as investments in services. MPGs may provide temporary support, but more targeted support may be required in the form of sectoral grants (see above and below and Figure 3), particularly when there are ongoing health needs that can be costed (e.g. chronic conditions, pregnancy-related health care for uncomplicated pregnancies). Consider conducting a Health Access and Utilization Survey to better understand the health expenditures.¹⁰

2. Sector-specific unconditional and unrestricted cash assistance

In order to promote equity with unrestricted and unconditional cash assistance, it is important to ensure careful targeting of beneficiaries based on health care needs. Health care needs which particularly lend themselves to cash assistance are those which are known in advance (non-acute) and can be costed (e.g. pregnancy-related costs or chronic disease management). As well, a minimum threshold of income to meet basic needs is required before unrestricted, unconditional cash is introduced to meet sectoral needs, otherwise the grant may be diverted to meet these basic needs. In the case of *unrestricted* cash assistance, there is a risk that the recipient uses the funds on substandard or ineffective service providers or medicines. To address this risk, it is important to ensure quality providers and/or services are pre-selected and recommended to cash recipients.¹¹

9 UNHCR. Multi-Purpose Cash and Sectoral Outcomes: a Review of Evidence and Learning (2018) <https://www.unhcr.org/5b28c4157.pdf>

10 <https://data2.unhcr.org/en/documents/details/67944>

11 Global Health Cluster and WHO Cash Task Team (2018). Working paper for considering cash transfer programming for health in humanitarian contexts. Available at: <https://www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf?ua=1>

Other health sector specific cash grants

1. Conditional Cash Assistance

The provision of cash assistance may be **conditioned** on the use of particular health services, generally with the intention to introduce a behavioural change. In development contexts, unambiguous evidence shows that conditional cash increases the **utilisation** of health services, particularly preventative services. Whether increased utilisation directly translates into improved health status depends on the **quality** of the health services that the target recipients can access¹² including whether the facilities can cope with the increased demand, as well as if the patient is able to comply with the prescribed health action. If lack of utilization is found to be due to non-cash barriers in the response analysis, the provision of cash alone will not increase utilisation. Sustainability of behaviour change beyond the cash assistance is variable, and therefore conditional cash is best paired with other health promotion activities. It is not known if conditional cash assistance increases uptake when user fees are charged. **Note that conditionality of cash assistance has significant administrative costs due to the need to monitor adherence to the condition.**

*There is evidence that cash for health programmes can be more effective with complementary activities/programmes to change attitudes and behaviour. For example, programmes aiming at supporting adolescent well-being have been effectively complemented by adolescent empowerment programmes (e.g. life skills teaching on sexual and reproductive health, economic literacy and micro-finance) and by community mobilization programmes, targeting the wider community with communications and spaces for dialogue to shift social norms. For example see **UN Women's Policy Brief 12***

2. Vouchers

Vouchers are entitlements that can be exchanged for specific goods or services. Vouchers are restricted by default since they are inherently limited to where and how they can be used. Vouchers may be issued for use for health commodities (e.g. long-lasting insecticide treated mosquito nets) or services (e.g. obstetric care for delivery) and may be used to cover indirect costs such as transport. Vouchers may improve equity if targeted to those with a health need; may be used to pay indirect costs; and may assure quality of services and medicines if designated providers are chosen with quality in mind. They may protect against catastrophic expenditure if linked to referral or patients with recurrent health needs. Note that vouchers are costly to set up and manage and will not reduce reliance on user fees if present. UNHCR hence recommends the use of vouchers only as the last resort.

Cash assistance for Referrals: Special cash assistance provided to refugees/PoCs to access referral health services (including secondary and tertiary care) must be provided in line with referral guidelines and after consultation with UNHCR's public health staff in-country or in the regional bureaux. Cash should not be provided to circumvent referral guidelines.

12 Gaarder M, Glassman A, and Todd J (2010). Conditional cash transfers and health: unpacking the causal chain. Journal of Development Effectiveness (2:1), available at <http://www.pegnetifw-kielde/members/gaarder.pdf>

MONITORING

A structured monitoring plan must be in place to monitor the impacts on health utilization and outcomes as well as to identify any unintended consequences of the intervention. The monitoring plan should include process, output, and outcome indicators in line with UNHCR's cash based intervention [Post Distribution Monitoring toolkit](#) and the [Indicator Framework](#).

In addition, health-specific considerations should be included in monitoring:

- ▶ Health Access and Utilisation surveys may be conducted by telephone to determine access, utilisation, expenditures and barriers to care.
- ▶ Periodic random telephone calls can be conducted to a sample of recipients of cash assistance to achieve health outcomes to determine whether the cash was used for the intended purpose, utilisation of services, whether care was received by the pre-selected or recommended health provider, whether the cash received covered all costs, and satisfaction with care.
- ▶ Monitor for intended and unintended impacts, positive and negative, on both recipients and host community. Non-participants should also be monitored (e.g. to ensure they are not losing access due to overcrowding).
- ▶ Keep in mind that health service utilization and outcomes are influenced by numerous factors therefore it can be difficult to attribute changes to any one intervention.
- ▶ Assessment on impacts on quality of care of health services should be included in the monitoring plan including the impact on waiting times, interruptions to medicines stocks and bed occupancy.
- ▶ Note that increased access cannot alone improve health, but rather impact will depend on the quality of services provided and whether participants understand and comply with treatments received.
- ▶ Inclusion of refugees/PoCs in national surveys such as Demographic and Health Surveys or MICS is a stated objective of UNHCR, but these are too infrequent to specifically monitor the impacts of cash on health outcomes
- ▶ Disaggregated data from national health information systems and vital registration systems may also provide information on access and outcomes

The following table is a non-exhaustive list of the types of health services that may or may not benefit from cash assistance to facilitate access. This is based on available evidence and experience within UNHCR's operations. **However, this does not negate the need for a context specific response analysis** and does not necessarily endorse or reject cash assistance as the preferred option for these services.

Figure 3: Health activities and cash assistance programmes

	<ul style="list-style-type: none"> ▶ Cash assistance possible, discuss considerations with Public Health Officers ▶ More evidence-based research needed to categorize as green or red; inconclusive or mixed evidence; or caution required ▶ Not compatible with cash-based interventions
Primary health care	<ul style="list-style-type: none"> ▶ Preventive primary health care services for children under five (immunization, deworming, Vitamin A supplementation, screening for malnutrition) ▶ Curative primary health care services (treatment of acute conditions, acute injury management, and exacerbations of chronic conditions or unstable chronic conditions) ▶ Management of stable chronic medical conditions such as diabetes, hypertension and ischaemic heart disease ▶ Long lasting insecticide treated nets ▶ Support to those on TB treatment
Secondary health care	<ul style="list-style-type: none"> ▶ Referrals for management of acute medical or surgical conditions (unless reimbursement) ▶ Referrals for elective or predictable, recurring health service utilisation ▶ Transport costs for referral when use is predictable
Maternal & newborn care	<ul style="list-style-type: none"> ▶ Delivery services, antenatal and postnatal care ▶ Comprehensive Emergency Obstetric Care (incl. caesarean and blood transfusion)
Other sexual and reproductive health services	<ul style="list-style-type: none"> ▶ Family planning counselling and provision of contraceptives ▶ GBV prevention and treatment ▶ Cash payments to adolescent girls to promote attendance in school and reduce HIV risk, early marriage and early pregnancy ▶ STI and HIV transmission prevention and treatment
HIV prevention and treatment	<ul style="list-style-type: none"> ▶ Voluntary Medical Male Circumcision (VMMC) ▶ Prevention packages in key populations ▶ Male and female condom provision ▶ Support to HIV testing and /or antiretroviral treatment
Mental Health	<ul style="list-style-type: none"> ▶ Delivery of mental health services within general care ▶ Improving treatment adherence for chronic mental disorders
Health Insurance	<ul style="list-style-type: none"> ▶ Health insurance premiums

Summary of evidence: [here](#)

