Case study: Cash transfers in the health and nutrition sector.

Cash transfers for transport to health centres and malnutrition treatment centres

© WFP - Marwa Awad, illustrative photo, November 2019

Help
Hilfe zur Selbsthilfe

Financé par la protection civile et l'aide humanitaire de l'Union européenne

NOR CAP
NORWEGIAN CAPACITY

HEALTH CLUSTER

CaLP
The Cash Learning Partnership

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Preface

This case study has been produced as part of a project to document experiences of cash transfers in the area of health, financed by the Swiss Agency for Development and Cooperation (SDC) and supported by the Cash Learning Partnership (CaLP), CashCap/NORCAP and the Cash Task Team (CTT) in the Global Health Cluster. Several case studies will be produced to illustrate different uses of cash transfers for health in various contexts.

The idea for this project arose from the observation that there is a lack of documentation about the use of cash transfers (CTs) in emergency responses related to health. However, the lack of documentation does not mean an absence of experience and a growing number of health actors are using emergency cash transfers even if the transfers are not called cash transfers.

With the Ebola and the Covid-19 pandemics, the humanitarian community's interest in the use of cash and vouchers assistance (CVA) in the field of health has increased considerably and there has been a proliferation of research projects in the last five years that aim to make up for the lack of documentation on the benefits of CVA in this field.

The objective of this case study is to present the experience of the ONG HELP in Burk na Faso from an operational perspective, presenting the logic of the project, its successes and challenges, as well as its shortcomings and the lessons that have been learned by the project team.

Through the series of case studies being produced by CaLP, the Cash Task Team of the Health Cluster and SDC, the aim is to encourage health actors to share their experiences, facilitate peer learning and begin a dialogue on "how" rather than "if" or "why" cash transfers can be used in humanitarian health projects.

Acknowledgements

The author of these case studies would like to thank HELP and, in particular, Kristina Rauland-Yambré (Country Director), Dr Frida Bonou-zin (Health and Nutrition Coordinator), Dr Noufou Zidwemba (Nutrition Focal Point), Arsène Ouédraogo (Project Lead), Lassina Millogo (Clinical Nutrition Care Supervisor), Mahamadi Kientega (Clinical Nutrition Care Officer) and Youmanli Lompi (Community Care Supervisor) for their willingness to share their experiences, their transparency about the challenges encountered and their collaboration in the drafting of this document. Thanks also to Dr Jerry Masuidi (NORCAP-WHO Burkina Faso), who helped identify the case studies for Burkina Faso and raise interest in cash transfers among health actors in the country.

Lastly, the author would like to thank the Cash Task Team of the Health Cluster, CaLP, CashCap and SDC for their support, their patience and their valuable advice that helped with the writing of this case study. It is thanks to their commitment to advancing knowledge on how CVA can contribute to health outcomes that this case study has come into being.

Contents

Tables and graphics

Acronyms and Abbreviations

CaLP	Cash Learning Partnership
CAMEG	Central Procurement Agency for Essential Generic Drugs and Medical Consumables (Centrale d'achat des médicaments essentiels génériques et des consommables médicaux)
CBHW	Community-based health worker
CRENI	Intensive Nutritional Recovery and Education Centre (Centre de Récupération et d'Éducation Nutritionnelle Intensive)
CT	Cash transfer
CTT-GHC	Cash Task Team - Global Health Cluster
ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
CVA	Cash and Voucher Assistance
HELP	Hilfe zur Selbsthilfe
HD	Health district
HSPC	Health and Social Promotion Centre
HW	Health worker
IMAM	Integrated management of acute malnutrition
IMCI	Integrated management of childhood illness
MAM	Moderate acute malnutrition
NGO	Non-governmental organisation
NHDP	National Health Development Plan
PNW	Pregnant and nursing women
RHA	Regional health authority
SA:	Severe acute malnutrition
SDC	Swiss Agency for Development and Cooperation (Agence Suisse pour le Développement et la Coopération)
SQUEAC	Semi-quantitative evaluation of access and coverage
WHO	World Health Organization

Summary

Since 2015, Burkina Faso has been facing a humanitarian and security crisis of unprecedented scale. Already affected by chronic food and nutrition insecurity, the country has now witnessed security incidents that have led to the internal placement of some 900,000 people and have affected 1.3 million families in the host communities.[1] Public services and infrastructure have been seriously impacted and are now operating at a minimal capacity or have been closed. Sahel is one of the regions of Burkina Faso that has been hardest hit and has a global acute malnutrition (GAM) rate of 12.8%,[2] which is well above the alert threshold of 10% set by WHO.

The NGO HELP (Hilfe zur Selbsthilfe) has been active in Burkina Faso's Sahel region since 2008 and has successfully carried out interventions to strengthen the health system and fight malnutrition. In 2018, HELP obtained funding from ECHO for a project to fight acute malnutrition in Sebba health district. Within the framework of that project, HELP introduced cash transfers to pay the costs of transporting children suffering from severe acute malnutrition to the Intensive Nutritional Recovery and Education Centre (CRENI) in Sebba.

> With the experience gained from this project, I see that cash is really under-used in the field of health
>
> **Arsène L Ouédraogo, Project Lead**

The idea of including "money for transport" is based on the observation that despite the policy of free care for children under the age of five, the cost of crossing the seasonal lakes during the rainy season constituted a considerable financial obstacle for poor households and discouraged them from promptly attending the CRENI.

The chosen transfer modality consisted of a conditional and unrestricted cash transfer of FCFA 5000 (approximately €7.60), the price of a return trip by canoe. To encourage parents to stay until the end of their child's treatment, beneficiaries only received the money at the end of their time at the CRENI. This cash-based intervention was part of a wider range of activities aimed at strengthening the health system, community mobilisation and nutrition surveillance to combat child malnutrition.

Although it is difficult to evaluate which effects are attributable solely to the "money for transport" component of a health and nutrition project, positive results were observed with quicker treatment of cases of SAM, an increase in CRENI attendance (up 50%) and a reduction in the mortality rate for cases of SAM during the cash distribution period compared with 2018 (down 23.7%).

However, there were numerous challenges, particularly in setting up and monitoring this pilot activity. The project team also learned a number of lessons, for instance about the importance of good coordination between the community dimension and the medical dimension, to optimise the impact of the cash transfer.

1 UNOCHA. (2020). *Burkina Faso Humanitarian Needs Overview.*
2 Nutrition Cluster, Nutrition Information Bulletin No. 1, March 2020.

01. Introduction

Burkina Faso is a landlocked country whose economy is based primarily on agriculture and livestock farming. Despite average economic growth of 6% between 2000 and 2016,[3] the Human Development Index (HDI) for Burkina Faso is one of the lowest in the world, ranking the country 182nd out of 189 countries.[4] The poverty level also remains high with 43.7% of the population earning less than USD 1.90 a day.[5]

This situation of chronic poverty is characterised by the difficulty poor households face in accessing basic social services, a literacy rate of only 41% in 2018 (33% for women),[6,7] and high levels of acute malnutrition. HELP is a German emergency and development NGO that has been working in Burkina Faso since 2008. Adopting an integrated approach to tackling poverty, HELP describes its vision as "a world where all men, women and children can live autonomously in dignity, peace and security".[8] Its fields of intervention cover health, development, nutrition, food security, livelihoods, hygiene and sanitation.[9] In 2018, HELP obtained 22 months' worth of funding from ECHO for a project to fight acute malnutrition in Sebba health district (Sahel region). Within the framework of that project, HELP introduced cash transfers to cover part of the transport costs ("money for transport") to the Intensive Nutritional Recovery and Education Centres (CRENI). The project ended in April 2020, before the Covid-19 pandemic was declared and the first cases were detected in Burkina Faso.

1.1 Humanitarian situation

After having long been spared from the instability that affected its neighbouring countries, in 2015, Burkina Faso was plunged into a humanitarian and security crisis of unprecedented scale. Already affected by chronic food and nutrition insecurity, the country is now the scene of violent and complex security incidents that initially affected the regions of the Sahel belt and then spread throughout the country in successive waves. In December 2018, a state of emergency was declared in several provinces.

Since 2016, the escalation of attacks has led to the internal placement of some 900,000 people and has affected 1.3 million families in the host communities.[10]

Between 2018 and 2019, essential public services were operating at a minimal capacity or were closed in the regions of Sahel, Nord, Centre Nord and Est (map 1).

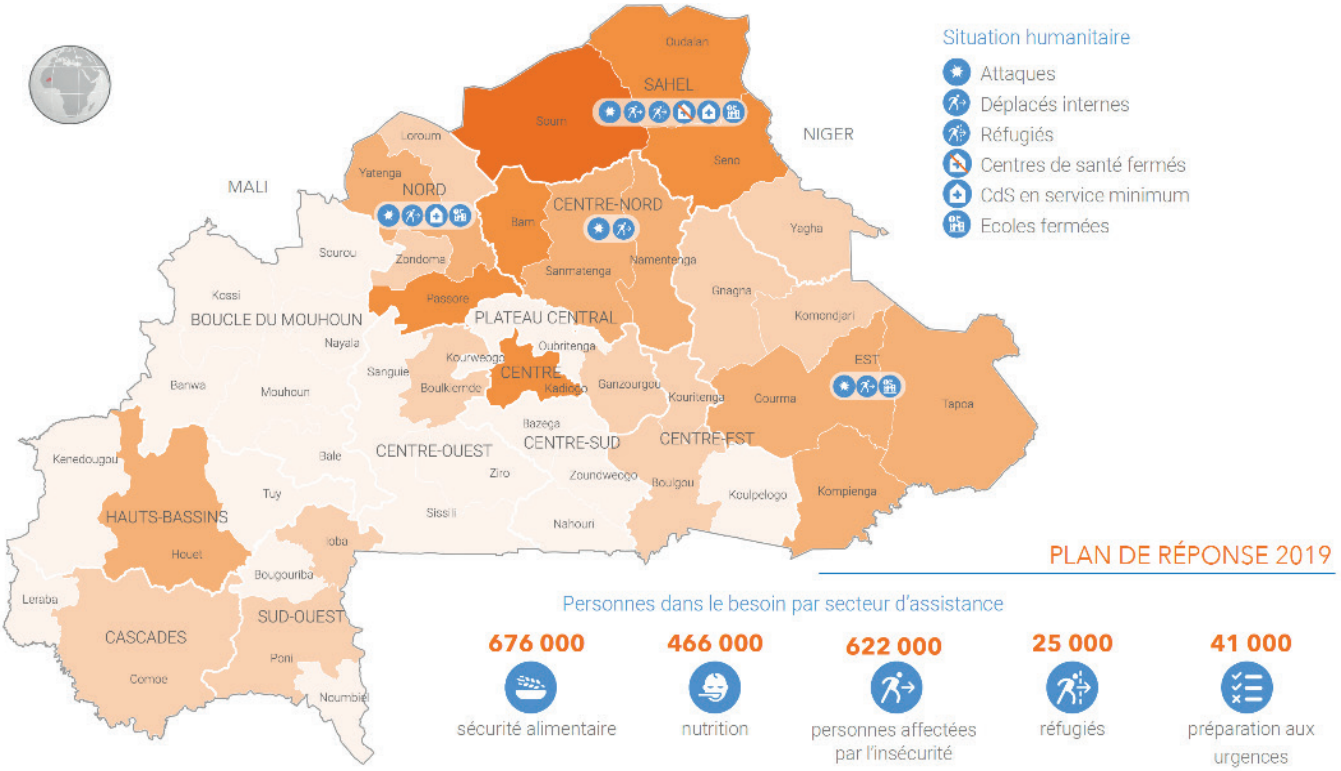
In the area of health, the availability and quality of care have deteriorated considerably under the pressure of the flows of displaced persons and some trained personnel have left healthcare centres due to the heightened insecurity. Pregnant women, children, people with disabilities, people with chronic diseases and older people have been the most severely affected by the situation.[11]

3 World Bank, GDP growth (annual %) in Burkina Faso. Accessed on 01/08/2020. *https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=BF*
4 UNDP, Inequalities in human development in the 21st century - Burkina Faso, 2019.
5 World Bank, Poverty headcount ratio at $1.90 a day (2011 PPP) (% of population). *https://data.worldbank.org/indicator/SI.POV.DDAY?locations=BF*
6 World Bank, Literacy rate, adult total (% of people ages 15 and above) - Burkina Faso. *https://data.worldbank.org/indicator/SE.ADT.LITR.ZS?locations=BF*
7 World Bank, Literacy rate, adult female (% of females ages 15 and above) - Burkina Faso. *https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS?locations=BF*
8 *https://www.helpbf.org/spip.php?article3*
9 *https://www.helpbf.org/spip.php?article24*
10 UNOCHA (2020). Burkina Faso Humanitarian Needs Overview.
11 Ibidem.

Finally, the security situation has also impacted the supply of drugs and other inputs, as well as reducing the capacity of humanitarian actors to access the affected areas and provide adequate humanitarian assistance to those affected.

In December 2019, the cluster system was officially activated in Burkina Faso in order to coordinate the humanitarian response, mobilise resources and engage in advocacy on the most pressing humanitarian needs.[12]

Map 1: Overview of humanitarian needs in Burkina Faso in January 2019 (UNOCHA)



12 *https://www.who.int/health-cluster/countries/CCPM-Annual-Report-2019.pdf*

1.2 Health and nutrition situation in Burkina Faso

Before the outbreak of this crisis, Burkina Faso had made encouraging progress towards achievement of the Sustainable Development Goals.

Between 2000 and 2016, the mortality rate for children under five years of age halved,[13] but nonetheless remained at one of the highest levels in the world (76.4 per 1,000 births).[14] In 2010, Sahel province had the highest child mortality rate at 235‰, compared with 80‰ in the Centre-Est region.[15] Although the causes of death vary depending on the age of the child, in 54% of cases, the deaths were linked to acute malnutrition.[16]

Prevalence of malnutrition in Burkina Faso

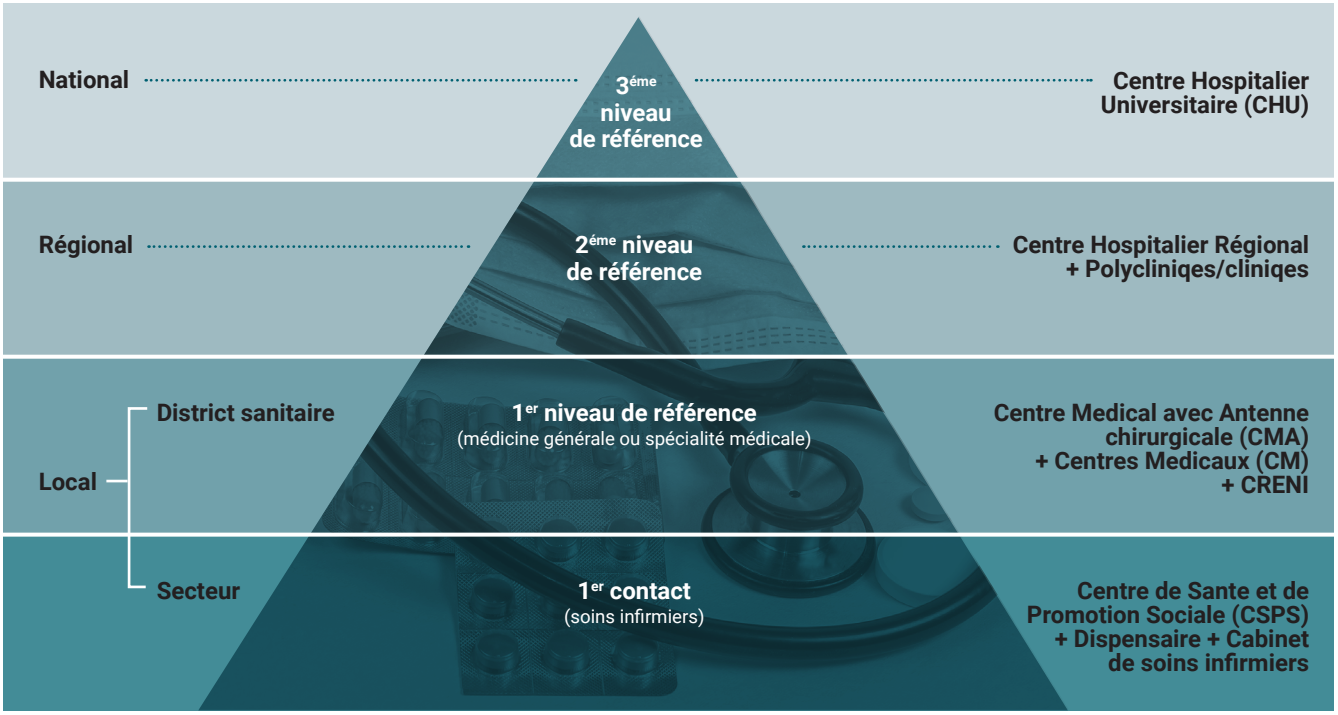
The 2018 national nutrition survey revealed that 9 of the country's 45 provinces had a global acute malnutrition (GAM) rate above the alert threshold of 10% set by WHO.[17] Sahel region has the highest prevalence of child malnutrition in the country, with 3.1% SAM and 12.8% GAM.[18]

Free care policy to improve affordable access to healthcare

In 2016, the government introduced a policy of providing basic healthcare free of charge to "children under five years of age and women, at all public health facilities and at private health centres that agreed to the implementation procedures."[19] The patients do not pay any fees upfront; the health facility invoices the State which then reimburses the cost of the services provided.

Graphic 1: Organisation of the levels of healthcare in Burkina Faso

Adapted from Kpoda et al., 2019



13 UNICEF, Burkina Faso: Demographics, Health and Infant Mortality. *https://data.unicef.org/country/bfa/*
14 Ibidem.
15 INSD (2010), Multiple Indicator Demographic and Health Survey (MICS IV).
16 Ministry of Health of Burkina Faso (2011), National Health Development Plan: 2011-2020.
17 Nutrition Cluster, Nutrition Information Bulletin No. 1, March 2020.
18 Nutrition Cluster, Nutrition Information Bulletin No. 1, March 2020.
19 Monthly bulletin of the Government Information Service, No. 1, January 2019. Accessed on 25/07/2020 *https://www.sig.bf/wp-content/uploads/2019/01/Mag-Numerique-Action-Developpement-Ok.pdf*

The healthcare services covered by the free care policy are:[20]

1. **Surgical consultations and procedures;**
2. **Drugs and medical consumables, including blood products;**
3. **Additional tests (e.g. serology, radiography);**
4. **Hospital admission costs (hospitalisation, placing under observation);**
5. **Transportation for medical evacuations between healthcare facilities.**

However, by the government's own admission, difficulties have been encountered in implementing this free care policy and monitoring its application. For instance, the fees charged have not been harmonised, reimbursement by the State can take up to six months and the total budget has become insufficient to honour 100% of the invoices issued.[21] Consequently, there are regular reports by NGOs and patients of 'informal' fees being charged, particularly for primary health services and the purchase of medicines.[22]

Barriers to coverage and use of SAM treatment services in Sebba health district

Although some progress has been made in the last 10 years, healthcare coverage in Sebba health district remains low (46% in 2013, 55% in 201723). A number of factors linked to the healthcare offering and demand for services might help explain this:[24,25]

a. Insufficient provision of health and nutrition services:
- *Sub-optimal quality of care, particularly due to high staff turnover and insufficient training of health workers in the various malnutrition treatment protocols;*
- *Insufficient collection and analysis of health and nutrition data (recording, analysis, sharing), which limits the capacity to offer appropriate responses;*
- *Shortages of drugs and other inputs, with recurring supply and quality-control problems;*
- *Low rate of referral (20%) of cases of SAM between the different levels of care.*

b. A low SAM treatment service utilisation rate[26] and late arrivals at the CRENI27:
- *Lack of knowledge about the signs of SAM and appropriate treatments at the household and community levels;*
- *Poor state of the road network in the province, especially during the rainy season;*
- *Geographical distance between the village and the CRENI (sometimes more than 50 km) and difficulty of access during the rainy season when the level of the seasonal lakes and rivers rises;*
- *Despite the free provision of care for under-fives, the associated costs such as transport or accommodation costs for parents accompanying their children discourage them from coming to the CRENI early or at all;*
- *Mothers lack time as they must work the fields during the period that coincides with the SAM peak.*

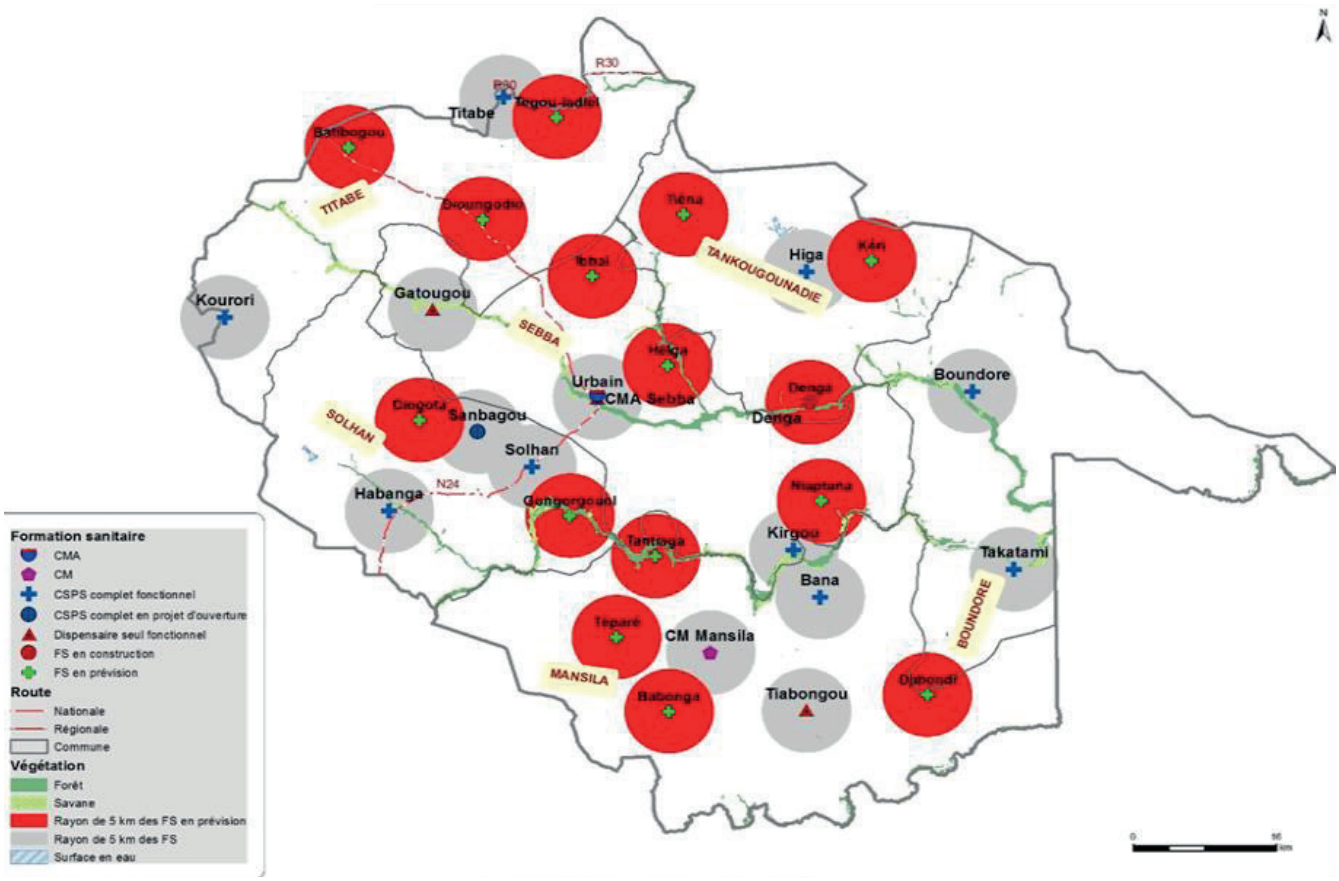
20 Ibidem.
21 Ibidem.
22 Ministry of Health, Report on the fourth national meeting to assess implementation of the free healthcare measures, 2018.
23 2013 and 2017 SQUEAC surveys for Sebba health district.
24 Woodhead, S (2013), SQUEAC Assessment Report, Sebba health district.
25 Slim, H et al. (2004) Inequalities in access to healthcare services and their determinants in Burkina Faso, Santé, Société et Solidarité, No. 2,. pp. 199-210.
26 "Utilisation rates give an overall picture of the population's interest in the health centre, taking into account all the factors that encourage or deter people from using the services: attraction of quality services where users know they can find an answer to their health problems; obstacles related to distance, cost or failure of the care or service to meet expectations." Galland, B et al. (1997), Evaluating the viability of health centres - Methodological Guide, p.18.
27 Woodhead, S (2013), SQUEAC Assessment Report, Sebba health district.

02. Description of the project
& the "money for transport" component

HELP has been active in Sahel region since 2008 and has successfully carried out interventions to strengthen the health system and fight malnutrition.

In 2018, HELP obtained funding from ECHO for a project to fight acute malnutrition in Sebba health district. Within the framework of that project, HELP introduced cash transfers to cover part of the cost of crossing the seasonal lakes to reach the CRENI in Sebba.

Map 2: Sebba health district



Box 1: Project overview

Name of the project: Project to fight acute malnutrition in Sebba health district, Burkina Faso

Duration: March 2018 - April 2020

Intervention area: Sebba health district, Yagha Province, Sahel Region

Overall objective of the project: Contribute to reducing child morbidity and mortality due to acute malnutrition in Burkina Faso

Objective of the "money for transport" component:
Facilitate access to the CRENI from remote villages by covering part of the transport costs (canoe) to cross seasonal lakes during the rainy season

Population targeted by the CT component:
children aged 0-59 months suffering from SAM with complications and the person accompanying them

Transfer amount:
FCFA 5,000 for a return trip

Frequency of the transfers:
at the end of the period of admission to the CRENI

Cash transfer modality:
conditional and unrestricted cash transfer

Number of CT beneficiaries:
23 people accompanying children suffering from SAM

Planned distribution period:
4 months during the raining season (June-September)

2.1 Objectives and activities

The general objective of the project was to fight acute malnutrition in Sebba health district. The specific objective of the cash assistance to cross the seasonal lakes was to facilitate access to the CRENI from remote villages by covering part of the transport costs (canoe) to cross seasonal lakes during the rainy season.

2.2 CTs as part of an integrated approach to improve access to health and nutrition care

To achieve these objectives, HELP has implemented a range of activities to both support the health system and improve demand for healthcare:

- *Building the capacity of the health system through training supervisions, donations of technical medical supplies and inputs, donations of motorcycle ambulances and support with data management;*
- *Support with human resources and the transfer of skills with the placement of seven people in the CRENI;*
- *Stepping up screening and referral of cases of acute malnutrition in the community by training and supervising CBHWs and setting up a community data collection mechanism for nutrition surveillance;*
- *Raising awareness of the signs of malnutrition and IYCF practices for mothers of children and/or pregnant women through the village HSPCs;*
- *Training mothers and grandmothers to screen for and monitor malnutrition in the community;*
- *Distribution of FCFA 5,000 of "money for transport" to mothers of children suffering from SAM with complications who live in villages cut off by seasonal lakes;*
- *Distribution of bedding kits, hygiene kits and two meals a day to mothers throughout their child's period of hospitalisation.*

2.3 "Money for transport" to facilitate travel to the SAM treatment centre

The distribution of cash transfers to help patients travel to the CRENI was not included in the initial project. It was introduced in 2019, a year after the start of the project, following evaluations of barriers to accessing the CRENI in Sebba.

The majority of cases of severe acute malnutrition referred to the CRENI are from villages located more than 50 km from Sebba. In the rainy season (which corresponds to the SAM peak), the cost of transport increases considerably as the area becomes almost entirely surrounded by temporary lakes. Some of these seasonal lakes can be over a kilometre long and patients must often cross several of them by canoe in order to reach the CRENI.

The observation made by HELP from discussions with the communities and parents, and corroborated by the SQUEAC healthcare access and coverage study,[28] was that geographical distance and transport costs constituted significant obstacles in parents' decision whether to take their malnourished child to the CRENI. In the case of severe acute malnutrition with complications, the speed with which the child receives treatment is a key factor in increasing their chances of survival.

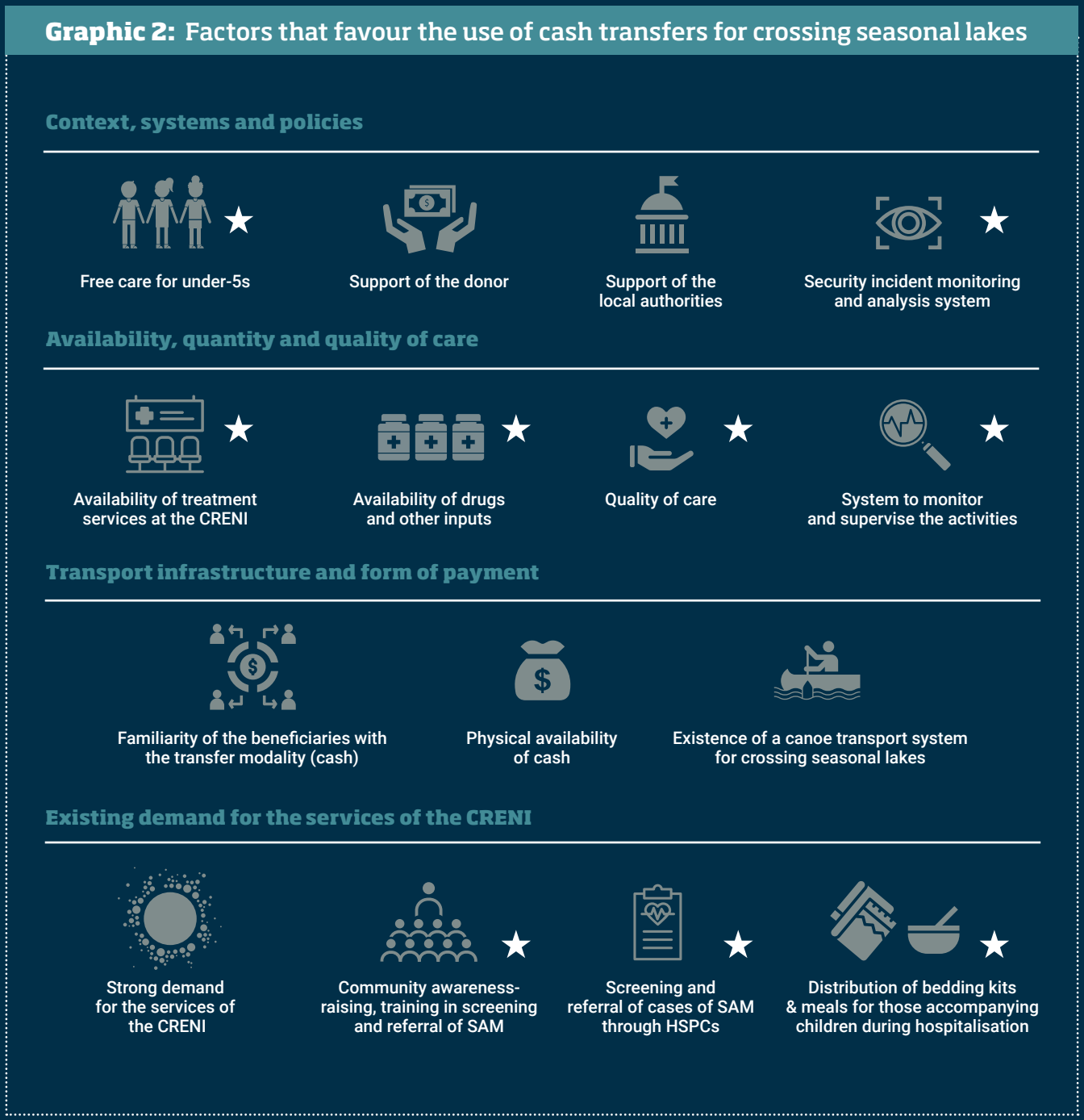
Although there is growing insecurity, the analysis of risks and monitoring of security incidents in the area show mixed results. For instance, in the last quarter of 2019, admissions to the Sebba CRENI increased despite a rise in the number of security incidents and the closure of several health centres (see graphic 3).

28 Woodhead, S (2013), SQUEAC Assessment Report, Sebba health district.

2.4 Determining the feasibility of cash transfers

A quick evaluation of healthcare supply and demand was conducted by HELP during drafting of the project. Graphic 2, below, presents the factors that favour the use of cash transfers in this project. The stars indicate the activities supported by HELP.

Graphic 2: Factors that favour the use of cash transfers for crossing seasonal lakes



2.5 CT beneficiary selection

To select the families that will receive this CT, HELP has established the following criteria:

- *Children under five years of age suffering from severe acute malnutrition with complications;*
- *Living in a village separated from the CRENI by at least one seasonal lake (HELP had previously mapped those villages).*

No distinction was made between internally displaced persons and host populations; every child under five with MAS and living in one of the villages concerned was eligible.There were no socio-economic criteria in the selection of the beneficiaries.

2.6 Conditionality, transfer modality & delivery mechanism

The choice of the CT modality and delivery mechanism took into account:

- *The objective of the intervention;*
- *The HELP teams' capacity to finance and manage the intervention;*
- *The risk of the cash being spent on other activities;*
- *Familiarity and ease of use by the beneficiaries;*
- *The ease and flexibility of implementation and monitoring.*

Consequently, the project team opted for a conditional[29] and unrestricted[30] cash transfer.

The money was conditional insofar as it was only given once the child had completed its treatment at the CRENI. The health worker employed by HELP at the CRENI was tasked with monitoring the nutritional state of the children, checking that the eligibility criteria had been met and, finally, giving the money (in cash) to the accompanying parent.

In this case, the objective of the conditionality was to encourage parents to take children suffering from MAS to the CRENI as soon as possible, without being deterred by the travel costs. The other costs incurred during the stay at the CRENI were covered by HELP with the distribution of bedding kits, hygiene kits and free meals for the accompanying mothers. In cases of severe acute malnutrition, early treatment is a determining factor in the child's chances of survival.

Furthermore, the scientific literature shows that conditional transfers - when accompanied by investments in health systems - have positive impacts on the rate of use of health services.[31]

However, a significant disadvantage for the beneficiaries is that they had to pay the travel costs to the CRENI (approx. FCFA 2,500 or EUR 4) up front, which may have deterred the poorest households. The project team took the decision not to issue advances for the outward trip as it feared that the recipients might spend it on other needs

29 CaLP defines conditionality as referring 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. [...] conditionality is distinct from restriction (how assistance is used) and targeting (criteria for selecting recipients). Examples of conditions include attending school, building a shelter, attending nutrition screenings, undertaking work, training, etc. Cash for work/assets/training are all forms of conditional transfer." CaLP (2018), Glossary of terminology for cash and voucher assistance.

30 CaLP defines a transfer as restricted in relation to "limits on the use of assistance by recipients. Restrictions apply to the range of goods and services that the assistance can be used to purchase, and the places where it can be used. The degree of restriction may vary – from the requirement to buy specific items, to buying from a general category of goods or services. Vouchers are restricted by default since they are inherently limited in where and how they can be used. In-kind assistance is also restricted. Cash transfers are unrestricted in terms of use by recipients. Note that restrictions are distinct from conditions, which apply only to activities that must be fulfilled in order to receive assistance. CaLP (2018) Glossary of terminology for cash and voucher assistance.

31 Glassman, A et al. (2013). Impact of Conditional Cash Transfers on Maternal and Newborn Health. Journal of Health, Population and Nutrition, 31(4). Retrieved from *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4021703/*

and the child would not ultimately be taken to the CRENI.

The choice to distribute the money in cash (rather than using vouchers) was based on the following reasons:

- *Cash is easier and quicker to roll out than vouchers, especially for a small-scale pilot activity. Vouchers often require more staff for implementation and monitoring, and administrative arrangements that can initially be more burdensome (e.g. identifying and contracting service providers);*
- *Familiarity of the beneficiaries and HELP staff with this form of payment;*
- *Flexibility of use by the beneficiaries, even though the small amount of the transfer (FCFA 5,000 or EUR 7.6) did not allow for 'misspending' by beneficiaries.*

2.7 Amount and frequency of the cash transfer

The amount of the transfer was calculated based on the average cost of crossing a seasonal lake by canoe (return trip). The amount was estimated at FCFA 5,000 (EUR 7.6).

However, the amount remained the same if the person needed to cross several lakes or incur additional costs (e.g. motorcycle-taxi to the lake).

The mothers of children were informed that the cash transfer was a contribution to ease the financial burden of going to the CRENI, but that it was not intended to cover 100% of their transport costs.
For this project, HELP considered that each beneficiary would only need to travel to the CRENI once in four months. Nonetheless, if a child relapsed, making it necessary to return to the CRENI more often, the family could receive the cash transfer more than once.

© WFP - Simon Pierre Diouf, illustrative photo, April 2018

2.8 Monitoring and evaluation

For the cash transfer component of the project, HELP set up a 'light' monitoring system that can easily be integrated into the monitoring system already in place for health and nutrition activities without significantly increasing the workload of the staff at the CRENI.

To monitor the CT distribution process, tools were introduced such as an attendance sheet with the contact details, place of residence, proof of identity of the beneficiary and payment record, jointly signed by the health worker and the beneficiary.

To monitor the impact of the project activities, indicators such as the numbers of admissions, recoveries, treatment drop-outs and deaths at the CRENI were monitored.

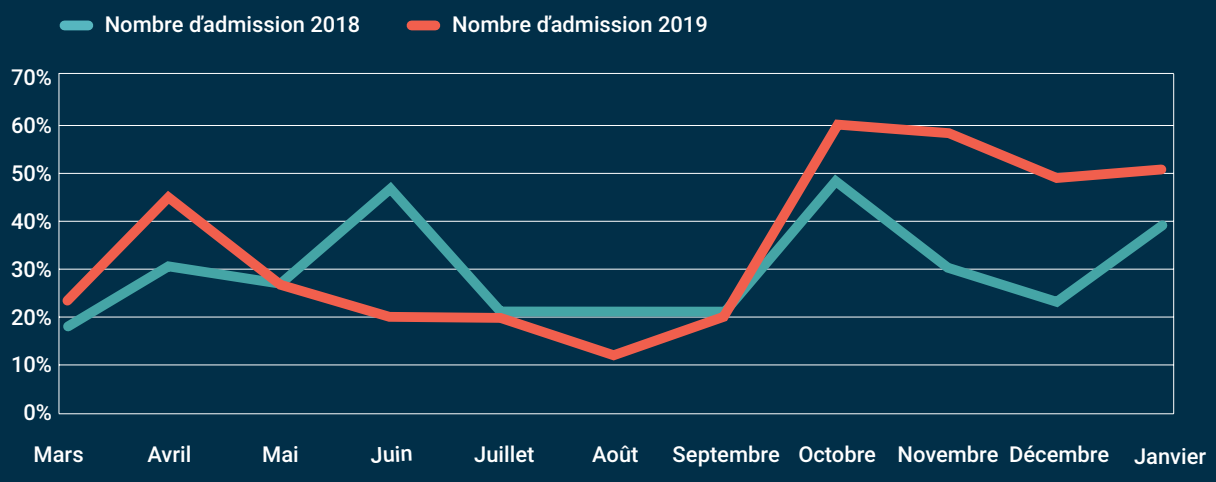
- **Impact on the number of SAM admissions at the CRENI**

The first transfers of "money for transport" took place in September 2019. This graph shows that the peak of SAM admissions starts around September, at the end of the rainy season. However, the number of cases admitted in 2019 was higher, with an average increase of 50% between September and December compared with the same period in 2018.

- **Impact on speed of treatment**

The impacts of the cash transfers were also monitored through observations, testimonies and interactions with the beneficiaries during visits to the communities and

Graphic 3: Number of admissions of SAM cases to the CRENI in 2018 and 2019



by monitoring the number of admissions to the CRENI.

The health supervisors at the CRENI report that the cash transfer led to:

- *A reduction in the severity of the cases brought to the CRENI from the beneficiary villages;*
- *A reduction in the latency period between the referral of the case of SAM and its treatment.*

If this "money for transport" trial is continued and extended to other intervention areas, more in-depth evaluations will be necessary to better measure the effects attributable to the cash transfers on access and the utilisation rate of the health services.

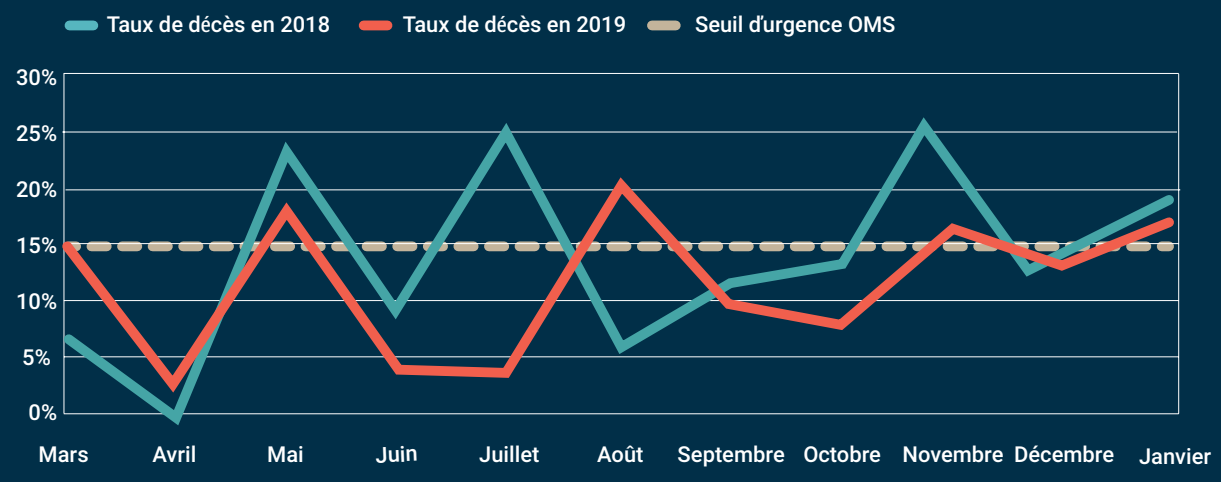
Impact on the mortality rate

Although it is difficult to evaluate the effects attributable to the CTs on the child mortality rate, it can be observed that the mortality rate between September and December 2019 was lower than during the same period in 2018, with an average reduction of 23.7%.

> Before, lots of SAM cases would be referred during the rainy season, but the parents had to wait for the water levels to go down before they could come, as it was too expensive for them to cross. The parents would wait 5 or 6 days, by which time the child's condition would have deteriorated. Now [with the cash transfer], they no longer wait so long; perhaps just a few hours

Lassina Millogo, Supervisor of Clinical Nutrition Care at the Sebba CRENI.

Graphic 4: Death rate for SAM cases at the Sebba CRENI between 2018 and 2019



Testimony of Maimouna, the mother of a 10-month-old infant admitted to the Sebba CRENI

“When he saw the state of my child, the nurse decided to send us to Sebba. I was worried about my child’s health and the conditions of our stay at the hospital. By the time we arrived at the hospital, my child’s condition had deteriorated further; I even asked the nurse if she was going to survive. The saddest day for me was the day they connected a tube to my child because she was no longer able to feed; two days later, she opened her eyes and started to suckle, and her condition started to improve.”

“During our stay, we were happy with how we were treated. As well as kits made up of a bucket, a pot, a blanket, some plates and soap, we were given two meals a day. When we left, we were given some money to help us pay the boatmen to cross the lakes. The person in charge told us that it was from their partner HELP, to support us during our time at the hospital. I’m really thankful to the nurses and HELP for how they’re helping people. I’m willing to share the advice received with the other women so that they can go to the HSPCs if there is sickness in their family. I would ask HELP to continue supporting us, particularly with the fuel to get home, because the ambulances can no longer come to the villages because of the insecurity.”

“I’m really happy! Today my daughter is 14 months old; she’s started walking and is no longer being monitored [ed.: she was discharged on 27 January 2020] ”.

03. Challenges encountered

In the health/nutrition cash transfer trial, HELP encountered challenges at various levels.

Contextual challenges:

- Worsening insecurity, particularly from the last quarter of 2019, which prompted some medical staff to leave the health centres and HSPCs, which then closed.
- Strikes in the public sector for several months (June to November 2019), which disrupted the running of public health services and data collection at the local and national levels.

Programmatic challenges:

- Delay in implementation of the cash transfers as more time than anticipated was needed to explain the project to the health workers and set up the distribution and monitoring procedures. The first transfers did not take place until September 2019, towards the end of the rainy season.
- Communicating and justifying the selection criteria: the need for financial assistance for transport is considerable in the province and does not only concern the villages cut off by seasonal lakes. There was a fear of creating too much demand that HELP would not then be able to meet. The solution applied was to only inform the person that they were eligible for the CT when they were leaving the CRENI.
- Lack of coordination between the community mobilisers and the staff at the CRENI. The community supervisors were not sufficiently informed about the cash transfer component and were not able to effectively communicate about it or actively participate in monitoring the impact on the communities.
- Lack of official identity documents to verify the identity of the parents when delivering the money. The compromise found was to ask for the details of a contact person linked to the child who had an identity card.
- Lack of mechanisms for gathering exhaustive data on screening and referrals at the community level.

Monitoring and evaluation: the CT monitoring system had to be quite simple and light so that it could be quickly used by the staff at the CRENI, but it was not sufficiently sophisticated to measure the impacts of the CTs on access to care.

Funding challenges:

Finding funding to continue the CTs and even increase the number of beneficiaries and extend the trial to other intervention areas.

04. Lessons learned and recommendations

Planning and coordination

- Allow enough time before distributing the money to train the teams, inform the local authorities and mobilise the communities (approx. 1 month). Coordination with HELP's "cash" teams or other actors with experience of cash transfers could also speed up the preparation stage.
- If possible, involve the finance/administration department in the planning stage: it might have valuable advice regarding payment monitoring tools.
- Good communication about the objectives and selection criteria for this cash transfer is essential, whether internally among the members of the project team, or externally with the healthcare facilities, authorities and communities.

Choice of cash transfer modality

- While there are pros and cons to every cash transfer modality, it is important to maintain a degree of flexibility in the type of modality used in order to be able to adapt to changes in needs, the security context and internal management capacity.
- To reduce the cost of the outward journey for families, other options could also be considered:

  a. *"transport vouchers", which would be handed out in the village or through the HSPCs at the time of referral rather than at the end of the visit to the CRENI; the transporters would collect the vouchers on the return journey and then cash them in with HELP;*

  b. *a cash advance for the cost of the outward journey at the time of referral of SAM cases to the CRENI. The risk of this advance being spent on other needs could be reduced by raising parents' awareness about the objective of this assistance, as well as by ensuring through complementary interventions (food security, livelihoods, etc.) that the households' primary needs are covered to the extent possible*.
- Calculating the amount of the transfer for other types of transport (motorcycle, etc.): a calculation grid by distance or by cost of fuel/type of transport (or a combination of the two) would be needed to calculate a fixed amount to be given.
- The duration of the stay at the CRENI (from days to weeks) and the costs incurred (food, accommodation, etc.) might also discourage mothers from taking their children to the CRENI. The fact that HELP also distributed bedding kits, hygiene kits and free meals for the accompanying mothers further reduced the financial burden of the child's hospitalisation.

Prevention of misuse and corruption risks

- In the interest of impartiality and preventing misuse of the money, it is not usually advisable for the person who distributes the money to the beneficiaries to also perform the post-distribution monitoring. If possible, delegate the monitoring to a 'neutral' team (HELP monitoring and evaluation team) or get the community mobilisers more involved in this task. Also use the existing complaints mechanisms to feed back any problems and triangulate the information.


© WFP - Mahamady Ouedraogo, illustrative photo, April 2020

Monitoring and evaluation

- Define impact indicators linked to the "money for transport" prior to the distributions and integrate them into the monitoring and evaluation tools.[32]
- When introducing a cash transfer component in a health/nutrition project, monitoring must be carried out after each distribution cycle to check that the distribution process was respected, gather comments from the beneficiaries and measure the impact of the cash transfer. This monitoring usually takes the form of post-distribution household surveys, which are conducted no more than two or three weeks after distribution of the cash and can be complemented with the data already gathered by the teams (CRENI attendance rate, anthropometric data, etc.).

32 Some examples of indicators for cash in the area of health are described here: https://www.calpnetwork.org/publication/multipurpose-cash-outcome-indicators-final-draft-for-testing/

Case study: Cash transfers in the health and nutrition sector.

Hilfe zur Selbsthilfe

Financé par la protection civile et l'aide humanitaire de l'Union européenne

NORWEGIAN CAPACITY

HEALTH CLUSTER

The Cash Learning Partnership

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra