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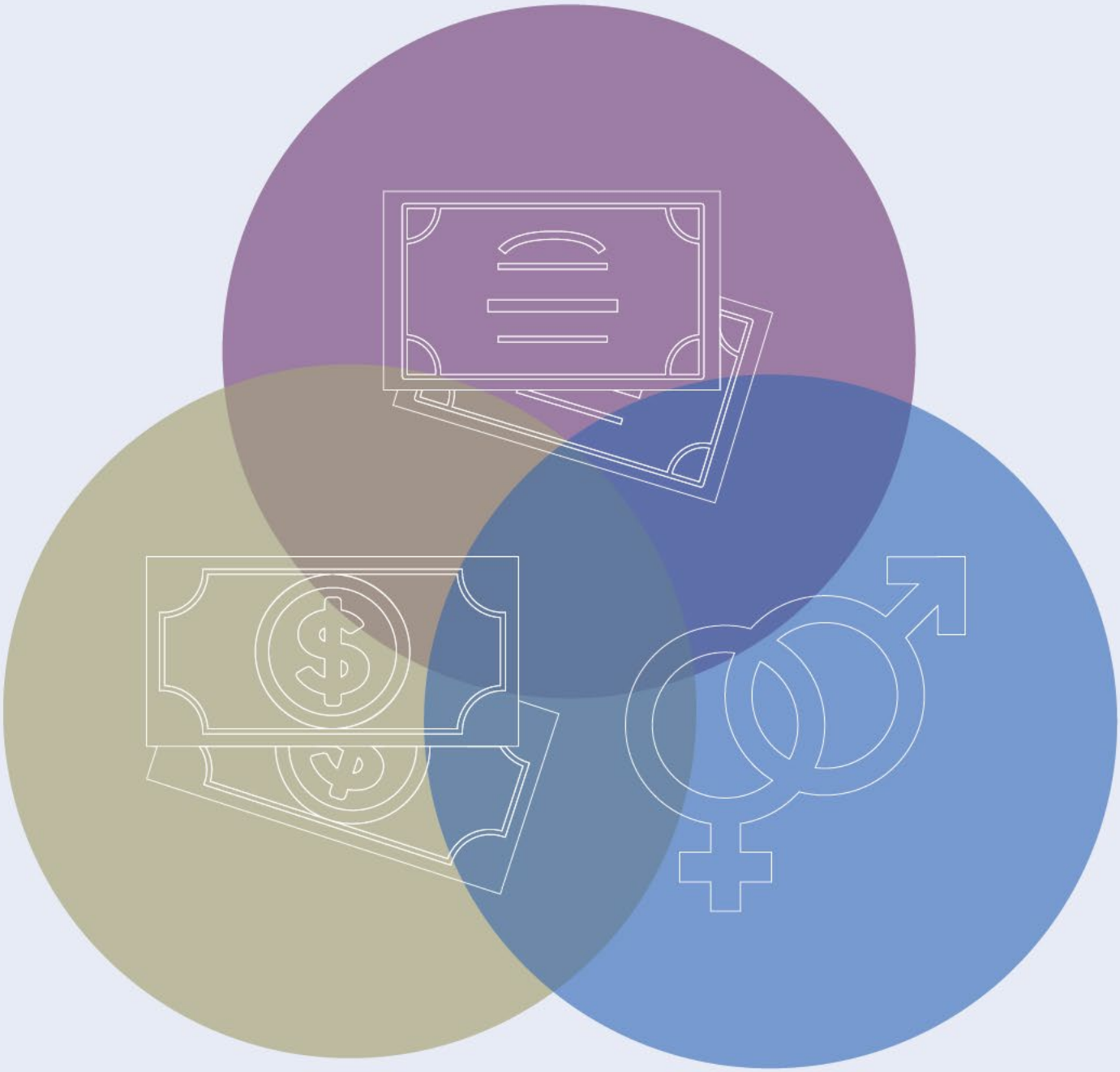
Ministry of Foreign Affairs of the Netherlands



Literature Review

Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian emergencies

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August 2020

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List of abbreviations

AFRO	Regional Office for Africa
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
CaLP	Cash Learning Platform
CBI	Cash Based Interventions
CCT	Conditional Cash Transfer
CE	Cost effectiveness
CHW	Community health worker
CTP	Cash Transfer Program
CVA	Cash and voucher assistance
DHMT	District Health Management Team
DSF	Demand-side financing
EmONC	Emergency Obstetric and Newborn Care
EMRO	Eastern Mediterranean Regional Office
FGM/C	Female Genital Mutilation/Cutting
FP	Family planning
GHC	Global Health Cluster
HF	Health Facility
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IAWG	Inter Agency Working Group (on reproductive health in crises)
LMIC	Low- and middle-Income Countries
MISP	Minimum Initial Service Package (for Reproductive Health)
OOP	Out-of-pocket
PAHO	Pan American Health Organization
PBF	Performance Based Financing
PNC	Post-natal care
RBF	Results based financing
SEARO	South East Asia Regional Office
SGBV	Sexual and Gender Based Violence
SM	Safe motherhood
SRHR	Sexual and Reproductive Health and Rights
SSF	Supply Side Financing
STI	Sexually Transmitted Infection
UCT	Unconditional cash transfer
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization

1. Introduction

1.1 Background

Cash and voucher assistance (CVA) refers to programs where cash or vouchers, exchangeable for goods or services, are directly provided to community members. The term is often used interchangeably with cash transfer programming, cash-based Interventions, cash-based assistance, and cash and voucher programming (CaLP, 2017).

CVA can be useful to improve access to and the utilisation of health services, by reducing direct and indirect financial barriers and/or by incentivising the use of free preventive services. In addition, there is a growing body of evidence that highlights that CVA should always be considered complementary to other supply- and demand-side interventions rather than a stand-alone action (WHO, 2018).

Following commitments related made in the World Humanitarian Summit Grand Bargain, donors and aid organisations are increasingly encouraged to consider CVA in their health response option analysis. While the body of evidence around CVA for health is growing, most of it comes from development contexts rather than from humanitarian settings. Given the major differences in a wide range of areas/dimensions, it is not always possible to directly transfer evidence generated in development contexts to humanitarian ones.

Sexual and Reproductive Health and Rights (SRHR) services are an essential component of the humanitarian response and include:

- Maternal health services (antenatal care, safe delivery, postnatal care)
- Family planning (FP)/contraception
- Abortion
- STIs and HIV/AIDS services
- Gender-based violence
- Information/education/counselling on human sexuality and reproductive health
- Infertility.

These components shouldn't be addressed in silo's. It is important to avoid fragmentation, ensuring that there is alignment across women's, children's and adolescents' health and wellbeing in humanitarian settings, taking a life-course approach, with the aim to increase effectiveness of interventions throughout a person's life.

Despite a growing interest in including CVA while planning and providing SRHR services and ample evidence for its demonstrated added value in development settings, there is still limited evidence in humanitarian settings about its effectiveness and feasibility, and about its overall effect on SRHR outcomes. Therefore, there is a need to consolidate existing evidence around CVA for SRHR services, document current practices, and discuss the findings with key actors, with the aim of defining its potential role in the planning and provision of SRHR services in humanitarian settings.

This work was commissioned by the Global Health Cluster (GHC), and funded by the project "Delivering integrated Sexual Reproductive Health Rights services in emergencies through the Health Cluster" supported by the Ministry of Foreign Affairs of the Netherlands. Members of the GHC were actively contributing to the design and review of products related to this assignment.

1.2 Sexual and reproductive health in humanitarian settings

In 2019, the number of people in need of humanitarian assistance across the world was larger than predicted. In 2020, the number of people in need of humanitarian assistance is expected to reach almost 170 million. This large number of people in humanitarian need is not only the result of ongoing conflicts in different parts of the world, but also a clear trend linked to changes in the climate (OCHA, 2019), which can contribute to the creation of the conditions necessary to increase tensions between populations leading to conflicts.

People face many challenges during humanitarian crises. In these contexts, people are often unable to fulfil some of their basic needs such as food, water, or shelter. It is, therefore, not surprising that under these circumstances malnutrition, infectious disease outbreaks, violence, and mental health problems appear. These circumstances not only affect people, they also bring challenges to health systems, often rendering them unable to fulfil their role.

The right to health includes the right to a healthy sexual and reproductive life. Despite crises, and any challenges that the health system may be facing, the necessity to respond to people's sexual and reproductive needs do not disappear. It is also important to recall that during crises people do not only struggle to fulfil their sexual and reproductive needs. In these circumstances, when people are on the move while escaping from conflict, or when insecurity increases, women and young people are also often victims, whether intentionally or not, from violations to their sexual and reproductive rights. Furthermore, crises often exacerbate pre-existing conditions in relation to SRHR, which are compounded by a disruption of services (UNFPA, 2019), resulting in a disproportionate burden for these population sub-groups. From the point of view of equity, it is impossible not to prioritise the SRHR needs within a population.

Responding to the health needs, and specifically the SRHR needs, of a population during humanitarian crises is challenging. The difficulty is not just operations but also ensuring that services of sufficient quality are available. A good SRHR response requires, among other things, a problem analysis that looks at things not only from a technical perspective, but that takes into account and responds to the perceived needs of individuals and of the community. It requires a response that is adapted to the local culture and traditions whilst at the same time ensuring that each individuals' right to health is fulfilled. It also requires links with services from other sectors to allow continuity and harmonisation.

With the articulation of a minimum standard in reproductive health service delivery—*the Minimum Initial Service Package (MISP) for Reproductive Health*—addressing priority activities to prevent excess morbidity and mortality, particularly among women and girls at the onset of humanitarian emergencies, the humanitarian response has evolved in a way that provision of SRHR services is considered standard (IAWG, 2018). However, the completeness of the offer, the quality of the services, and access to them, remain issues to be addressed (Singh, 2018; Casey, 2015; Casey et al, 2015). Despite funding and technical support for the delivery of SRHR services, different types of barriers often remain key factors in the ability to

access these services. Even if services are offered free of charge, financial barriers may contribute to low utilisation (WHO, 2018).

1.3 Cash and voucher assistance in humanitarian settings

Voucher schemes and cash transfers have a place under the family of Results Based Financing (RBF) interventions. Both modalities of assistance are aimed at: "enabling households and individuals to meet their basic needs for food, non-food items, and/or services, or to buy assets essential to resume economic activity" (OECD, 2017). The effect of voucher schemes and cash transfers mostly impacts "users" of the health system. Therefore, they are called demand-side interventions. This is in contrast with other types of RBF modalities (e.g. performance-based financing, and incentives) that focus on the elements on the provision-side; therefore called supply-side interventions. See Annex 1 for a table describing the different types of CVA.

CVA has taken a more prominent role in the humanitarian world, reflecting the commitments and declarations made by donors and humanitarian actors. CVA is mentioned in the World Humanitarian Summit Grand Bargain, Commitment 3; as Good Humanitarian Donorship principle N°9; as part of the Core Humanitarian Standards; and is reflected under the Cash Learning Partnership (CaLP) Global Framework for Action (CaLP, 2017; OECD, 2017).

There are a series of reasons why CVA is becoming a more common component in humanitarian operations. Firstly, evidence demonstrates that CVA can be an effective way to reduce financial barriers and incentivise access to services (WHO, 2018). Secondly, compared to in-kind assistance, cash-based interventions can sometimes have lower costs (Doocy et al, 2016). Thirdly, cash-based interventions can contribute positively to the recovery of the local economy by helping to inject money into the market system (Doocy et al, 2016). Fourthly, CVA can give recipients the opportunity to prioritise and decide for themselves about what to do with the aid received, which is obviously not the case with in-kind assistance (Doocy et al, 2016; WHO, 2018).

Despite of all these positive points, it is important to keep in mind that CVA can only work if services of adequate capacity and quality are available, and if there is a demand from people to use them. Therefore, it is essential to combine CVA with other supply- and demand-side interventions to improve availability and/or quality of health services. In addition, in situations where services are available and of sufficient quality, CVA should not replace supply-side financing strategies as the key source of funding for the health system, as doing so, would mean pushing for a system where out-of-pocket payments (OOP) become a major source of revenue for the health system (Jowett et al, 2020). This is known to lead to inequitable and inefficient health systems.

1.4 Rationale for this literature review

As previously mentioned, SRHR services are an essential component of the humanitarian response. Despite the growing interest in including CVA while planning and providing SRHR services among humanitarian partners, there is limited evidence about its effectiveness and

feasibility in humanitarian settings. This contrasts greatly with the larger body of evidence available while using CVA as a component of SRHR programs in development settings, as summarised in the next paragraph and in more detail in Annex 2.[1] Given the fact that experiences from the development sector cannot be automatically transferred to humanitarian situations, there is a need to consolidate existing evidence around CVA for SRHR services, document current practice, and discuss the findings with key actors, with the aim of defining its potential role in the planning and provision of SRHR services in humanitarian settings.

1.5 Summary of the evidence on the use of CVA for SRHR in development settings

There is ample evidence from low- and middle-income countries in Asia, Africa, Central and South America which demonstrates that CVA has a strong positive effect increasing the utilisation of safe motherhood and family planning services. Evidence on the effect of CVA on access to and utilisation of other SRHR components (STI/HIV, post-abortion care and safe abortion) is more scarce. The diversity of experiences described in the literature reflects the variety of contexts where CVA interventions are implemented and highlights the importance of understanding and addressing the different factors influencing access to and utilisation of services. While the assistance can take multiple forms, most of the evidence is built around interventions using value vouchers, transport vouchers, and conditional cash transfers (Bellows et al 2013; Bellows et al 2016; Glassman et al 2013; Gopalan et al, 2014; Hunter et al, 2017; Hunter & Murray, 2017; O'Neil et al, 2017; Till S et al, 2015).

Despite the documented results on SRHR service utilisation, the evidence on the effect of CVA on SRHR health outcomes is not fully conclusive as multiple other factors play a role (e.g. social determinants of health, the quality of care received at the facility). There is an indication that CVA can have a positive long-term effect on health seeking behaviour (Glassman et al, 2013). This effect seems clearer in projects using voucher schemes than in those using direct cash transfers.

The increases in service utilisation and the extra administrative responsibilities resulting from the implementation of CVA can lead to higher workload for clinicians and administrative staff at the health facility level. This can affect staff wellbeing and motivation. The higher workload added to eventual stock ruptures can have a negative influence on the quality of care. In order to limit any unanticipated effects resulting from an increased demand for and utilisation of services, it is necessary to combine CVA with supply-side interventions aimed at strengthening the health system, such as investments in service availability, health facility infrastructure or human resources for health (Glassman et al, 2013).

[1] Generally there is less research done in humanitarian settings, compared to humanitarian settings as research in these settings requires consideration of flexible methods. Global health researchers, funders, policymakers and practitioners don't always recognise humanitarian health as integral to progress in global health (Khort, 2019).

2. Methodology

2.1 Overall research questions and specific objectives for the review of literature

The review of evidence is part of a larger assignment including the development of case studies and a compendium of guidelines and tools. The research questions for the larger assignment are:

1. What are the effects of CVA on SRHR outcomes in humanitarian settings?
2. What is the operational feasibility of CVA within or complementary to other SRHR interventions in humanitarian settings?
3. What are the comparative advantages/disadvantages of CVA within or complementary to other interventions as a means to reduce financial barriers and/or increase access to and utilisation of SRHR services in humanitarian settings?
4. What are the lessons learned and the operational recommendations for future CVA for SRHR programming?
5. What are appropriate guidelines and tools aimed at assessing feasibility and assisting implementation of CVA in humanitarian settings?

The review of literature examined qualitative and quantitative studies with the aim of compiling and mapping the available evidence on effectiveness and feasibility of implementing CVA in reducing financial barriers and/or increasing utilisation of SRHR services in humanitarian and development contexts. Particular attention was paid to:

Focus areas	Description
Effects of CVA on SRHR outcomes	Focusing on effects of CVA on demand- and supply-sides of access to SRHR services, and on utilisation of SRHR services.
Operational feasibility of CVA for SRHR services	Focusing on situation of the market systems, financial and administrative infrastructure available to implement CVA, protection-related risks, acceptance of CVA, and cost-efficiency/cost-effectiveness.
Contextual factors influencing the effect of CVA on access and utilisation of SRHR services	Exploring a broad set of contextual factors, including, but not limited to, physical environment, security situation, socio-economic and cultural contexts, living and working conditions, social networks, individual behaviour, personal characteristics.
Comparative advantages/disadvantages of CVA within or complementary to other SRHR interventions	Whenever described in the literature.

2.2 Approach and conceptual model

Given the assumption that little evidence is available on CVA for SRHR services in humanitarian settings, it was proposed that this desk review would take the form of a scoping review.

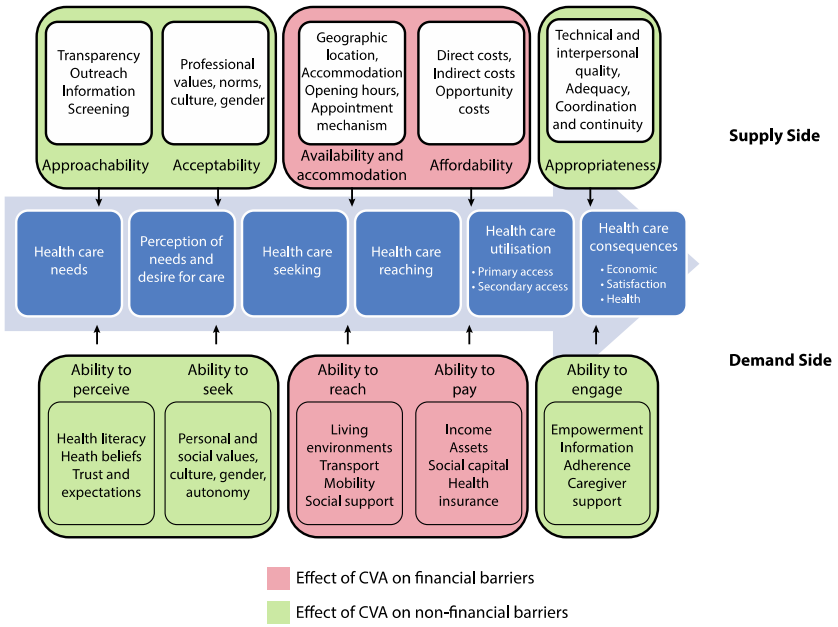
Scoping reviews are suitable for quickly compiling evidence from various sources as opposed to full-fledged systematic reviews, yet they retain a level of rigor and transparency. It also allows research gaps to be identified in existing literature and findings to be summarised and disseminated. To this end, they are well suited for mapping the available evidence in a new field of study (Arksey & O'Malley, 2005). The scoping review was conducted following the stages proposed by Arksey & O'Malley's framework:

Stage	Description
Stage 1	Identify the research question(s)
Stage 2	Identify relevant studies
Stage 3	Study selection
Stage 4	Chart the data
Stage 5	Collate, summarise, and report results

The results from the scoping study are presented in the form of a literature review document as well as an evidence mapping document.

The framework of Levesque et al (2013) was used in this study to classify and present the reported effects (both intended and unintended) of CVA on access and utilisation of SRHR services. Following the logic of the framework we explored, on the demand-side, the effects of the CVA on financial and non-financial barriers to access SRHR services (e.g. ability to perceive, seek, reach, pay, engage) and on the supply-side we explored the effects of CVA on approachability, acceptability, availability, affordability and appropriateness. Effects on the demand-side have been further classified into effects of CVA on financial barriers to access (ability to reach and ability to pay), and effects of CVA on non-financial barriers to access (ability to perceive, ability to seek, and ability to engage). See figure 1.

Figure 1. Levesque's conceptual model for access to health care (Levesque, 2013)



2.3 Parameters and search strategy

2.3.1 Intervention setting

The review includes publications describing interventions in humanitarian settings. For the purpose of this study, a humanitarian setting is defined as any acute or protracted crisis at local, national or regional level stemming from either complex emergencies or natural disasters. It is often seen that there is an overlap between these circumstances. The definition has been kept as broad as possible on purpose to ensure collection of the maximum amount of publications given the expected scarcity of results. The Global Humanitarian Overview 2020 was used as the starting point while listing the countries affected by humanitarian crises (OCHA, 2020).

In addition, the top 40 countries in the 2019 Fragile states index (Fund For Peace, 2019) were also considered during the search and screening phases.

2.3.2 Types of publications

This review includes information found in a wide range of documents including peer-reviewed articles as well as reports and other type of grey literature such as case studies, program/project evaluations amongst others.

2.3.3 Delimiters

The search included articles published in the last fifteen years (from 2004 onwards) in order to retrieve a relatively recent set of literature. Searches were limited to English for feasibility reasons.

2.3.4 Search strategy

The search for literature was done in a comprehensive set of academic databases and search engines, including PubMed (including Medline), Scopus, JSTOR, Cochrane, EconLit, IDEAS/RePEC, and Google Scholar. Specific searches were also conducted in online libraries, including the WHO Library Information System (http://kohahq.searo.who.int/), CaLP, ALNAP,

and other relevant websites such as those of UN organisations and International NGOs. The reference lists from relevant articles were also screened with the aim of finding additional sources of information. Finally, the research team approached members of the steering group (for this assignment), WHO office representatives and focal points of cash working groups at the national level, as well as authors of relevant publications, in an effort to identify additional sources of information for this review. In addition, the set of selected articles and preliminary results were discussed during a workshop with key experts (Minutes of this meeting are available in a separate document[2]). See Table 1 for an overview of the keywords used.

Table 1. Keywords used for the search

Intervention/publication characteristics	**Key words**
Intervention characteristics	SRHR, SRH, Sexual and reproductive health and rights, Maternal health services (ANC, safe delivery, PNC), Family planning/contraception, STIs and HIV/AIDS services, Gender-based violence (intimate partner violence, FGM/C, chid marriage), Information/education/counselling on human sexuality and reproductive health, Infertility
CVA Modalities	Cash and voucher assistance (CVA), Cash based intervention (CBI), Cash transfer programming (CTP), demand-side financing, multi-purpose grant, cash+, e-cash, e-voucher
Intervention setting	For humanitarian settings: Humanitarian, crisis, emergency fragile and conflict affected states/settings, emergency, natural disaster For development settings: development, low-income, Africa, Asia, Latin-America, Caribbean

2.3.5 Study selection

The review authors assessed the titles and abstracts of the identified records to evaluate their potential eligibility. The full text of all the papers and other literature identified as potentially relevant by one or both review authors were retrieved. These papers were reviewed by two review authors, based on the review's inclusion criteria. At all stages, disagreements between the review authors were be resolved via discussion. Where appropriate, the study authors were contacted for further information.

2.4 Data extraction and analysis

The data was extracted by a team of three people using an Excel spreadsheet as the standard extraction tool. To standardise the process of extracting information, five articles were extracted separately by the different team members. Results were compared and alignment was done where necessary. The final version of the extracted information was fully reviewed by the team member in charge of writing the first draft of the report.

[2] Documents related to this assignment can be found on the websites of KIT, GHC and CaLP)

3. Results

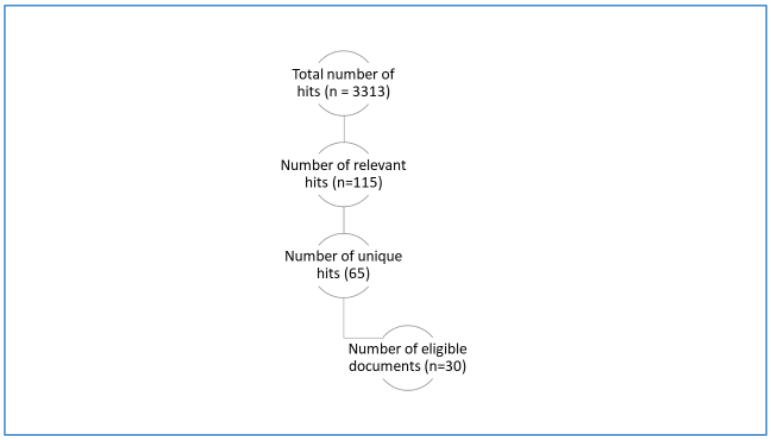
3.1 Results literature search

The literature search in the different databases and search engines resulted in a total of 3,313 hits. Out of those, 115 were considered relevant based on title and abstract. After removing duplicate hits, 65 unique articles remained and were checked against the inclusion criteria.

The search for articles on websites of multilateral agencies, donors, technical platforms, and NGOs resulted in 20 additional documents to be examined.

See Figure 2 for the flow chart and Annex 3 for the detailed results of the literature search.

Figure 2: Flowchart of the search results



3.2 Overview of included studies

The broad search for literature included the top 40 countries in the Fragile States Index (Fund For Peace, 2019), among which are countries supported by development assistance and others by humanitarian assistance. We also looked at countries supported by humanitarian assistance, but not high in the fragility ranking (often refugee related) (OCHA, 2019). This search resulted in 30 eligible documents. Four (4) of these papers present results from more than one setting which adds up to 35 different "cases" in total. In addition, there are also five situations in this review where more than one paper refers to the same project. Despite the duplication, they have been included because they either present things from a different angle, or because they report events and results from a different period in time. In total, there are 29 projects presented in this review. See Annex 4 for a summary of the documents included in this review.

Three (3) of the documents are journal articles, eight are project reports, and one a PhD thesis. In relation to the 18 documents from countries located in the first 40 positions in the Fragile States Index, 14 of the documents are journal articles and 4 are project reports. In total, 20 documents are descriptive in nature, while 10 present characteristics and/or results from quasi-experimental studies.

In relation to the 35 "cases" included in this review, 15 come from the region covered by WHO's Regional Office for the Eastern Mediterranean (EMRO), 14 from the Regional Office for Africa (AFRO) region, 4 from South East Asia (SEARO), and 2 from the region of the

Americas, Pan American Health Organization (PAHO). Cases from Ecuador, Egypt, Jordan, Lebanon, and Morocco are added to the review because they report about humanitarian activities. See Table 2 for details.

From projects from humanitarian contexts included in this review, there are six in countries where there is active conflict (Afghanistan, Syria and Yemen), there are nine in countries receiving refugees (Ecuador, Egypt, Jordan, Lebanon and Morocco), which were included to demonstrate interventions for crisis-affected populations on the move, and one country in a protracted crisis (DRC).

Table 2. Country of the cases presented in this review.

	Active health cluster	**Grand Total**
Afghanistan	Yes	2
Bangladesh	Yes	4
Democratic Republic of Congo	Yes	1
Ecuador	No	2
Egypt	No	1
Ethiopia	Yes	1
Jordan	No	4
Kenya	No	5
Lebanon	No	1
Morocco	No	1
Nigeria	Yes	1
Pakistan	No	3
Syria	Yes	1
Uganda	No	6
Yemen	Yes	2
Grand Total		**35**

3.3 Overview of projects described in the included studies

When looking closely at the SRHR components offered by the 29 projects described in this review, we see that 20 out of the 29 do have a safe motherhood (SM) component. The family planning component is mentioned in seven projects. SGBV appears 7 times out of 29, and STI/HIV only once. The literature search did not lead to any eligible piece of evidence about the use of CVA for SRHR components such as safe abortion. Although none of the papers explicitly describe CVA in the context of a life course approach, two papers described interventions for which CVA included not only maternal health, but also child health. See table 3 for details.

Table 3. SRHR components mentioned in the literature included in this review

	Number of projects described
Safe motherhood (SM)	15
Family planning (FP)[3]	3
SGBV	6
SM + FP	3
SM + STI/HIV	1
SM + FP + SGBV	1
Grand Total	**29**

Table 4 shows which CVA modalities are more commonly described in the literature. It should be noted that from the literature reviewed there was seldom a justification given for the modality chosen. In addition, it is possible that the modalities described in the literature reviewed give a skewed perspective of reality, due to publication bias. While looking at which modalities are used for which SRHR components it seems that a wide range of modalities are used for Safe motherhood. In contrast, the family planning interventions included in this report are mostly linked to vouchers (5 out of 7), while the SGBV interventions reported tend to use UCTs (4 out of 5). Five (5) out of 15 programs using value vouchers opted for a subsidised voucher (meaning that the recipient had to pay to get it).

Table 4. Classification of CVA modalities found in the literature*

Row Labels	**Grand Total**
CCT	6
UCT	8
Value voucher	8
Value voucher – Subsidised	5
Value voucher (only transport to HF)	2
Grand Total	**29**

**CCT = Conditional Cash Transfer; UCT = Unconditional Cash Transfer*

In relation to the process to identify participants for the cash and voucher schemes: The two main targeting approaches (23/29 projects) were based on place of residence (geographic targeting) or on socioeconomic status (poverty targeting). Programs with refuges implemented by UNHCR largely used vulnerability scores. In a couple fragile settings other criteria were used, but these reflected the nature of the project (e.g. young groups, or survivors of GBV). The criteria for eligibility closely reflect the target group of each project.

In relation to the conditionality to get a cash transfer: All schemes operating with some sort of conditionality required women to visit/make use of health services. There were 20 schemes with restrictions in relation to the use of the assistance, all were value vouchers linked to specific services. In all cases the role of the voucher was to encourage utilisation.

[3] The family planning component in most contexts focused on increasing access and utilisation, which included both counselling and access to a method of choice.

Of all the projects included in this review, only three operated in urban areas. Out of these three projects, one focused on pregnant women (aiming to increase FP), and two focused on refugees from Syria and not on host population. Eleven (11) projects focused on rural areas and 10 on a combination of urban and rural. In relation to who was in charge of service provision (SRHR services in this case), there were only three projects (out of 29) working fully with public providers. All these projects were in Uganda and Afghanistan. While the paper refers to the facilities as public, it is important to highlight that the Afghan health system contracts out services to private providers. As such, the only programs implemented and managed solely by the Ministry of Health are the examples from Uganda. Similarly, there were also few projects (6/29) working exclusively with private providers. While some of the papers did not include information about the type of provider, almost half of the SRHR projects included in this review (12/29) worked with some sort of public-private mix.

Twelve (12) projects (out of 29) reported combining/complementing the CVA component with a supply-side intervention. The projects using a combined approach seemed evenly distributed across the type of provider and the type of CVA modality. The supply-side interventions provided can be roughly classified into moderate/heavy HSS (4 projects), trainings on clinical topics or on procedures/standards (4 projects), incentives to CHWs (2 projects), performance-based financing (PBF) (1 project), and QA via support and supervision (1 project).

Table 5. Type of supply-side intervention combined with CVA

Row Labels	**CCT**	**UCT**	**Value voucher**	**Value voucher – Subsidised**	**Value voucher (only transport to HF)**	**Grand Total**
Combined with “baby kits” and HSS support over 5 years					1	1
Combined with “modest” HSS investments and refresher trainings			1			1
Combined with HSS support	1				1	2
Combined with HSS support at HF and DHMT level				1		1
Combined with quality improvement program (support and supervision)				1		1
Combined with trainings on clinical and procedural issues			1	2		3
No supply-side intervention mentioned in the paper	2	8	6	1		17
Combined with incentive for CHW	2					2
Combined with PBF	1					1
Grand Total	**6**	**8**	**8**	**5**	**2**	**29**

The modality of delivery described in the articles in this review were predominantly paper vouchers. CVA modalities were used indifferently across different SRHR programs.

Table 6: Different types of modalities used by the programs included in the review

Row Labels	Count of Delivery mechanism
Direct cash	7
Direct cash/E-transfer	2
E-transfer	4
E-voucher	1
Paper voucher	14
Unclear	1
Grand Total	**29**

3.4 Synthesis – Effects of cash and voucher assistance on access and utilisation of SRHR services

The initial intention was to classify the reported effects of the CVA interventions on the demand- and supply-side of health care provision according to the elements in the model about access to health services from Levesque (2013). These are ability to perceive, ability to seek, ability to reach, ability to pay, ability to engage. However, the level of detail in the retrieved documents about where precisely the effect of CVA falls in the demand-side did not allow for a detailed picture. In most cases (details in Table 7), the outcomes reported refer directly to the utilisation of services and bypass any reflection/analysis about what happens at the access level. Effects of CVA on ability to reach and pay are better described in the literature than barriers related to the ability to perceive, seek, or engage. More information about these areas seems to be available on projects that focus on SGBV than on projects that focus on safe motherhood or family planning.

In relation to the outcomes reported in the papers reviewed. As mentioned before there is a big emphasis on reporting effects using indicators focusing on health service utilisation. Among this big group it is worth highlighting that there were a couple of documents providing some description coming from their PDM and confirming that some of the beneficiaries (in this case of UCT) were using part of the money to pay the costs of delivering a baby. Also worth highlighting that there are some reports (2) with more qualitative evidence about effects of CVA on recipients/beneficiaries. Finally, there are also 3 documents where some sort of cost-effectiveness analysis is done (Ahmed & Khan, 2011; Alfonso et al, 2013; Massavon et al, 2017).

Table 7. types of outcomes reported in the documents included in this review

Row Labels	Grand Total
Analysis PDM	2
Measures of association - SM	1
No outcomes reported	5
Qualitative information about effects - SGBV	2
Unsupported claims	4
Utilisation - FP	4
Utilisation - SM	3
Utilisation - SM + FP	1
Utilisation - SM + FP + CE analysis	1
Utilisation - SM + STI/HIV	1
Utilisation - SM + voucher redemption	3
Utilisation – SM + CE analysis	2
Grand Total	**29**

When looking at the results reported by the different projects, 19 projects included reports with quantitative outcomes. Out of those, 10 reported a statistically significant increase in utilisation linked to the introduction of the CVA component. In most cases (8/10), the projects reporting significant results focused on safe motherhood interventions (alone or in combination with other SRHR components like FP). Four (4) projects with statistically significant results focused on FP (two exclusively and two combined with a SM component). Out of the 19 projects reporting quantitative outcomes, one project (Meng Hsuan, 2016) reported a significant association between cash assistance and odds of delivering in a health facility.

Interestingly none of the articles reviewed reported negative changes in utilisation. It is unclear if this a publication bias, or if it somehow suggests that CVA is not associated with negative changes in the utilisation of SRHR services.

Five (5) studies included in this review reported results from qualitative studies. In all cases, the studies reported perceived positive effects by beneficiaries in relation to household (HH) tensions, psychosocial benefits, social cohesion, empowerment of women, and improvement on livelihoods. See Table 8 for a summary of results reported and Table 9 for a detailed description of the studies.

Table 8. Summary of results reported

	Grand Total
Quantitative studies	
Descriptive - Cash used to pay for SRHR services	3
Increase in utilisation - not-significant	3
Increase in utilisation - unclear if significant	2
Increase in utilisation - significant	10
Significant association	1
Not reported	5
Qualitative studies	
Qualitative - positive effects HH tensions, psychosocial benefits, social cohesion	1
Qualitative - positive effects on empowerment	3
Qualitative - positive effects on livelihoods	1
Grand Total	**29**

Thirteen (13) projects described effects of the CVA intervention on the supply-side. Out of these, four described some effects on the supply-side which were not anticipated, linked to the creation of increased demand, including increased in-service utilisation resulting in extra clinical and administrative work as well as increased waiting times in health facilities and sometimes stock-outs. One study also reported that vouchers allowed women to bypass PHC level facilities and go directly to hospitals. The remaining projects did report positive effects on the supply-side, including increased revenue at the facility level, allowing to continue offering services in spite of harsh conditions. The increased revenue also encouraged service providers (mostly private) to offer services that did have demand, but for which the population did not have means to pay for (e.g. LARCs and PM). Two (2) projects also reported that following the implementation of the voucher schemes, the quality of services provided improved. This change was explained as a consequence of health systems strengthening and quality assurance efforts as part of the CVA projects, including training and improvements of the health infrastructure made possible by the incoming flow of cash through the CVA program. Despite the latter claims, no evidence was presented in the documents to support them. Among other positive effects described was the opportunity to strengthen links between public and private sectors. Private providers being supervised and/or accredited by public servants, and alignment among providers were mentioned. Finally, none of the projects reported an adverse effect on the provision of services. No projects reported abnormal increases in rates of medical procedures that could have led to higher revenues for the providers (e.g. C-section rates).

Table 9. Overview effects of CVA on demand, supply-side, operational considerations, and contextual factors

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
1	Boddam-Whetham, L et al.	Yemen and Pakistan	Value voucher	Safe motherhood	Yemen Substantial Increase in use of LARC and IDUs; not on PMs Pakistan Tenfold increase in use of LARC and PMs 80% of clients showed up with a voucher	Yemen Providers motivated to offer services Users with more options Services running in spite of conflict Pakistan Private providers are motivated to offer LARCS and PMs thanks to the incentive of the vouchers. Given that people can't pay for them there is no real market.	Yemen Acceptability from GVT Pakistan -	Yemen Active conflict DHS 2013: Knowledge about FP is almost universal. But CPR is <30% -> services not available or accessible (public sector). Private sector unaffordable. Pakistan Public sector offers FP in rural areas; private in urban. CPR <30% No LARCS in public sector _unavailable, unaffordable 9% VFS -> 2/3 public sector
2	Dumbaugh, M. et al	DRC	Subsidised care; CCT; Non-monetary incentive Combined with PBF	Safe motherhood Family planning	Not reported	Not reported	Not reported	Not reported
3	Edmond et al.	Afghanistan	CCT Combined with incentive for CHW	Safe motherhood	Only significant result – increase ANC Other indicators increased but not significantly Larger effect among the less poor	Claim that thanks to incentives to CHWs for referring women, they continued active in spite of the conflict (compared to CHWs from areas without incentives).		Conflict limiting capacity to continue with activities Improvements on QoC but still big issues with staffing Research identified that main barriers are geographic access and affordability

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
4	Grainger, C et al.	Yemen	Value voucher – Subsidised Combined with clinical trainings	Safe motherhood	Overall: the number of services utilised in Lahj was significantly higher than expected. ANC1 -> 31% increase; ANC2 or 3 -> 24%: Delivery attended by SBA -> 17%; Institutional delivery - >25%; PNC -> 32%	Capacity at the local level to address stockouts of drugs and supplies; and support for quality assurance of both public and private providers. Financed upgrading of health facilities Allowed to buy supplies that were out of stock, due to interrupted supply chains affected by the ongoing conflict. Voucher programs can be used to standardise quality assurance processes	Voucher structure gives a lot of flexibility to adjust to chancing situations (e.g. value, package of services, network of providers). Changes are possible despite not having functioning policies or structures VS give service providers some sense of security about future of market VS allows to work with private sector without undermining public sector	DHS 34% of Yemeni women in rural areas give birth with the help of a skilled birth attendant compared with 73% in urban areas, while only 23% of rural women deliver at a health facility Low ANC coverage. Some pop in urban areas can access and afford private sector. Women in rural areas not. Need to pay fees to use public services + distance + insecurity
5	Maunder et al	Syria	Value voucher Combined with training MISP and on SGVB	Safe motherhood	Not reported	Not reported	Not reported	Not reported

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
6	Meng Hsuan (Ann) Lin	Afghanistan	CCT Incentives (for CHW)	Safe motherhood	Ability to reach and to pay: the cash helped pay for a range of direct and indirect costs incurred during seeking care. Direct cash incentive to the households for institutional delivery (i.e., HH arm) is associated with higher odds of delivering at a health care facility (OR: 1.389, CI 1.010-1.911). However, no association was observed in the CHW arm (OR: 1.014, CI 0.757-1.358). Finally, women in the combined arm are less likely to deliver at a health facility than women in the control arm (OR: 0.285, CI 0.203 - 0.401).	CHWs indicated that the money made them feel appreciated and compensated for some expenses.	Trust in system undermined when funds for women and CHW are not available on time Variation of results between intervention sites reflects the different conditions in each place (culture, geographic access, security) Mistrust on capacity of agency behind the scheme. Limitations on their side related to communication and incapacity to distribute cash on time to all sites	Culture: many women indicated they prefer to deliver at home or are pressured by to do so by family. Other factors similar to those described in Record 3.
7	UNHCR	Egypt and Jordan	CCT	Safe motherhood	Not reported	Not reported	Not reported	Syrian people have a strong demand for health services

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
8	UNHCR	Jordan	UCT	Indirect link with safe motherhood	PDM: 2% of families use money to pay for costs related to delivery. 64% of families used money to pay for health-related costs. PDM report from 2018 -> 25% families report that the cash assistance has "significantly" improved their access to health. This report does not include information about % of families using funds to pay for deliveries or other SRHR services.	Not reported	Not reported	Not reported
9	UNHCR	Jordan	UCT	Safe motherhood	"Syrian refugees pay for costs of NVD or for C-section. No further description in report"	Not reported	$400,000 were saved by providing cash directly to women to access services themselves. UNHCR is charged up to three times more if they refer through the referral system than if refugee women pay the delivery themselves.	The low level of security concerns, the advanced banking systems, existing provision of cash to meet basic needs provided an ideal environment for cash assistance to achieve health outcomes. The intervention may not be successful in a context where refugees basic needs were not met (resulting in diversion of cash provided to meet basic needs) or did not have high demand for facility delivery (requiring investment in behaviour change to create demand). The program also used existing systems of vulnerability identification.

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
10	UNHCR	Lebanon, Ecuador, Morocco	UCT (no details)	SGBV	Lebanon Although the evidence confirms that cash contributes to a certain level of empowerment, resilience appears to be more contingent on the individual human and social capital. Cash does not appear to influence the underlying factors that make individuals vulnerable to SGBV, such as unequal gender dynamics or social norm, nor to alleviate the suffering and trauma that derive from it. Ecuador Cash transfers were found to be effective in preventing and mitigating SGBV insofar as they are received in conjunction with other elements of the GA, including psychosocial support, support and regular visits by social workers, training and capacity building in areas such as human rights, self-confidence, and financial independence.	Not reported	The duration and transfer amount of cash assistance, even when multiple cash components are considered in combination, is for the most part not sufficient to cover for the multiple and ever increasing needs of refugees in a context of protracted displacement, increasing vulnerability and limited economic opportunities.	Not reported

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
11	Yoshikawa, L	Jordan	UCT	SGBV	GBV: Women in the FGDs perceived the cash assistance to reduce household tensions. Also positive reactions about effects on psychosocial benefits and social cohesion. Women widely reported that they benefited from receiving both cash transfers and psycho-social support, rather than cash alone.	No reported	ATMs are available and its use allows to maintain confidentiality of the SGBV survivor. Trainings needed to be sure that people can use ATMs Hawala system tested -> more expensive but friendly The ERD and WPE monitoring and case management systems not interconnected. It is hard to follow individuals across systems (continuity)	Not reported
12	WRC/CARE	Ecuador	UCT	SGBV	51% of participants used the CVA to access health services (in general). Not from the document review! During a presentation (webinar) it was mentioned that although on paper services for SGBV survivors is for free in Ecuador, it is not strange that facilities do not have supplies. as such, it is possible that some survivors used the money to buy medicines.	Not reported	High acceptance on delivery mechanism. It is seen as safe and accessible (ATMs)	Discrimination and xenophobia against Venezuelan migrants

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
13	Agha	Pakistan	Value voucher Subsidised	Safe motherhood Family Planning	High redemption rates; significant increase in institutional deliveries; positive but not significant increase for ANC and PNC; no effect on FP.	Strengthening of quality of service provision (ANC, PNC) alluded to, but not measured.	Not reported	Rural areas: limited availability of maternal health providers; inadequate management, non-availability of female staff, shortage of medicine, low motivation levels of service providers and restricted hours of operation (office hours for public sector providers are from 8 am to 2 pm); facilities charge for services Pakistani women who can afford to pay for services exhibit a clear preference for the private sector
14	Ahmed & Khan	Bangladesh	Value voucher	Safe motherhood	Voucher recipients were 3.58 times more likely to be assisted by skilled health personnel during delivery than others. Voucher program participants were also 2.5 times more likely to deliver baby in a health facility and 2.8 times more likely to receive PNC than women not in the program. The voucher recipients were twice as likely to use ANC services and 1.5 times more likely to seek treatment for obstetric complications.	Not reported	Communication and coordination issues leading to deviation in implementation plan. Delay in releasing funds for reimbursements creating discomfort among providers and recipients. Difficult to follow the strict selection criteria. The poorest women had more than two children which made them ineligible. Staff considered the selection criteria unfair and difficult to enforce. Some stakeholders thought that providing nutritious	Poor availability and quality of services. No accredited private providers available. This meant less choice for women.

							food and other necessary items for the mother and the new-born would have been a better approach than the cash benefits. On the other hand recipients were satisfied with type of assistance and with the services that they could access/use with the voucher.	
15	Ahmed & Khan	Bangladesh	Value voucher Combined with creation of seed funds to be sussed by providers for quality improvement	Safe motherhood	See record 14	See record 14	See record 14	See record 14
16	Alfonso, N et al.	Uganda	Value voucher Combined with "modest" HSS investments and refresher trainings	Safe motherhood	Institutional deliveries: increase (significant) Cost Effective Analysis comparing the status quo and VS's most conservative effectiveness estimates shows that VS had an incremental cost-effectiveness ratio (ICER) per DALY averted of US$302 and per death averted of US$20 475. From the medical perspective, the ICER per DALY averted is US$338. According to the WHO, interventions are very cost-effective if the ICER is lower than the GDP per capita.	VS helped providers finance supplies and equipment, and access to improved provider training. HF users' increased provider choices, which increases competition among HFs improving quality of services provided. Note: these claims are not supported with the information available in the paper.	Huge initial response that required to review (reduce) the package.	Participation of private transportation providers who became active promoters of attended deliveries.

					The Uganda Gross domestic product (GDP) per capita in 2010 was US$506 (World Bank Group 2013). Thus, a US$302 ICER is very cost-effective.			
17	Ali, M et al.	Pakistan	Value voucher	Family planning	The model (focusing on private providers) enables widespread access to costly, long-term family planning services. The public sector can use this model to increase the reach of their services. The role of community mid-level service providers in enhancing contraceptive use is highlighted -> increased acceptability.	Not reported	Not reported	Poorest people living in rural environments experience significant difficulty in gaining access to essential health services, including Contraceptive uptake is as low as 23% and 20% in the rural and in the poorest populations respectively. About 50% of FP services in rural areas are provided my private sector facilities.
18	Marie Stopes International Ethiopia	Ethiopia	Value voucher	Family planning	"The eVoucher seems to have increased awareness among young people of services offering contraceptive" Note: no data to support this claim	Not reported	High penetration of mobile phones Commitment of government to improve FP	Ethiopian women tend to marry young, (>50% of women bearing children by the age of 20). Very limited access to and choice of modern contraceptives. The unmet need for family planning in Ethiopia is highest among women aged between 15 and 19 years old.

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
19	Bellows, N	Kenya and Uganda	Value voucher – Subsidised	Safe motherhood STI/HIV	The Kenya voucher program has provided clients with over 96,000 facility-based deliveries and over 27,000 long-term family planning methods. By the end of phase II The proportion of C-Sections (in Kenya) was 16.7% of all voucher deliveries, which is considered acceptable for the population being served. In Uganda, the C-Section rate is 15%.	Facilities in both Kenya and Uganda were using voucher revenues to make quality improvements, such as infrastructure enhancements, additional staff, and renewed equipment and supply stocks. Private facilities, in particular, were using voucher income for additional staffing.		GBV is underreported, with few victims receiving adequate treatment.
20	Federal Ministry for Economic Cooperation and Development (Germany)	Kenya	Value voucher – Subsidised SGBV voucher free Combined with HSS support at HF and DHMT level	Safe motherhood Family Planning SGBV	Selected health facilities also showed an increase in professionally assisted births (among both voucher and non-voucher clients) of 57% overall, though with considerable variation between sites. By the end of phase I (October 2008), 76% of the safe motherhood vouchers sold had been used for assisted childbirth. However, stigma, shame and fear surrounding gender-based violence (GBV) make women extremely reluctant to report it and have limited	Although there is some dissatisfaction with the set rates, the voucher scheme remains attractive to service providers because it expands their client base and provides a predictable income stream that gives them the confidence to invest in their services. VS opens door for PPP - government undertakes checks and accreditation visits even for	Some dissatisfaction with the set rates, the voucher scheme remains attractive to service providers because it expands their client base and provides a predictable income stream that gives them the confidence to invest in their services. Opens door for PPP - government undertakes checks and accreditation visits even for private providers. Mixed steering group.	Not reported

					the impact of this component of the voucher scheme. By year three of phase II, GBV vouchers had achieved only 29% of the targeted uptake.	private providers. Mixed steering group.		
21	Janisch, C.P. et al	Kenya	Value voucher - Subsidised SGBV Voucher free	Safe motherhood Family Planning SGBV	See record 20 (same project)	The voucher reimbursements have also enabled a number of VSP to buy new medical equipment, hire more qualified staff, as well as optimise their medical treatments. The benchmarks for quality have not only helped the targeted population gain access to quality health services but have also heightened quality for non-targeted patients as they, too, are treated by additional qualified staff and benefit from newly purchased medical equipment	Not reported	Deficient pharmaceutical procurement and distribution system, leading to a lack of stock at the accredited facilities

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
22	Kanya et al	Uganda	Value voucher – Subsidised Combined with trainings on clinical and procedural issues	Safe motherhood	The program paid for 38% of estimated deliveries among the PP in the targeted districts, There was a significant negative correlation between the poverty density in a district and proportions of births to poor women that were covered by the program. -> not explained why. Improving coverage of health facility deliveries for poor women is dependent upon increasing the sales and redemption rates.	PPP -> the inclusion of public health facilities in the program offers potential for increasing the scope and coverage of contracted facilities within the regions and to address geographical access barriers.	Perceived need to accredit more facilities to expand the geographical coverage of the program. In particular, the inclusion of public health facilities Also consider mechanisms for implementing a transport voucher.	Not reported
23	Massavon , W et al	Uganda	Value voucher (only transport to HF) Combined with “baby kits” and HSS support over 5 years	Safe motherhood	Transport vouchers had greater effects on all four outcomes, whereas baby kits mainly influenced institutional deliveries. The absolute increase in institutional deliveries attributable to vouchers was 42.9%; the equivalent for baby kits was 30.0%. Additionally, transport vouchers increased the coverage of four antenatal care visits and postnatal care service coverage by 60.0% and 49.2%, respectively.	Some users “bypassed” the system taking advantage of the voucher. This means skipping the PHC facility that they should go to. Bypassing was explained as a result of poor perception of quality	Not reported	Access to facility delivery is limited in the district. Due to lack of PHC facilities, referral facilities are now also burdened with service provision/deliveries. Access issues due to large distances. Also perceived low level of quality.

					'Bypassing' was mainly related to transport vouchers and ranged from 7.2% for postnatal care to 11.9% for deliveries. The financial cost of institutional delivery was US$9.4 per transport voucher provided, and US$10.5 per baby kit. The incremental cost per unit increment in institutional deliveries in the transport-voucher system was US$15.9; the equivalent for the baby kit was US$30.6.			
24	Ngoma et al	Uganda (Zambia not included in this review)	Value voucher (only transport to HF) Combined with HSS support	Safe motherhood	Note: Results due to major HSS component. CVA component small in proportion. The proportion of deliveries in any health facility or hospital increased from 46% to 67% in Uganda between baseline and endline. Distance to health facilities was reduced by increasing the number of health facilities capable of providing basic emergency obstetric and new-born care services in Uganda - a 200% increase.	Not reported	Not reported	Not reported

					Access to facilities improved through integrated transportation and communication services efforts. In Uganda there was a 6% increase in the number of health facilities with communication equipment and a 258% increase in facility deliveries supported by transportation vouchers.			
25	Nguyen, H.T.H et al	Bangladesh	Vulnerable pregnant women (poor) on 1st or 2nd pregnancy who have used FP between both pregnancies Combined with monetary incentive for CHW	Safe motherhood	For the most recent births, nearly all women in the intervention group had at least one ANC visit (91.6%) while only 75.6% did so in the comparison group (p <0.001). The proportion of births attended by a qualified provider was nearly 2.8 times higher in the intervention than comparison areas (63.7% vs. 27.1%, p< 0.001), while the proportion of institutional births was twice as high (37.5% vs. 18.7%, p< 0.001). The amount of OOP payment is about 34% lower in the intervention than in the comparison sub districts (Taka 1441 vs. 2191, p < 0.001).	The supply-side investments have not kept up with the increased demand, resulting in long waiting lines, poor provider attitudes, and medication stockouts	Challenging to enforce the criteria of poverty, parity, and family planning practice between the first and second birth, Also problems with timely reimbursement of the providers and women and assuring quality of car	Not reported

	Author	Country	Type of CVA	SRHR component	Effects reported demand-side	Effects reported supply-side	Operational considerations	Contextual factors
26	Nuwakora, C.B.	Uganda	UCT	SGBV	"The program has impacted many beneficiaries by helping them to change their attitude towards poverty, so that they exhibit less of a "dependency syndrome". They seem to have an improved capacity to change their destiny through diversified livelihoods e.g. cultivation, saving/borrowing, trade and animal rearing. Gender relations are somewhat changing, with women more economically empowered to take on roles that were traditionally a reserve for men, e.g. paying school fees for school-going children. Additionally, there is mutual understanding where couples would have experienced differences."	Not reported	Rural setting was seen as a challenge in the delivery of cash, which was resolved by the usage of a mobile banking van which was supplied on the days when disbursement of funds occurred	Not reported
27	Obare, F et al	Kenya	Value voucher – Subsidised SGBV voucher free	Safe motherhood Family planning SGBV	The findings suggest that the program is associated with increased health facility deliveries and skilled delivery care especially among poor women. However, it has had limited community-level impact on the first trimester timing of antenatal care use and making four or more visits, which remain a challenge	Not reported	Qualitative data showed that some women who purchased the vouchers failed to use them because of higher transportation costs to accredited health facilities compared to service costs at nearby non-contracted providers	92% of expectant women in Kenya make at least one antenatal care visit to a skilled provider while only 43% of the births take place in a health facility

					despite the high proportion of women in the country that make at least one antenatal care visit during pregnancy.			
28	Okoli, U et al	Nigeria	CCT Combined with HSS support	Safe motherhood Family planning	Significant positive slope effects were observed after the program began on the number of women attending for four or more ANC visits. The facilities implementing the CCT program also showed a significant rise after the supply-side intervention began on the monthly rates of delivery with skilled attendance, although there was also a level decrease in neonatal immunisation Changes for other outcomes with the CCT intervention (number of women attending first ANC visit; number of deliveries with skilled attendance; number of neonates receiving OPV at birth) were not found to be statistically significant.	The additional demand generated, and some new reporting tools created additional workload for the participating facilities, which had varying levels of capacity to handle this work	Not reported	Not reported

3.5 Synthesis – Operational feasibility

Interestingly only two of the 29 projects mentioned some sort of feasibility assessment prior to the start of the project focusing on relevance, suitability, context, and risks (both protection and fraud). It is unclear if the lack of information results from the limited space available in certain publications to describe in detail all aspects of the project, or if this actually reflects a common practice.

Some of the key operational challenges described are delays in payments which undermines the trust of providers and beneficiaries of the system. In addition, poor capacity to deal with increased demand for services also undermines demand and may lead to reduced utilisation. As such, the success of the CVA component (increase demand) can bring unanticipated effects on the supply-side, and the systems' ability to deal with the increased demand, which should have been foreseen and managed alongside the support to increase demand. Another challenge mentioned was in relation to defining and agreeing on the fees for certain services. Some projects reported that service providers were unhappy with the agreed value of the voucher, however, the widening of the user base compensated for this issue. Finally, and as a particular issue reported in Kenya, where some women failed to use the vouchers due to high transport costs to reach the facilities, to use the vouchers. This highlighted the need to do a full analysis on the key underlying financial and non-financial barriers to the utilisation of services prior to choosing the most appropriate mix of response options, in addition to assessing the capacities and quality on the supply-side, before the start of the project. Finally, one of the projects run by a UN organisation reported that by providing cash directly to women the organisation could save money as they were charged international rates of up to three times more if the organisation would refer women to receive care, compared to allowing women to pay the providers directly at national rates. This of course raises the issue of not being able to control the quality of services that beneficiaries chose to use. This is a problem with UCT but not so much with vouchers. In this case, there was an attempt to mitigate the risk, by discussing preferred facilities, based on existing health seeking behaviour. Finally, an issue for projects focusing on SGBV. Given the intersectoral response that is needed to provide care and protection to survivors, it is essential to ensure that systems are interconnected allowing survivors to be followed across the different platforms. CVA interventions should therefore be embedded in this system and can't be an intervention on their own.

Operational factors that have a positive effect on the CVA included the acceptance of SRHR services and cash and/or vouchers by authorities and the target group. In addition, populations with a strong health seeking behaviour but experiencing difficulties in accessing services (e.g. financial barriers) tend to benefit the most. This is particularly the case with voucher schemes, because they are very flexible, allowing the modification of the target group, the package of services, the value of the voucher, and the mode of delivery rapidly according to the changes in the context.

3.6 Synthesis – Contextual factors

The review of contextual factors highlighted the importance of looking at all barriers to accessing services, not only the financial ones. Security, culture, gender, distance, as well as awareness of the availability of services, are key factors to take into account. Also, in places where other basic needs of the target group are not met, it is unlikely that a CVA intervention will be of much help in increasing service utilisation. Health outcomes are also affected by other determinants than health services alone. We should, therefore, avoid forcing households to choose between goods and services that are essential for their wellbeing.

4. Discussion

4.1 Summary and discussion of key findings

The objectives of this scoping review were to describe the effects of CVA on access to and utilisation of SRHR services in humanitarian settings and to describe operational and contextual factors influencing the implementation and results obtained by CVA interventions in humanitarian settings, to identify any advantages or disadvantages of CVA as a way of reducing financial barriers and/or increase access to SRHR services, and, finally, to identify lessons learned for future CVA for SRHR programming.

Given the limited number of publications found from humanitarian settings, the review was expanded to include evidence on the use of CVA for SRHR in any of the top 40 countries in the Fragile States Index (often overlapping with humanitarian settings). Thirty (30) documents were identified for extraction. These reported the experiences of 29 projects in Africa, Asia, Latin America, and the Middle East.

In line with the body of evidence on CVA for SRHR in development settings, most of the documents reviewed were from projects focusing on safe motherhood and family planning. Few documents from projects focused on SGBV or STI/HIV, and none on other SRHR components such as post-abortion care/safe abortion, or adolescent SRHR were found. While it is possible that the search strategy failed to identify those papers, it is more likely that the set of documents reflects the type of interventions that are actually implemented in the field. Another possibility is that there is some sort of publication bias. In any case, from feedback during the consultative meeting in Amsterdam, it seems that there are a lot of experiences of using CVA for SRHR which are not being documented or shared. If that is the case, this would be a lost opportunity for knowledge sharing and learning.

Unfortunately, the papers do not include detailed information about the assessment(s) done before designing and implementing the CVA intervention. Having such information could help to understand the response analysis (e.g. the selection of a specific modality for the delivery of the assistance and the type of assistance). This is key, as any choice for an intervention mix should be based on a needs-, supply-side- and barriers-analysis. This situation is not exclusive for evidence coming from fragile and humanitarian settings as documents describing experiences in development settings have the same issue. The few documents from projects

focusing on SGBV tend to have more information about the work done in preparation for the CVA intervention.

It is important to highlight that almost half of the projects described in this review worked with a mix of public and private providers. Such a mix allow the government to improve private sector oversight. This, for example, allowed for working on the accreditation of facilities for a voucher program or provided opportunities for harmonising protocols and procedures. It is also important to recall that certain voucher programs can be seen as a first limited step towards national health insurance. In addition, the public-private mix increased the flexibility of the system, by allowing decision-makers to add or withdraw facilities according to the constantly evolving needs in the field. The flexibility of CVA interventions, and especially of voucher schemes, was found to go beyond service provision, as the package of services, the value of the voucher and services, the target population, and the processes around it can also be modified depending on the need.

Given the previously explained need to combine CVA with supply-side interventions it is not surprising to find that almost half of the projects described mentioned some sort of Health System Strengthening intervention (e.g. training, PBF, health facility infrastructure improvements). It remains unclear why the other projects did not consider adding such components. Only a couple projects reported unanticipated effects on the supply-side following the implementation of the CVA intervention. It is, therefore, possible that more projects did include a supply-side intervention in the design, but this information was omitted to give more space in the publication to the results of the intervention itself.

As described earlier in this paper, the initial intention was to describe the effects of CVA on access to and utilisation of SRHR services using the dimensions described in the Levesque model. Unfortunately, this was not possible, due to the tendency to report results mostly focusing on indicators of the utilisation of services. Such ways of reporting offer, in most cases, a clear way to quantify the effect of the intervention. Nevertheless, by missing the chance to explore and describe what happens in the different dimensions of access, decision-makers and researchers miss the chance to better understand the different factors influencing the access and utilisation in a given context. A thorough analysis of the needs, capacities, barriers and bottlenecks as the basis to analyse response options would help to determine what mix of financial and non-financial interventions on both demand and supply-side are most likely to contribute to improved access and utilisation of SRHR programming. In general, reports and articles focusing on projects addressing SGBV tend to have more detailed qualitative components that allow a better understanding of how the CVA intervention works.

The findings of this review are in line with the results coming from research around CVA for SRHR projects in the development sector. In short, CVA interventions can increase the utilisation of services, also in humanitarian contexts (some pieces of evidence reporting statistically significant results). This statement applies mostly to the safe motherhood and family planning components as documented evidence on the effects of CVA on the utilisation of other SRHR components is scarce. A preliminary presentation of results to the representatives of agencies implementing CVA for SRHR in humanitarian settings allowed the preliminary findings to be discussed with the group. The impression of the group of experts was that, yes, there is often more emphasis on SM and FP services, but it is also possible that

there is underreporting. As such, there may be experiences using CVA for other types of SRHR services, but the results have not been published.

4.2 Study limitations

The review team tried to reduce the chance of missing relevant documents by reviewing the search terms, by adding more search engines and databases, and by approaching authors of relevant papers as well as members of the steering committee to share key documents for this review. In addition, the review only took documents in English into consideration. From the discussions with representatives of the implementing agencies, it seems realistic to expect that there is a considerable amount of evidence that remains unpublished. Furthermore, the review intended to analyse the effects of CVA on the dimensions of access, however, the high proportion of papers using only service utilisation indicators to report results meant such a detailed view was not possible.

The last remark concerns the different ways to describe the interventions, settings, and results of the CVA components. The use of a standard extraction tool as well as a team of three reviewers aimed at reducing the chances of missing information during the extraction or analysis phase.

5. Conclusions

There is a limited body of evidence about the use of CVA for SRHR in fragile and humanitarian settings. Despite this, the suggested picture seems to match that which is described in the evidence from the development sector. That is, CVA does lead to an increase in the utilisation of certain types of SRHR services, and acts on both the demand- and supply-side enablers/barriers. There is little or no information on how the CVA intervention affect the different dimensions of access, as the articles reviewed did not provide details on these aspects.

Although the evidence from humanitarian settings is limited, there is no indication that approaches with CVA which have proven to be effective in development settings would not work in humanitarian settings. Translating the experiences from development settings to humanitarian ones will perhaps require more explicit risk management analysis to understand and address the specific operational challenges of the setting. Although this study tried to find information about the assessments done prior to implementation of the different interventions, little information was found.

The review highlights the importance of doing a full analysis on the key underlying financial and non-financial barriers to the utilisation of services before choosing the most appropriate mix of response options, in addition to assessing the capacities and quality on the supply-side, before the start of the project. This is key to determining what mix of financial and non-financial interventions on both demand and supply-side is most likely to contribute to improved access and utilisation of SRHR programming, as CVA is never a standalone intervention. When demand is increased, it should be anticipated that there is a need to invest in health system delivery capacity to meet this. When availability is increased, there is

a need to understand if the target population face possible barriers to use these, and address them. This analysis is needed before considering different response options, to understand what the status of needs, supply & demand-side barriers, availability, capacity and quality is in a context.

Despite the importance of addressing SRHR throughout a continuum of all stages in life, none of the articles reviewed explicitly mentioned a life course approach. It would be of great value to explore how the utilisation of each component of SRHR (including child health) can be supported as a continuum throughout the lifecycle within CVA interventions in humanitarian settings.

Finally, in addition to this review, two case studies of CVA programs in Afghanistan and Yemen have been documented. As case studies demonstrate practical examples of CVA programs, describing the context, problem analysis, and operational aspects and discussing the lessons learned from these experiences, they are perhaps more useful to inform future practice compared to formal publications.

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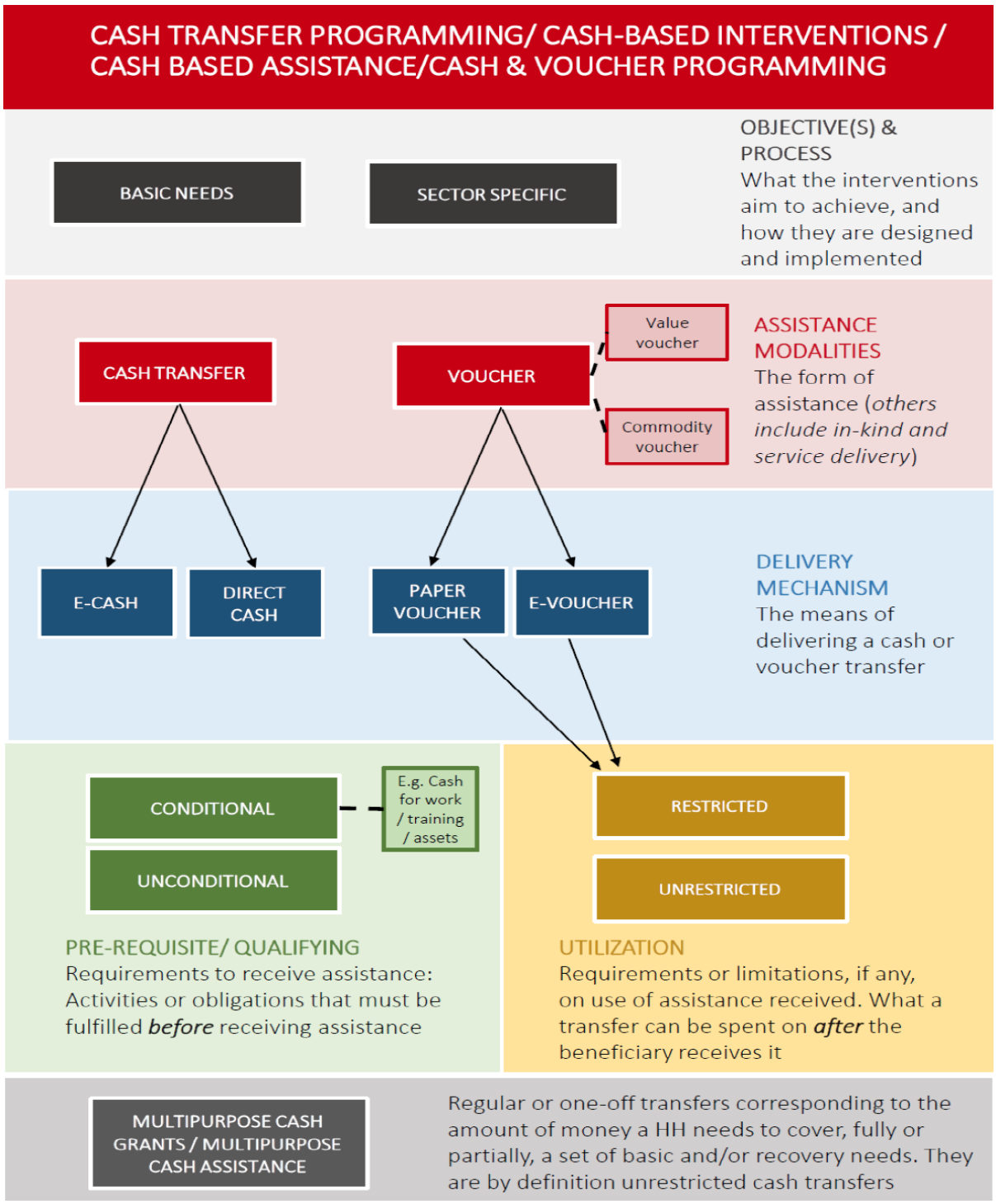
7. Annexes

Annex 1. Types of Cash and Voucher Assistance



Source: (CaLP, 2017)

Annex 2: Evidence for CVA for SRHR from Development settings, derived from the presentation by Anna Gorter during the expert meeting 2020		
Topic	**Key findings**	**Sources**
Summary of evidence of CVA for SRHR in development settings	• CVA increases utilisation of ANC (including earlier and more frequent ANC), skilled attendance at birth, institutional delivery and PNC (strongest effect with vouchers) • CCTs have shown little effect on MNH outcomes (mortality, low-birthweight, post-delivery behaviours, fertility) • CCTs have no effect on improvements in quality of maternity care unless accompanied by supply-side investments • CVA can have a positive effect on equity, specifically when using vouchers. For CCTs the evidence is mixed, partly due to lack of. robust studies and also because the effect is highly context specific with little research on costs and effectiveness of targeting approaches	Alatas et al. 2012; Amudhan et al, 2013; Bowser et al. 2016; Glassman et al. 2013; Hunter & Murray 2017; Keya et al. 2018; Lim et al. 2010; Malqvist et al. 2013; Ng et al. 2014; O'Neil et al. 2017; Owusu-Addo et al. 2019; Powell-Jackson et al. 2015; Randive et a. 2013; Till et al. 2017
CCTs work only at the demand--side - several high quality reviews find:	• A complex picture of experiences with DSF which reflect the importance of financial and other cultural, social, geographical and health systems factors as barriers to accessing care • The majority of studies underline the need for concurrent (or staggered) supply-side investments to overcome important barriers to access (see below) • Some evidence that CCTs can affect behaviours and learning in the longer-run (i.e. once CCT stopped) • Challenges with evaluation study designs which do not investigate the pathways through which CCTs impact on outputs and outcomes	Glassman et al. 2013; Hunter & Murray 2017; O'Neil et al. 2017
CCTs for maternal newborn care lead to increased demand and utilisation of services putting pressure on already constrained service delivery capacities. Quality improvements – particularly as perceived by clients (i.e. hygiene, respectful care)	There is a strong need for concurrent investments in: • Service availability 24/7 (incl. PHC) • Health facility infrastructure • Strengthening referral systems • Human Resources for Health (midwives, community health workers) • Community awareness raising activities • Systems for targeting the poor and vulnerable	Amudhan et al. 2013; Glassman et al. 2013; Hunter & Murray 2017; Jehan et al. 2012; Vellakkal et al. 2017
Enabling factors for implementation of CCTs:	• Clear and simple operating procedures and guidelines + training/orientation at all levels to ensure implementation fidelity • More efficient operational management incl. financial transparency and funds flow • Sufficient and/or increasing cash payments to cover costs (i.e. transport) • Transport availability (particularly for EmONC) • Giving the cash to women (and not family members) • Built-in plans for sustainability and/or transition • Strengthened accountability mechanisms	Glassman et al. 2013; Jehan et al. 2012; Owusu-Addo et al. 2019; Salve et al. 2017
Barriers to effective implementation of CCTs:	• Payments that are too low (access for very poor & youth) • Lack of transport options and long distances • Administrative inefficiencies (i.e. flow of funds, overly complex & bureaucratic schemes) • Health system challenges (HRH – lack of midwives, poor infrastructure, supply-chain, etc.)	Hunter & Murray 2017; Hunter et al. 2017; Jehan et al. 2012; Murray et al. 2014

	• Poor awareness of schemes in communities and lack of community support • Some gaming (i.e. beneficiaries made to share cash with health staff, additional and/or informal payments) • Eligibility conditions can lead to difficulties with exclusion of migrants, young and multiparous women (i.e. Bangladesh, India, Nepal)	
There is more robust evidence for voucher schemes, which work on both the demand- and supply-side, than for other forms of DSF:	• Utilisation: robust evidence vouchers increase service utilisation • Equity: strong evidence vouchers can reach underserved populations (effective targeting) • Quality: modest evidence that vouchers can increase quality of services • Efficiency: emerging evidence that vouchers are cost-effective and can change health seeking behaviour in a sustainable manner • Impact: some programs have shown impact on health outcomes	Ali et al. 2019; Belaid et al. 2016; Bellows et al. 2013 and 2016; Bowser et al. 2016; Bright et al. 2018; Gopalan et al. 2014; Gorter et al. 2013; Grainger et al. 2014; Hunter and Murray 2017; Hunter et al. 2017; Meyer et al. 2011; Murray et al. 2014; Nachtnebel et al. 2015
Effect of vouchers on the supply-side, contribution to improved quality:	• Mapping identifies most appropriate clinics: private, NGO, public; near target group, cultural/social context etc • Assessment identifies clinics with best quality • Training in voucher services, if necessary • Periodic QA ensures quality is maintained • Clinics tailor their services to client's needs (even clinics which before had no interest in attending a specific client group, e.g. poor) • Clinics use voucher income to make clinic more attractive for clients	
Effect of vouchers on the demand-side, contribution to increased use of services:	• Financial: vouchers pay for costs; sometimes transport/ other costs • Involvement of the communities to organise voucher distribution • During voucher distribution face-to-face information/ education/ guidance is given • The voucher acts as a personal invitation; empowers clients to seek services; and provides proof-in-hand (paper voucher or e-code) she/he will be attended • Some clients such as adolescents also refer that the voucher reduces embarrassment; no need to explain reason of clinic visit	
Cash and Vouchers for transport:	There is strong evidence that transport and distance to a facility are major barriers to access for maternal healthcare: • Barriers can be addressed through • transport vouchers and/or cash transfers for transport/ birth preparedness	Hunter & Murray 2017; Khanal 2018; Mutebi & Ekirapa-Kiracho 2015 (E. Uganda); Options 2018 (Kenya); Raje

	• Provision of transport, including community savings schemes and community support for arranging transport • In general, a lack of research and studies on effectiveness of transport subsidies: no reviews, few studies - findings are mostly descriptive • One study showed that utilisation of facility deliveries increased with the provision of transport vouchers: • Eastern Uganda transport vouchers - combined with supply-side payments	2018; Serbanescu et al. 2019

Annex 3. Results literature search

0 CVA desk review search results.xlsx

Annex 4. Overview literature included in this review

	Title	Author	Year	Country	Type of publication	Target group	Type of CVA	SRHR component	Outcomes reported
1	Vouchers in Fragile States: Reducing Barriers to LARC in Yemen and Pakistan	Boddam-Whetham, L et al.	2016	Yemen and Pakistan	Journal article	Vulnerable women (poor)	Value voucher	Safe motherhood	Utilisation of LARC and PM*
2	Evaluating the comparative effectiveness of different demand-side interventions to increase maternal health service utilisation and practice of birth spacing in South Kivu, DRC: an innovative, mixed methods approach	Dumbaugh, M. et al	2017	DRC	Journal article	Pregnant women	Subsidised care; CCT; Non-monetary incentive Combined with PBF	Safe motherhood Family planning	Protocol describing intervention – no results retrieved
3	Conditional cash transfers to improve use of health facilities by mothers and new-borns in conflict affected countries, a prospective population based intervention study from Afghanistan	Edmond et al.	2019	Afghanistan	Journal article	Pregnant women CHW	CCT Combined with incentive for CHW	Safe motherhood	ANC, institutional delivery rates
4	Providing safe motherhood services to underserved and	Grainger, C et al.	2017	Yemen	Journal article	Pregnant women	Value voucher – Subsidised	Safe motherhood	ANC, institutional delivery rates

	neglected populations in Yemen: the case for vouchers						Combined with clinical trainings		
5	Evaluation of the Use of Different Transfer Modalities in ECHO Humanitarian Aid Actions 2011-2014	Maunder et al	2016	Syria	Report – review of different projects	Vulnerable women (IDPs or living in most in need communities)	Value voucher Combined with training MISP and on SGVB	Safe motherhood	No outcomes reported
6	Stimulating demand: an assessment of the CCT project in Afghanistan	Meng Hsuan (Ann) Lin	2016	Afghanistan	PhD thesis	Pregnant women CHW	CCT Incentive (for CHW)	Safe motherhood	Odds of delivering in a health facility
7	Cash-based Interventions for Health programmes in Refugee Settings. A Review	UNHCR	2015	Egypt and Jordan	Report	Pregnant Syrian refugees	CCT	Safe motherhood	No outcomes reported
8	UNHCR Cash assistance: Improving refugee lives and supporting economies PDM for Syrian Refugees Jordan	UNHCR	2016	Jordan	Report	Syrian refugees	UCT	Indirect link with safe motherhood	% HH using part of funds received to pay costs of institutional deliveries
9	Cash for Health Key learnings from a cash for health intervention in Jordan	UNHCR	2016	Jordan	Project description	Pregnant refugees	UCT	Safe motherhood	No outcomes reported
10	Cash assistance and the prevention mitigation and response to SGBV	UNHCR	2018	Lebanon, Ecuador, Morocco	Summary of research findings	Female refugees and migrants (at risk and	UCT (no details)	SGBV	Claims on effectiveness of

	Findings from research in Lebanon, Ecuador and Morocco					survivors of GBV)			intervention – no data
11	Integrating cash transfers into gender-based violence programs in Jordan: Benefits, risks and challenges	Yoshikawa, L	2015	Jordan	Report	Syrian female refugees and migrants (at risk and survivors of GBV)	UCT	SGBV	Qualitative information about effect of intervention on SGBV, social cohesion, and psycho-social wellbeing
12	Utilising Cash and Voucher Assistance within GBV Case Management to Support Crisis-Affected Populations in Ecuador	WRC/CARE	2019	Ecuador	Report	Venezuelan refugees (at risk and survivors of GBV)	UCT	SGBV	% participants using part of funds to use health services
13	Changes in the proportion of facility-based deliveries and related maternal health services among the poor in rural Jhang, Pakistan: results from a demand-side financing intervention	Agha	2011	Pakistan	Journal article	Vulnerable women (poor) Combined with quality improvement program (support and supervision)	Value voucher - Subsidised	Safe motherhood Family planning	ANC, institutional deliveries, PNC, FP
14	Is demand-side financing equity enhancing? Lessons from a maternal	Ahmed & Khan	2011	Bangladesh	Journal article	Vulnerable pregnant women (poor) on 1st	Value voucher	Safe motherhood	ANC, institutional deliveries, PNC, FP

	health voucher scheme in Bangladesh					or 2nd pregnancy			CE analysis
15	A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh?	Ahmed & Khan	2011	Bangladesh	Journal article	Vulnerable pregnant women (poor) on 1st or 2nd pregnancy	Value voucher Combined with creation of seed funds to be sussed by providers for quality improvement	Safe motherhood	See record number 14 – same program
16	Cost-effectiveness analysis of a voucher scheme combined with obstetrical quality improvements: quasi experimental results from Uganda	Alfonso, N et al.	2013	Uganda	Journal article	Pregnant women	Value voucher Combined with "modest" HSS investments and refresher trainings	Safe motherhood	Institutional deliveries Incremental cost-effectiveness ratio (ICER) per DALY and per death averted
17	Are family planning vouchers effective in increasing use, improving equity and reaching the underserved? An evaluation of a voucher program in Pakistan	Ali, M et al.	2019	Pakistan	Journal article	Vulnerable women (poor) who are clients of a social franchising network	Value voucher	Family planning	Contraceptive use
18	E-vouchers in Ethiopia	Marie Stopes International Ethiopia	2013	Ethiopia	Report	Young people between 15 and 29 years old	Value voucher	Family planning	Generic claim: increased awareness among young about services

									offering contraceptives
19	Vouchers for reproductive health care services in Kenya and Uganda	Bellows, N	2012	Uganda	Report	SM – vulnerable pregnant women (poor) STI – general population	Value voucher - Subsidised	Safe motherhood STI/HIV	Assisted deliveries, STI service provision
20	Vouchers: making motherhood safer for Kenya's poorest women	Federal Ministry for Economic Cooperation and Development (Germany)	2012	Kenya	Report	Vulnerable women (poor)	Value voucher – Subsidised SGBV voucher free Combined with HSS support at HF and DHMT level	Safe motherhood Family planning SGBV	Assisted deliveries Redemption of all types of vouchers See records 21 and 27 – same project, different year
21	Vouchers for health: A demand-side output-based aid approach to reproductive health services in Kenya	Janisch, C.P. et al	2010	Kenya	Journal article	Vulnerable women (poor)	Value voucher – Subsidised SGBV voucher free	Safe motherhood Family planning SGBV	Assisted deliveries, utilisation of FP services, Sale and redemption of vouchers See records 20 and 27
22	Safe motherhood voucher programme coverage of health	Kanya et al	2014	Uganda	Journal article	Vulnerable women (poor)	Value voucher – Subsidised	Safe motherhood	Assisted deliveries

	facility deliveries among poor women in South-western Uganda						Combined with trainings on clinical and procedural issues		Sale and redemption of vouchers
23	Effects of demand-side incentives in improving the utilisation of delivery services in Oyam District in northern Uganda: a quasi-experimental study	Massavon, W et al	2017	Uganda	Journal article	Pregnant women (later also extended to those who recently delivered)	Value voucher (only transport to HF) Combined with "baby kits" and HSS support over 5 years	Safe motherhood	Institutional deliveries, ANC, PNC, "by-pass" the local service provision CE analysis
24	Addressing the Second Delay in Saving Mothers, Giving Life Districts in Uganda and Zambia: Reaching Appropriate Maternal Care in a Timely Manner	Ngoma et al	2019	Uganda (Zambia not included in this review)	Journal article	Pregnant women	Value voucher (only transport to HF) Combined with HSS support	Safe motherhood	Institutional deliveries Redemption of vouchers
25	Encouraging maternal health service utilisation: An evaluation of the Bangladesh voucher program	Nguyen, H.T.H et al	2012	Bangladesh	Journal article	Pregnant women	Vulnerable pregnant women (poor) on 1st or 2nd pregnancy who have used FP between	Safe motherhood	ANC, institutional deliveries, C-sections, OOP payment for MH services See record 14

							both pregnancies Combined with monetary incentive for CHW		
26	Combating gender-based violence and enhancing economic empowerment of women in Northern Uganda through cash transfers	Nuwakora, C.B.	2014	Uganda	Report	Vulnerable women (relocated after the war 2002-2006 and residing permanently in the area; female headed households)	UCT	SGBV	Findings from qualitative research about the effects of the program Quantitative part is limited to outputs (e.g. trainings and other activities)
27	Assessing the population-level impact of vouchers on access to health facility delivery for women in Kenya	Obare, F et al	2013	Kenya	Journal article	Vulnerable women (poor)	Value voucher – Subsidised SGBV voucher free	Safe motherhood Family planning SGBV	Institutional deliveries, deliveries attended by SBA, timing of ANC, 4 or more ANC visits See records 20 and 21
28	Conditional cash transfers schemes in Nigeria: potential gains for maternal and	Okoli, U et al	2014	Nigeria	Journal article	Pregnant women (via geographic targeting)	CCT	Safe motherhood	First ANC, 4 or more ANC visits, deliveries

	child health service uptake in a national pilot programme						Combined with HSS support	Family planning	assisted by SBA, CCT participants LFU
29	Free contraception and behavioural nudges in the postpartum period: evidence from a randomised control trial in Nairobi, Kenya	McConnell, M et al	2018	Kenya	Journal article	Pregnant women	Paper voucher	Family planning	Uptake of modern contraceptives in the postpartum period
30	Does healthcare voucher provision improve utilisation in the continuum of maternal care for poor pregnant women? Experience from Bangladesh	Mahmood, S et al	2019	Bangladesh	Journal article	Pregnant women	Paper voucher	Safe motherhood	Utilisation in the continuum of maternal care

* LARC = long-acting reversible contraceptives; PM = Permanent method