

Social protection measures for increasing access to health services

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Question

What social protection interventions (e.g. cash transfers, vouchers, etc.) have been shown to support the most vulnerable to access health facilities at individual, community or health service level in the DRC or similar country contexts?

Contents

1. Summary
2. Introduction
3. Social protection measures: evidence of use
4. Health service level of social protection: country evidence
5. References

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1. Summary

Social protection is concerned with preventing, managing, and overcoming situations that adversely affect people's well-being. According to the World Bank (2013) social protection in health (SPH) mechanisms are public interventions that assist households and communities to better manage financial risks caused by health expenditure, as well as provide support to the critical poor. Various social protection interventions have been used to support the most vulnerable to access health facilities at individual, community or health service levels. Successful examples in the Democratic Republic of Congo (DRC) include *cash transfers*, *vouchers*, and *mutual health insurance*. Many aid interventions can also be classified as forms of social protection, and the attention given to this sector is increasing (Weijts et al., 2012). Key successes are noted below:

- Utilisation of health services in the DRC is low, particularly in rural areas - more than 30 million Congolese do not have access to quality healthcare (Richard et al., 2017).
- The National Social Protection Policy was drafted in 2015 to offset this – a law passed in 2016 will introduce social insurance maternity and prenatal benefits (effective 15 July 2018). However, DRC policies on social protection are said to be “incoherent,” and the few social protection schemes only benefit a limited number of people (Wasso, 2013; SOLIDAR, 2016).
- There are two social security measures in the DRC: (i) Compulsory membership for employees in the state body in charge of social security (*L'Institut National de Sécurité Sociale*, or INSS), or (ii) Membership by choice in a mutual health insurance scheme.
- The INSS used to receive all the workers in the formal sector, but due to its organisational weaknesses, some people prefer to join a mutual health insurance scheme (Wasso, 2013). An emerging phenomenon in DRC, only 1.4% of the population is currently covered by a mutual health scheme (SOLIDAR, 2016: 6-7).
- The Province of South-Kivu has the largest number of mutual health insurance organisations. However, the penetration rate remains low compared to the general population (Wasso, 2013).
- Cash transfers were the more cost-effective modality in research on internally displaced households paying health expenses in eastern DRC (Evans and Popova, 2014; Aker, 2017); they also improved the outcome of children treated for severe acute malnourishment (Grellety et al., 2017).
- Conditional cash transfers (CCTs) with increasing payments have been shown to benefit pregnant women newly diagnosed with HIV in terms of accessing available health care (Yotebieng et al. 2016; Owusu-Addo et al., 2018).
- Many international aid agencies are in favour of using vouchers in the DRC context for access to primary health care services (UNICEF, 2012; Aker, 2017; UNHCR, 2018), however ODI research shows aid agencies still have further to go in embedding cash transfers within their systems and cultures (Bailey, 2017).
- A financial subsidy from the Belgian Development Agency reduced the cost level of the health service flat fees in Kisantu in order to increase access (Stasse et al., 2015).
- Social and community health insurance schemes in effect define an essential health package which is available to all their members. Evidence from Cambodia shows that districts with health services that were contracted out to non-government

organisation/non-state providers delivered care more efficiently and equitably than those that remained under government control (Abramson, 2009; Palmer et al., 2006; Carpenter et al., 2012).

- This programme was also associated with an increase in the use of reproductive health services, improved immunisation rates, and a decline in time lost to illness (High-Level Forum on the Health MDGs, 2004; Carpenter et al., 2012: 40). As a result of the Cambodian package of health prototype, other countries, including the DRC, have also adopted large-scale contract-out health services successfully as part of social protection measures.
- Health insurance cards as part of the *Terintambwe* programme in Burundi (Devereux et al., 2015), and the *Mutuelle de Santé Communautaire* (MUSACOM) in DRC have also proved successful (Luneghe, 2018). Other positive country evidence on access to health services from Ghana (Livelihood Empowerment Against Poverty, LEAP), and Child Grants Programmes in Lesotho are included.

There are few data sources about specific health-seeking behaviours in the DRC, and they vary according to region, local health service providers, and rural vs. urban density (Naughton et al., 2017). There also was a dearth in information on access to health services for refugees. Experts consulted for this review concluded that effects of social protection on access to and use of health services are greatly enhanced if they include explicit linkages to health insurance mechanisms. As the majority of social protection programmes target female head of households, the evidence found for this review focussed more on female and child use of health services. Data on access to health care for disabled children (UNICEF, 2018) and adults (Handa et al., 2014; Beales Gelber, 2018) as a result of variable cash transfer and regular cash transfer programmes, respectively, was also found.

2. Introduction

Health status in DRC

Between 2007 and 2013, mortality for children under the age of 5 years decreased from 148 to 104 deaths per 1,000 live births in DRC. Overall, 45% of children aged 12 to 23 months received all recommended vaccines, up from 31% in 2007. The DRC has been polio-free for over three years, a major achievement given its size and the lack of infrastructure for delivering health services.

Still, the fertility rate in the DRC is 6.6 children per mother, among the highest in the world. The prevalence rate for contraceptives grew to just 8% from 6% between 2007 and 2013. Nearly 39% of women of childbearing age are anaemic, and 14% are underweight. In addition, rates of malnutrition have remained very high for two decades: 43% of children under age 5 years are stunted, indicating chronic malnutrition, and 8% are wasted, an indication of acute malnutrition.

Malaria remains a major health problem. The DRC has the second-highest number of malaria cases worldwide, accounting for 11% of the global total in 2013. Malaria is responsible for nearly one out of five deaths of children under age 5 years, and for an estimated 40% of outpatient visits by that age group.

The DRC ranks 6th out of the 22 countries that account for 80% of tuberculosis (TB) cases in the world. However, the prevalence of HIV/AIDS in the DRC is lower than in many sub-Saharan African countries, at 1.2% in the general population, but higher in urban areas and among women.

Health system access in the DRC

More than 30 million Congolese (approximately 70%) do not have access to quality health care (Richard et al., 2017: 2). Utilisation of health services is particularly low in rural areas and amongst the poorest. There are few data sources about specific health-seeking behaviours in the DRC, and they vary according to region, local health service providers, and rural vs. urban density (Naughton et al., 2017: 17). In 2013, it was estimated that 74% of the population lived more than 5km from a health centre. Data, including that from a 2010 cross-sectional study in Lubumbashi, the second largest city, show that key barriers to accessing the health sector include insufficient human resources, lack of well-trained staff, long wait times at clinics, lack of centralised supply chain management systems leading to frequent stock outs of commodities, and loss to follow-up (SOLIDAR, 2016: 6, Naughton et al., 2017: 17).

Organisation

As a result of the conflict and a chronic lack of investment, the health care system in DRC is weak, poorly managed, and inefficient (SOLIDAR, 2016: 6). DRC has a thriving not-for-profit indigenous network of religious health care providers who are major partners in the management of the district health system (Strasse et al, 2015). USAID report that the country has made measurable progress in recent years, due to improved leadership, coordination and investments in priority health issues by the government of DRC (GDRC) and international partners.¹

The organisation of the health system is decentralised, with primary and first-referral services integrated in Health Zones corresponding to geographical areas. There are four levels in the DRC health system: (i) the central government level with the Minister of Health (MOH) and Secretary General of the MOH; (ii) an intermediate level with the provincial health departments; (iii) administrative health districts (65 districts subdivided from the DRC's 26 provincial divisions), and (iv) a peripheral level with health zones and health centres. There are 516 health zones, each divided into health areas with catchment areas of 10,000 people and usually containing a hospital (Naughton et al., 2017: 15). Each Health Zone typically has between 10-20 health centres and comprises around 200 communities. Through user fees these sectors function as an alternative tax base, transferring money from the local health zones upwards through the national organisation (Weijjs et al., 2012: vii).

Social protection

As health insecurity has emerged as a major concern among health policy-makers, particularly in low- and middle-income countries (LMICs), social protection in health (SPH) has moved to the top of the agenda among health policy-makers globally (Gama, 2016: 183).

¹ <https://www.usaid.gov/democratic-republic-congo/global-health> 27 February 2018.

According to the World Bank (2013), SPH mechanisms are public interventions that assist households and communities to better manage financial risks caused by health expenditure, as well as provide support to the critical poor. Many such mechanisms aim at removing financial barriers preventing access to existing healthcare services, or providing incentives for their uptake and protecting poor people from the impoverishing effects of medical expenditures (Gama, 2016: 183).

Social protection can encompass a range of instruments, including: school feeding; general food distributions (GFDs); cash transfers (CTs) or conditional cash transfers (CCTs); in-kind transfers (including vouchers); grants for goods and basic foodstuffs; subsidies; health insurance, public works programmes, and pensions (Browne, 2015; Kardan et al., 2017: 2).

Formal vs informal

Formal social protection (FSP) refers to transfers (cash or in-kind) from the state to citizens to help smooth consumption and protect individuals or families from destitution (social security measures). Formal, state-based social protection mechanisms include social insurance, public provisioning of health care and education, food subsidies, direct cash support)

Informal social protection (ISP) refers to the (cash or in-kind) support provided by family and community members to the poor and vulnerable in times of difficulty. These can include (traditional risk pooling systems; mutual health organisations; rotating, saving and credit associations).

According to work by the Australian Department of Foreign Affairs and Trade, FSP has a unique and increasingly important role to play alongside ISP. FSP can address shortcomings in ISP because it can distribute resources according to needs, rights, and citizenship, without requiring reciprocation (Calder and Tanhchareun, 2014).

While ISP plays an important role, it does not always support or protect. It tends to exclude certain groups of people or include them on unequal terms. And it is often those with the least resources who are least able to rely on others in times of need (Calder and Tanhchareun, 2014). Where FSP does crowd out ISP, it is not necessarily negative. It may make the poor and marginalised less dependent on informal social protection relations based on patronage and structural inequality. Indeed, FSP can enable poor individuals to build their social capital and increase access to ISP networks.

3. Social protection measures: evidence of use

Current public spending on social protection is low in the DRC - estimated at 3.48% of GDP in 2012 (SOLIDAR, 2016: 10). However, social protection is now on the agenda, with the drafting of a National Social Protection Policy in 2015 to recognise the role of social protection in enabling individuals to face risks and to guarantee them a minimum income allowing their integration into society. The World Food Programme (WFP) has also provided technical assistance for the establishment of a national social protection system as part of the DRC Interim Country Strategic Plan (2018–2020), including a national school feeding programme (WFP, 2017: 8). However, the NSPP was not adopted formally (SOLIDAR, 2016). Previously in 2001, lawmakers in DRC drafted a universal health care bill, but it was never adopted by Parliament. Policies on social protection are said to be “incoherent,” and the few social protection schemes only benefit a limited number of people (Wasso, 2013).

Social security

Social security refers to issues related to health, pension, and family allowance. In the DRC, there are two ways for employees to receive these benefits: (i) Compulsory membership in the state body in charge of social security called INSS (*L'Institut National de Sécurité Sociale*), or (ii) Membership by choice in a mutual health insurance scheme. The INSS used to receive all the workers in the formal sector, but due to its organisational weaknesses, some people prefer to join a mutual health insurance scheme (Wasso, 2013). However, the only data available states that 12% of the population are covered by social security (Wasso, 2013); 1.4% of the population is currently covered by a mutual health scheme (SOLIDAR, 2016: 6-7). A law passed in 2016 will introduce social insurance maternity and prenatal benefits, effective 15 July 2018.²

Mutual health insurance: MUSACOM

A 2014 World Bank report on health financing in the country found that 80% of health care expenses are paid by international aid groups or individuals. Government assistance makes up much of the remaining 20%; few are covered by health insurance as the mutual health insurance scheme is an emerging phenomenon in DRC.

The first experience in this field was that of the Zaire Christian Mutuality (MCZa). It was created in the early 1950s with the collaboration of the National Alliance of Christian Mutual Societies of Belgium (ANMC). Other mutual health insurance organisations have been created in some provinces. The Province of South-Kivu has the largest number of mutual health insurance organisations. However, the penetration rate remains low compared to the general population of South-Kivu: out of the 34 health districts that make up the Province of South-Kivu, only ten have mutual health insurance organisations, a coverage of 29.4% (Wasso, 2013).

A new campaign looks to take advantage of local community reliance to promote a new mutual aid fund for health care called *Mutuelle de Santé Communautaire*, or MUSACOM. An initiative of the Community of Baptist Churches in Central Africa, the fund seeks to make healthcare more accessible. The fund came to the Lubero territory, a rural region of eastern DRC, in late 2017 and has so far garnered more than 380 members (Luneghe, 2018).

Given the lack of familiarity with health insurance, MUSACOM had to be simple and relatively inexpensive for community members to take part. Individuals become members of the fund by investing just USD1, then they pay an annual membership fee of USD12. In case of illness, a patient pays 15-20% out of pocket, and the fund covers the remaining costs.

Experts consulted for this review stated that effects of social protection on access to and use of health services are greatly enhanced if they include explicit linkages to health insurance mechanisms.

² <https://www.ssa.gov/policy/docs/progdesc/ssptw/2016-2017/africa/congo-democratic-republic-of-the.html>

Cash transfer programmes in the DRC

Cash transfer programmes (CTPs) aim to strengthen financial security for vulnerable households. This potentially enables improvements in diet, hygiene, health service access, and investment in food production or income generation (Grellety et al., 2017). However, in the DRC, cash transfers account for only a very small proportion of overall humanitarian aid, with continuing in-kind assistance, i.e. food vouchers for malnourished children (Bailey, 2017: 5).

Case study: Mother-to-child HIV Transmission (PMTCT) Study, Kinshasa

A randomised controlled trial by Yotebieng et al. (2016) aimed to determine whether small, increasing cash payments (USD5, plus USD1 increment at every subsequent visit), conditional on attendance at scheduled clinic visits and receipt of proposed services in the capital city of Kinshasa, can increase the number of HIV-infected pregnant women who accept available PMTCT services and remain in care. This small scale CCT programme increased the probability of newly diagnosed HIV-infected pregnant women remaining in care (RR = 1.13) and the uptake of mother-to-child HIV transmission services (RR = 1.31) (Yotebieng et al. 2016; Owusu-Addo et al., 2018).

Case study: Malnourished in children in Goma, eastern DRC

Social protection and safety-net interventions are important to protect maternal and child nutrition. Grellety et al. (2017) tested whether CTPs improved the outcome of children treated for severe acute malnutrition (SAM) in the DRC over 6 months. It was emphasised that participation in the study was not a pre-condition for obtaining nutritional treatment and free medical services. The parents of malnourished children need to choose between attending the health centre and all their other competing activities essential to the integrity of the household. If the parents consider that the treatment at the health centre is not helping, competing activities critical or the costs of attending excessive, attending will not be a priority and they will default. Children are much less likely to recover if they default from treatment.

After 6 months, 80% of cash-intervened children had re-gained their mid-upper arm circumference measurements and weight-for-height/length Z-scores and showed evidence of catch-up. Less than 40% of the control group had a fully successful outcome, with many deteriorating after discharge from therapeutic care. There was a significant increase in diet diversity and food consumption scores for both groups from baseline; the increase was significantly greater in the intervention group than the control group. In this case, CTPs should be considered as an alternative to in-kind assistance and services, or as a complement to more traditional interventions.

Cash vs vouchers in the DRC

A systematic review on the effects of cash transfers and vouchers on the use and quality of maternity care services, noted that cash transfers and vouchers are forms of 'demand-side financing' that have been widely used to promote maternal and newborn health in low- and middle-income countries during the last 15 years (Hunter et al., 2017). One example where access was increased using short-term cash payments include the Janani Suraksha Yojana in India: the programme increased the proportion of women receiving three or more antenatal visits compared to women who were not programme-recipients – especially in high-focus states

(where payments are larger and are made irrespective of income or parity)³; in Kenya's Vouchers for Health programme, receipt of any antenatal care and of at least four antenatal contacts increased among the 4,362 recipients.⁴

The provision of humanitarian assistance as cash and vouchers has been the most significant evolution in humanitarian assistance in the DRC in the last decade. Vouchers are considered to be safer than cash transfers, as they limited the risks associated with transporting and distributing cash (UNICEF, 2012; Aker, 2017). While voucher programmes have increased substantially, cash transfers remain a very small proportion of humanitarian assistance (Bailey, 2017).

ODI research shows that a major decision is needed regarding use of cash transfers in the DRC (Bailey, 2017). On the one hand, the use of cash is increasing, and most donors and aid agencies accept it as an appropriate approach. UN agencies and non-governmental organisations (NGOs) work collaboratively and – unlike in other contexts – have not become embroiled in inter-agency politics around where cash fits in humanitarian strategies and who coordinates it. Through cash and voucher responses, humanitarian organisations have encouraged traders, money transfer agents and mobile network operators to go to areas they have never been. These positive developments are thanks to the creativity of practitioners and the support of key donors interested in improving how assistance is provided (Bailey, 2017).

On the other hand, humanitarian strategy and leadership in DRC have largely been catching up to these developments more than encouraging them. In contrast to voucher approaches, which are used quite widely, cash transfers are driven by a core group of champions, rather than being a standard response, and aid agencies still have further to go in embedding cash transfers within their systems and cultures. In-kind assistance continues to be used where it should not be, and cash transfers account for only a very small proportion of overall humanitarian aid (Bailey, 2017).

Case study: Displaced households in eastern DRC

Aker (2017) compared cash and voucher transfers in a humanitarian context in the DRC. The results of a randomised transfer programme in eastern DRC, where internally displaced households living in an informal camp were randomly assigned to cash and voucher transfer modalities. The first intervention, an unconditional cash transfer, was provided in three distributions over a six-month period. The second intervention, an equal-valued voucher, was a coupon that could be redeemed at an organised “voucher fair” selling a variety of food and non-food items for the first transfer, but restricted to food items for the second and third transfers (Aker, 2017).

Households' purchasing decisions differed significantly by transfer modality. Unsurprisingly, cash households used their transfer to purchase a diverse set of food and non-food items, including paying for health expenses and school fees, and did not appear to buy “temptation” goods

³ Lim, S.S., Dandona, L., Hoisington, J.A., James, S.L., Hogan, M.C., Gakidou, E. (2010). India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation. *Lancet.*, 375(9730):2009–23. pmid:20569841

⁴ Amendah, D.D., Mutua, M.K., Kyobutungi, C., Buliva, E., & Bellows, B. (2013). Reproductive health voucher program and facility based delivery in informal settlements in Nairobi: a longitudinal analysis. *PLOS One*, 8(11):e80582–e. pmid:24260426

(Evans and Popova, 2014; Aker, 2017). However, as there were no significant differences in household well-being, the cash transfer programme was the more cost-effective modality for the implementing agency in this context (Aker, 2017).

Case study: ARCC II

The Alternative Assistance for Communities in Crisis II (ARCC II) programme, funded by DFID, ran from March 2013 to September 2015.⁵ Its primary component was the provision of cash transfers or vouchers to conflict-affected families to enable them to meet basic needs, access services and pursue livelihoods. Results show that families spent the cash and vouchers on essential needs, accessing basic services including education and health, and making investments in livelihood activities – all of which were in line with the objectives of the ARCC II programme.

Individual and community levels of social protection. Many aid interventions can essentially be classified as forms of social protection, and the attention given to this sector is increasing in DRC (Weijjs et al., 2012). The following case studies are examples of how individuals and communities benefit from social protection:

International evidence of use

Case study: Cambodian Basic Package of Health Services

Social and community health insurance schemes in effect define an essential health package which is available to all their members. To date, the introduction of a Basic Package of Health Services (BPHS) in fragile and conflict-affected situations has gone hand-in-hand with the contracting-out of health service provision to non-state providers (NSPs). Cambodia was the prototype for this model and its successful results spurred policymakers on to expand the approach to other countries affected by conflict – indeed, recent years have seen DRC, South Sudan, Bangladesh and Afghanistan all contract-out health services on a large scale (Arur et al., 2009: 136; Carpenter et al., 2012: 40). An extensive evaluation of the approach in Cambodia showed that districts with health services that were contracted out to NGOs delivered care more efficiently and equitably than those that remained under government control (Abramson, 2009; Palmer et al., 2006; Carpenter et al., 2012: 40). More specifically, results showed large positive effects on the utilisation rate in contracting-out districts, with decreased out-of-pocket costs per capita and a 40% drop in family health expenditure, but increased public spending per capita (Abramson, 2009; Carpenter et al., 2012: 40). The programme was also associated with an increase in the use of reproductive health services, improved immunisation rates, and a decline in time lost to illness (High-Level Forum on the Health MDGs, 2004; Carpenter et al., 2012: 40).

Case study: Kenyan CSO-community partnership

Civil society partners work with the grassroots to gather evidence on the impact on social protection schemes. Working within the community the Kenya Platform assesses the impact and monitors the delivery of existing cash benefits (USD20 every 2 months) to older persons aged 70 and over, persons with severe disabilities, and households with orphans. The Platform identifies glitches in registration that can lead to individuals being struck out of the scheme, and corrects

⁵ <https://odihpn.org/blog/cash-transfers-vouchers-conflict-affected-households-democratic-republic-congo/>

mistakes. Regular income coming into the hands of older women not only supported the care of their grandchildren and better nutrition for the family, but also resulted in flourishing local businesses run by women in their 70s and 80s. Regular cash received by a severely disabled young man has enabled him to support his own father to access proper medical care (Beales Gelber, 2018).

4. Health service level of social protection: country evidence

DRC

User fees and subsidisation

User fees have been shown to constitute a major barrier to the utilisation of health-care, particularly in low-income countries such as the DRC. The cost of care has led to a drastic reduction in health service utilisation rates from 0.60 consultations per year per inhabitant in the 1980s to an average of 0.15 between 1990 and 2010.⁶ Therefore, removal of such barriers in social protection measures can prevent exclusion of vulnerable individuals from health-care.

Case study: Multiple health zones

In 2008, a donor-funded primary health-care programme began implementing health service user fee subsidisation in 20 health zones of the DRC (Maini et al., 2014). In all health zones, utilisation rates were higher by the end of the programme compared to the start of the programme. However, the authors found mixed findings on the effectiveness of user fee subsidisation as a strategy to increase the utilisation of services: although subsidising or removing user fees can result in an increase in health-care utilisation in the short-term, user fee subsidisation did not generate the long-term positive effect one could expect. This is similar to the findings reported from a study on the abolition of user fees in Zambia and Niger (Lagarde et al., 2012), with the authors speculating that negative effects could be explained by varying degrees of enforcement of the new user fee policy; in some areas, informal fees may have continued to be charged at health facilities despite introduction of the policy.

Case study: Enable BTC reforms in Kisantu

The Belgian Development Cooperation (Enable, previously BTC) often promotes social protection as an efficient means to combat poverty and make inequalities more equitable.⁷ Between 2008 and 2011, the Belgian development aid agency launched a set of reforms in the Kisantu district, in the province of Bas Congo, through an action-research process deemed appropriate for the implementation of change within open complex systems such as the Kisantu local health system (Stasse et al., 2015). A financial subsidy from BTC allowed the reduction in

⁶ Zinnen, V. (2012). La Mise en œuvre de l'Agenda pour l'Efficacité de l'Aide dans le Secteur de la Santé en République Démocratique du Congo - Rapport d'Etat des Lieux en Vue de la Sélection d'Etudes de Cas. Institut de Recherche Santé et Société, Université Catholique de Louvain. February 2012. http://www.grap-pa.be/attachments/article/69/201202_capitalisationdp_rdc3.pdf

⁷ https://diplomatie.belgium.be/sites/default/files/samenvatting_2015_en_def_lr.pdf

the height of the flat fees. The results in terms of enhancing people access to quality health care were immediate and substantial. The Kisantu experience demonstrates that a systems approach is essential in addressing complex problems, and provides useful lessons for other districts, as well as the country as a whole.

Burundi

Case study: *Terintambwe* health insurance cards

The Graduation Model programme, also known as *Terintambwe* ('Step ahead'), was launched in Cibitoke and Kirundo, two provinces of Burundi, in April 2013.⁸ Improvements in health-seeking behaviour can be explained by the fact that T1 and T2 households received health insurance (*mutuelle de santé*) cards, making such health care – particularly in conjunction with higher incomes – more affordable. At baseline, only 6% of T1 and T2 households had health insurance for their households compared to 93% at endline. When asked about reasons for not visiting a formal health provider at baseline (before health cards were issued), the large majority of households in treatment and control groups (75%–80%) indicated that they were unable to afford such health care. At endline, only 20% of households in T1 and T2 that did not visit a formal health care provider indicated that this was due to the inability to pay; the majority of those households indicated that seeking informal health care from within the community, and the distance to formal health services, were reasons for not attending formal health services (Weijs et al., 2012: 32). The inability to pay remained the most important reason for control group households not seeking formal health care, despite an increase in the proportion of control households having health insurance from 6% at baseline to 21% at endline (Devereux et al., 2015: 66). Therefore, community members learned the value of having a *mutuelle de santé* card thanks to *Terintambwe* (Devereux et al., 2015: 109).

Ghana

Case study: LEAP

The Livelihood Empowerment Against Poverty Programme (LEAP) provides a cash transfer to ultra-poor households within three demographic categories: elderly, disabled, and Orphans and Vulnerable Children (OVC). LEAP households are poorer than the national rural average, with 51% falling below the national (upper) poverty line and a median per capita daily expenditure of approximately USD0.85. The cash is conditional on enrolment in the National Health Insurance Scheme (NHIS). As in most cash transfers targeted to the ultra-poor and vulnerable, the immediate impact of the programme is typically to raise spending levels, particularly basic spending needs for food, clothing, and shelter, some of which will influence children's health, nutrition, and material well-being. Once immediate basic needs are met, and possibly after a period of time, the influx of new cash may then trigger further responses within the household economy, such as use of services, and the ability to free up older children to attend school (Handa et al., 2014: 29). An important component of LEAP is the enrolment of participants in the

⁸ In each province, 500 poor households were selected to receive 'high treatment' (T1) support from Concern Worldwide, another 500 households were selected to receive 'low treatment' (T2) support – the main difference being in the number of home visits – and 300 similarly poor households were allocated to a control group, which allowed for a quasi-experimental 'difference-in-differences' research design.

NHIS. This enrolment may itself directly trigger potential behaviour change in terms of inducing households to use health services and is thus considered a potential mediator or mechanism through which the effect of LEAP is felt at the household level.

Ghana's programme increased the use of curative health care by 24% among OVC aged 0–5 years. This increased use of health services could be attributed to the high enrolment in the NHIS (34%), a scheme which allowed registered members to have access to free health care.

Lesotho

Case study: Child Grants Programme

Lesotho started thinking about a child grant over a decade ago. While initially designed and funded with support of the European Union (EU) and UNICEF, the Child Grants Programme (CGP) is now a nationally owned and funded programme (Government of the Kingdom of Lesotho, 2015). Since 2009, the CGP paid out unconditional cash transfers to beneficiaries. In 2014 it reached 25,000 households, with approximately 80,000 children (Pellerano et al., 2016: 255). Pellerano et al. (2014) noted that frequent transfers of “sufficient amount” were likely to have increased health services use and household consumption. However, it is noted in the ‘Child Grants Programme Impact Evaluation Follow-up Report’ that weak supply of government services (lack of access to clinics and schools and poor quality services) may dampen what might otherwise be expected to be an increase in the demand for schooling and health care services (Pellerano et al., 2014: 15). Although the study shows no significant increase in the proportion of children (0-17) that consulted a health care provider, The CGP contributed to a 15 percentage point reduction (from a baseline of 39%) in the proportion of both boys and girls ages 0-5 who suffered from an illness (generally flu or cold) in the 30 days prior to the survey.

Malawi

Case study: *Mtukula Pakhomo* UCT

The Government of Malawi's Social Cash Transfer Programme (SCTP, locally known as the *Mtukula Pakhomo*) is an unconditional cash transfer programme targeted to ultra-poor, labour-constrained households. The programme began as a pilot in Mchinji district in 2006. Since 2009, the programme has expanded to reach 18 out of 28 districts in Malawi. The programme has experienced impressive growth: by December 2015, the SCTP had reached over 163,000 beneficiary households (Abdoulayi et al., 2016). It also increased the likelihood of utilising health services for serious illness (OR =10.98) (Owusu-Addo et al., 2018).

An important coping strategy to access health services is that of the expansion of informal and private sector providers (Pavignani, 2005; Carpenter et al., 2012: 38).

Zimbabwe

Case study: Harmonised Social Cash Transfer

The Harmonised Social Cash Transfer (HSCT) provides a variable transfer⁹ to approximately 62,000 eligible households (AIR, 2014; Dewbre et al., 2015; Handa et al., 2018). This unconditional cash transfer programme targets ultra-poor households who are labour constrained. The UNICEF April 2018 Endline Impact Evaluation Report found that disabled individuals in small households are more likely to receive care as a result of the programme (UNICEF, 2018).

5. References

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