MPC

NFI

Winterization

Food

Rent

Cash for Health in Humanitarian Settings:

Household Health Needs, Spending, and the Burden of Health Care Costs

INTERNATIONAL RESCUE COMMITTEE

USAID

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Executive Summary

The humanitarian sector delivered [$4.7 billion in cash assistance](#) in 2018 and cash has now become a key tool in humanitarian response to meet basic needs following a crisis. This shift is, in part, driven by substantial evidence that indicates that by reducing monetary poverty and increasing purchasing power, cash assistance can help vulnerable populations meet their basic needs and avoid negative coping mechanisms. Evidence also suggests that cash transfers can be more efficient than in-kind assistance. This success of cash as a tool to help people meet their basic needs has generated interest among humanitarian actors to explore and understand whether multipurpose cash assistance can also be used to meet other outcomes, such as first-order health outcomes.

Despite the promising evidence, there are factors that complicate the extension of the evidence for cash for basic needs to health outcomes. First, there is no clear understanding of household-level prioritization, demand for and spending on various types of health needs in crisis contexts; and, second, health outcomes are dependent on availability and quality of healthcare provisioning and support for accessing healthcare is not uniform across a crisis-affected population.

In order to develop a better understanding of whether and how cash assistance can be used to improve first-order health outcomes, like utilization of and timely access to health services and products, for highly vulnerable populations, the International Rescue Committee (IRC) conducted a mixed-methods descriptive research study in Peshawar and Bannu, Pakistan, and Logone-et-Chari, Cameroon, between 2017-2019 with support from the Office of U.S. Foreign Disaster Assistance. The objective of the study was to understand household-level prioritization of health needs; spending on healthcare and how health needs are met; and, finally, mapping whether the introduction of cash assistance changed prioritization of, spending on or ways of meeting healthcare needs.

As a part of the study, the IRC conducted 11 rounds of high-frequency bi-weekly quantitative surveys in Pakistan with a 100 households each in Peshawar and Bannu, and 9 rounds of quantitative data collection with 128 households in Logone-et-Chari, Cameroon. This was complemented by qualitative research and a rapid supply side assessment on the availability of services.

The study findings revealed that, overall, **households experiencing a health need tended to seek care and incurred a cost for seeking care even when services were meant to be free**. This held true for most types of health needs including illness, injury, and delivery services. The two exceptions to this were vaccination services and antenatal care in Logone-et-Chari, Cameroon, where individuals received services and mostly did not report incurring a cost for receiving these services.

Spending on all types of health needs was a high percentage of aggregate reported income and aggregate cash transfer value during the period of the cash assistance. Aggregate spending on health needs was between **35-107%** of reported income and between **10-30%** of the cash assistance transfer amount, depending on location.

The percentage of households that met the threshold for incurring catastrophic expenditure because of healthcare costs varied across rounds of data collection but was as high as 45% in a given bi-weekly period during our data collection. On aggregate, 15.8% of households in Peshawar, 12.4% of households in Bannu, and 11.7% of households in Logone-et-Chari experienced catastrophic spending on health needs.

Households in all three locations incurred debt to cover health expenditure. The study showed that cash use increased and loan use decreased for health expenditure during the cash assistance period.

Utilization of preventive health care services was low in Peshawar and Bannu, Pakistan. We saw little to no usage of preventive health care services in these two locations, though were unable to determine whether this was because of a lack of information, prioritization or demand in a resources constrained environment.

Although the trends were not always clear, **we saw suggestive evidence that cash was influencing care seeking behavior for unpredictable health needs.** There was some evidence from Bannu and Logone-et-Chari that the percentage of people not seeking care decreased over time as the cash assistance started.

Overall, on the basis of this study, we offer the following recommendations:

- When relevant, health should be included in the ingredient list for the Minimum Expenditure Basket that is typically used to determine the cash transfer value in many humanitarian settings, not as a substitute for availability of high quality services, but to supplement household income to meet health needs

- Further research is necessary to understand the root cause of poor uptake of preventive healthcare services, as well as possible solutions

- More pilots, with a measurement component, are necessary to develop and test program models that aim to understand demand for specific types of services (like preventive services) or ensure "free" services are truly free when that is the desired goal, for example in the case of delivery services

Glossary

Bi-weekly: For the purpose of this report, bi-weekly means every two weeks

Cash for Work (CFW): The Cash Learning Partnership (CaLP) defines Cash for Work as: "Cash payments provided on the condition of undertaking designated work. This is generally paid according to time worked (e.g. number of days, daily rate), but may also be quantified in terms of outputs (e.g. number of items produced, cubic meters dug). CFW interventions are usually in public or community work programmes but can also include home-based and other forms of work."

Catastrophic Spending: Wagstaff et al., 2018, define catastrophic payments as "out-of-pocket payments that are especially large relative to a family's total income or consumption". In this report, we calculate catastrophic spending with total health expenditure in the numerator and non-food consumption in the denominator (setting the threshold at 40%).

Choukous: General name used for street vendors who sell drugs. This name is used by all local ethnic groups in Biamo.

Delayed Care: For the purpose of this research, delayed care was defined as waiting for more than 24 hours to seek care

Dependency Ratio: The dependency ratio is the number of dependents in the household, i.e. non-income earners, divided by the number of income earners in the household

Direct Health Expenditure: Direct Health Expenditure included costs incurred during a visit to the healthcare provider (consultation, drugs, lab tests, medical supplies, other) and additional costs not related to a visit during the same reporting period

Eid: A religious holiday that marks the end of Ramzan

Health Expenses: Any costs associated with seeking healthcare or practicing healthy behaviors, including direct and indirect costs

Indirect Health Expenses: Indirect Health Expenditure consisted of transportation for self and accompanying household member to health facility, meals while at facility, and other.

Mazri Work: Local handicraft in Pakistan

Multipurpose Cash Transfers (MPC): The Cash Learning Partnership (CaLP) defines Multipurpose Cash Transfers as "transfers (either periodic or one-off) corresponding to the amount of money required to cover, fully or partially, a household's basic and/ or recovery needs. The term refers to cash transfers designed to address multiple needs, with the transfer value calculated accordingly. MPC transfer values are often indexed to expenditure gaps based on a Minimum Expenditure Basket (MEB), or other monetized calculation of the amount required to cover basic needs. All MPC are unrestricted in terms of use as they can be spent as the recipient chooses. This concept may also be referred to as Multipurpose Cash Grants (MPG), or Multipurpose Cash Assistance (MPCA)."

Ramzan: It is one of the months in the Islamic calendar and is a month of fasting for the Muslim community

Predictable Health Needs: Although Predictable Health Needs captures expected needs such as antenatal care for a pregnant woman, immunization for infants, or medication for chronic illness, this report categories antenatal care, delivery costs and immunization as Preventive Care. Predictable Health Needs in this report only captures chronic illness or health needs arising due to a disability.

Unpredictable Health Needs: Acute illness or accident

Abbreviations

ACF	Action Contre La Faim	**KM**	Kilometers
AHA	Africa Humanitarian Initiative	**KP**	Khyber Pakhtunkhwa
CFA	Central African Franc	**MEB**	Minimum Expenditure Basket
CFW (XAF)	Cash for Work	**NGO**	Non-governmental organization
FATA	Federally Administered Tribal Areas	**OFDA**	Office of U.S. Foreign Disaster Assistance
GHC	Global Health Cluster	**Rs**	Pakistan Rupee
IDPs	Internally Displaced Persons	**WASH**	Water, hygiene, and sanitation
IRC	International Rescue Committee	**WHO**	World Health Organization

Background

STATE OF THE EVIDENCE ON CASH ASSISTANCE FOR BASIC NEEDS

There is a strong body of evidence that supports the use of cash assistance to help vulnerable people meet their basic needs. Evidence from stable contexts suggests that by reducing monetary poverty and increasing purchasing power, unconditional and conditional cash programs consistently and positively impact a variety of basic needs outcomes (especially related to food security) while simultaneously decreasing negative coping strategies (child labor, sale of assets, etc) (Kabeer et al., 2012; de Hoop and Rosati, 2014; Bastagli et al., 2016). While the evidence base specifically for humanitarian contexts is less expansive, there are studies suggesting that the findings from stable contexts extend to humanitarian contexts – including for food security, access to safe shelter, asset stability and decreased child labor (Doocy and Tappis, 2016). Furthermore, although, on average cash and in-kind transfers may be equally effective (depending on the specific objective), there is promising evidence that cash transfers are more efficient than in-kind transfers (World Bank, 2016). Moreover, cash transfers appear to have positive multiplier effects on the local economy (Doocy and Tappis, 2016; Lehmann et al., 2014).

Given the unprecedented scale of humanitarian crises and the strong evidence base for cash assistance, in 2015, the High Level Panel on Humanitarian Cash Transfers recommended large-scale expansion of the use of cash relief in humanitarian settings. At the World Humanitarian Summit in 2016, the Grand Bargain on humanitarian financing included global commitments to increase the use and coordination of cash-based programming and invest in new delivery models which can be increased in scale.

STATE OF THE EVIDENCE ON CASH ASSISTANCE TO ACHIEVE HEALTH OUTCOMES

Given the reach and success of cash programming to date, along with global and organization specific commitments to increase the use of cash in humanitarian programming, humanitarian actors are keen to explore and understand whether multipurpose cash can also be used to meet other outcomes aside from basic needs, including health outcomes. However, the evidence base here is less clear. A recent review examined 41 studies that measured the impact of cash transfers on selected health and nutrition indicators. Few of these took place in humanitarian settings, and the majority of studies evaluated conditional rather than unconditional cash transfers. Fifteen studies examined the effects on utilization of healthcare with nine showing significant positive impacts, but none of these was conducted in a humanitarian context. A 2016 World Bank review indicates that there is not even a single comparative study that looks at cash transfers in comparison to other health interventions in humanitarian settings.

Exploring the opportunity to use cash assistance to achieve health outcomes, particularly in humanitarian settings, is made more complex by the fact that health outcomes are dependent on availability and quality of healthcare provisioning and support for accessing healthcare is not uniform across a crisis-affected population, meaning level and type of support to achieve health outcomes may differ for segments of the population as well as across different contexts. The Global Health Cluster (GHC) and the World Health Organization (WHO) Cash Task Team released a working paper for considering cash transfer programming for health in humanitarian settings that highlights the need for services of sufficient quality that are "provided free of charge at the point of delivery" and the need to enable crisis affected populations to overcome financial barriers and have protection against catastrophic health expenditures.

Given the limited evidence base for humanitarian contexts, the WHO and the GHC commissioned a research agenda-setting exercise that resulted in 189 questions being prioritized across 9 research areas. These overarching areas include questions on: (i) modalities; (ii) outcomes and impact; (iii) intermediate outcomes; (iv) initial considerations; (v) effectiveness; (vi) pathways; (vii) methodologies and indicators; (viii) types of diseases or health issues, and (ix) context.

STUDY OBJECTIVE

The primary objective of the IRC's cash and health research was to understand whether and how cash assistance can be used to improve utilization of and timely access to health services and products for highly vulnerable populations, and the implications of that for practitioners.

This study therefore aimed to:

1. Understand how households prioritize health needs and what types of health needs by documenting spending on predictable and unpredictable health needs

2. Document how these needs are currently met

3. Calculate health spending as a percent of household income and of the cash assistance

4. Map how household spending on health needs changes with the introduction of a humanitarian cash assistance program and explore the role that cash is playing in any change that we observe

5. Evaluate whether there is any guidance we can offer to the humanitarian community on how to structure cash assistance in order to achieve first-order health outcomes.

CONTEXT

The study was conducted in the Bannu & Peshawar districts in the Khyber Pakhtunkhwa (KP) Province of Pakistan and the Makary district in Logone-et-Chari department in the Far North region of Cameroon.

In Pakistan, military operations that started in 2009 resulted in mass displacement (approximately 278,000 families and 1.8 million individuals displaced as of January 2015 according to the 2016 Humanitarian Needs Overview for Pakistan) from the Federally Administered Tribal Areas (FATA) to the Khyber Pakhtunkhwa province of Pakistan. Starting in 2015, after cessation of military operations, displaced families started returning to their areas of origin and the Humanitarian Needs Overview indicates that over half a million individuals went back in 2015. Many of those who remain in the host districts are unregistered and are living with host communities, primarily in Bannu and Peshawar.

The Far North region is one of ten regions in Cameroon and is the most populated. It is located in the North of the country and on the border with Chad and Nigeria. Composed of six departments, the Far North region covers an area of 34,246 square kilometers and is home to more than 3 million people according to the last national census conducted in 2005.

Since 2014, Cameroon has been involved in an armed conflict perpetrated by armed groups, mainly the Boko Haram sect active in North-East Nigeria. Recurrent and cross-border attacks and incursions continue to cause displacement of people living in the Far North region. Due to its geographical and cultural position, and in particular its proximity to Nigeria and Chad, the region suffered significant material and human damage.[1] There are approximately 428,289 individuals (68,701 households) displaced in the region (270,870 IDPs, 46,845 outside camp refugees and 110,574 returnees)[2] which represents 14% of its total population.

Among the 6 departments in the region, Logone-et-Chari is the most affected by the Boko Haram crisis. According to the IOM R18 report published in April 2019, out of 423,835 displaced persons living in the Far North region; 193,322 are hosted in Logone-et-

Chari, representing 40% of the population of the department. The districts of Makary and Fotokol are home to more than half of the displaced people in Logone-et-Chari. These populations, including the already vulnerable host communities, have been fully affected by displacement, particularly in terms of water, hygiene and sanitation, health and livelihoods needs.[3] Even before the arrival of Boko Haram, the Far North was already the poorest region of Cameroon, with 74% of the population living below the poverty line, as compared to a national average of 37.5%. The area is characterized by chronic fragility, low availability of basic services and high levels of poverty.

These locations were selected for the study because they represented

- a humanitarian context with a significant population of internally displaced persons;

- a setting where the International Rescue Committee (IRC) was committed to delivering multiple rounds (between 3-6 tranches) of cash assistance to vulnerable populations, and

- where there was a health system present that the target population could access.

INTERVENTION OVERVIEW

The interventions described below were independent of the research and were not developed as a part of this research. Instead, this study builds on already planned programs and interventions and sought to align the timing of the data collection to existing cash programs to understand how spending on health needs changes when a household receives an influx of cash.

In Pakistan, the study builds on a planned Cash For Work (CFW) program which aimed to provide 3 monthly tranches of cash assistance to vulnerable internally displaced and host community households in Peshawar and Bannu districts of Pakistan from April-June 2018. The CFW program required beneficiaries to complete 15 days of work and attend a one day session on health and hygiene. Female beneficiaries were primarily involved in two types of CFW activities: (i) Sewing and Cutting, and (ii) Mazri work. Male beneficiaries were involved in different community improvement activities such as improvement of water channels/drains, and improvement of roads. A total of 500 households were selected to participate in the CFW program in the Peshawar (200 households) and Bannu (300 households) districts.

The households were identified using a vulnerability criteria which included, but was not limited to, the following:

- Female or child headed households (including unaccompanied children/orphans and single or widowed women)
- Number of children and elderly household members
- Number of pregnant or lactating women
- Number of disabled or chronically ill household members
- Income and Asset ownership
- Recent history of receiving cash assistance
- Dependency ratio[4]
- Discrimination against religion, sexual orientation or place of origin

The money was distributed via mobile money using Telenor as the financial service provider. The total cash transfer per household for this cash-for-work project was Rs. 24,000 (~$216) which was planned to be distributed in monthly tranches of Rs. 8,000 (~$72).[5] The transfer amount was calculated on the basis of a monthly food basket for a household of seven members. The food basket consisted of the following items:

- Wheat flour
- Pulses
- Vegetable Oil
- Salt, Sugar & Black tea
- High Energy Biscuits
- Nutritional Supplements

In Cameroon, the study builds on a planned unconditional cash assistance program which aimed to provide six monthly tranches of cash assistance to vulnerable refugee, internally displaced and host community households in Logone-et-Chari division of Cameroon from January-July 2019. A total of 250 households were selected to participate in an unconditional cash assistance program in Logone-et Chari. The households were primarily identified using a combination of (i) a door to door data collection activity that was used to collect demographic and socio-economic data on households, and (ii) a community based approach. Twenty-five percent of beneficiaries were referred by IRC's Women's Protection and Empowerment team. Each beneficiary household was evaluated against the IRC's vulnerability criteria (which was finalized in collaboration with community representatives).

The vulnerability criteria included:

- Female or child or chronically ill head of household
- Inadequate shelter
- Number of children under the age of 5 (>3)
- Children showing signs of malnutrition
- No income
- Households without access to land
- Number of pregnant or lactating women

The total cash transfer per household for this unconditional cash assistance program was 239,400 XAF (~$420) which was planned to be distributed in monthly tranches of 39,900 XAF (~$70). There was no established Minimum Expenditure Basket (MEB) for the Far North at the time of the study, so the cash transfer amount was determined based on the IRC's experience in the intervention area given the needs of the target population. The money was distributed via mobile money using MTN as the financial service provider.

Methods

RESEARCH DESIGN

The study used a mixed-methods approach with multiple rounds of quantitative household surveys combined with qualitative semi-structured interviews at specific points in time. It further captured supply side information about the availability of health services and products through rapid health facility assessments. This was supplemented with information from secondary sources, such as publicly available information through the United Nations Office for the Coordination of Humanitarian Affairs and on-the-ground knowledge acquired by IRC field staff.

The facility assessments were conducted at the beginning of the research period and covered a range of formal and informal health facilities. The research team took two steps to identify relevant facilities: (i) independently map the health facilities in the intervention areas (within 25km radius of intervention area), and (ii) ask the beneficiary population which facilities they used. The research team first prioritized conducting health facility assessments for the overlapping facilities from steps (i) and (ii), i.e. those facilities that were within a 25km radius of the intervention areas and that study households reported using. If the overlap produced less than two facilities per facility type, the research team then randomly selected up to two facilities per facility type identified through step (i). The data collection team visited each selected health facility and interviewed the head of the facility. To assess the presence and functionality of equipment and supplies, interviewers noted any visible equipment and supplies, but otherwise referred to the head of the facility to provide the information.

The household surveys were high frequency (bi-weekly) surveys and were conducted with the same set of households over a 6 month period. The recall period for the quantitative surveys was two weeks, i.e. in each round of data collection, the research team asked about needs and expenditures for the previous two weeks. The only exception to this was information collected at baseline about delivery. The recall period for delivery in round 1 was 6 weeks. A total of 12 rounds of quantitative data collection and 3 rounds of qualitative data collection were planned as a part of this research.[6] The cash assistance was expected to start after the first month (2 rounds) of data collection. All subsequent data collection (months 2-6 and rounds 3-12) was expected to be influenced by the cash assistance intervention.

TARGET POPULATION AND SAMPLING

Study participants were drawn from households selected to receive cash assistance as a part of upcoming IRC cash transfer programs in all three locations. The details of the selection criteria and context have been provided in the previous section.

In all locations, at the time of beneficiary identification for the cash assistance program, the IRC informed households about an upcoming study looking at health needs and expenses. The IRC asked potential beneficiaries for their consent to use the data collected at the time of the baseline assessment for the cash assistance program to contact them in the future about participation in the research study. The sampling frame for the research in all locations consisted of the beneficiaries of the cash assistance program who consented to the IRC using their baseline data in order to contact them in the future. The research team imposed two additional restrictions on the sample: (i) households in which there was no adult in the household over the age of 18 were removed from the sampling frame, and (ii) only IDP and host community households (including returnees) were included in the sampling frame. This latter criterion was only relevant in the case of Cameroon where the cash assistance program also targeted refugees in the selected area.

In Pakistan, study participants were randomly selected for each district using Stata/IC 14.2. One hundred study households were selected per district. In Peshawar, 100 households were selected out of the eligible pool of 200 households, and, in Bannu, 100 households were selected out of the eligible pool of 300 households for the quantitative and qualitative components of the research. In addition to this, between fifteen to twenty additional households were also randomly selected per district using the same process as above in case some households refused participation in the study.

In Cameroon, the total number of internally displaced and host community households selected for the cash assistance program were 128. All households were selected to participate in the study for the quantitative data collection. Of the 128, 36 households were randomly selected to also participate in the qualitative research.

This study was not intended to measure the impact of cash on health outcomes, instead it sought to describe the types of health expenses that vulnerable people receiving humanitarian cash assistance face and how cash is used to meet these needs. To this end, we captured data from a representative sample of households (or all households in the case of Cameroon) receiving cash assistance through the IRC. Given the relatively small sample size and that it might be prone to outliers,
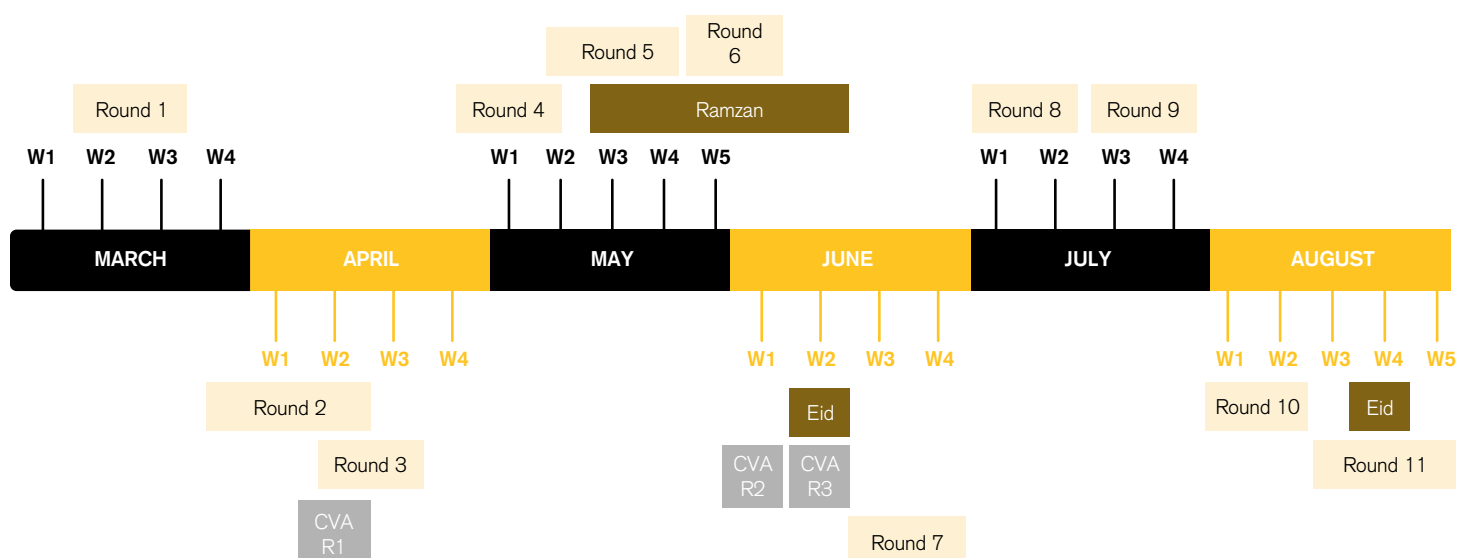
median values are used throughout in the presentation of results since median values tend to be more stable and more robust against extreme values. Trends in expenditure related median values are presented to provide an appropriate visualization of the trends with the timings of the cash assistance. Quantitative data analysis was carried out using Stata/IC 16.0. Qualitative data was first translated from local language into English and then entered into Excel. Key themes were then identified from the data, for example, as they related to challenges faced in accessing healthcare services or use of cash assistance.

LIMITATIONS

The objective of this study was to understand use of and spending on various types of health needs by internally displaced persons and vulnerable host community members. It further sought to understand how households meet these expenditures and attempted to quantify the burden of health expense. There are a number of limitations to this approach: First, it does not allow us to speak to the impact of cash assistance on health outcomes because we neither have a comparison group, nor measure health outcomes. Second, it does not allow us to conclusively draw a connection between health spending and health outcomes, as we only measure first-order health outcomes such as utilization and timely access. Given the numerous factors that contribute to health outcomes, most notably the availability of high quality supplies and services, we cannot assume that spending on health alone will result in health outcomes. This study does not make that claim, instead it only seeks to shed light on the role cash assistance may be able to play in meeting health outcomes and ensuring that households have the means to absorb catastrophic health expenditures. Third, this study only conducted rapid health facility assessments with a representative sample of facilities to establish supply side services. An extensive investigation of all services and costs associated with those services was not conducted. Therefore, although we can hypothesize about the demand for certain services based on the behavior of the households in our sample, we are unable to conclusively determine whether this is because of a lack of demand for these services or because of a lack of information or because of the unavailability of services (or services of sufficient quality) in the market. A deeper examination of this should be undertaken as a part of future research. Fourth, on the supply side still, there are a number of things that we don't capture including, but not limited to: (i) informal payments at facilities that are not a part of the official registration or consultation fee, and (ii) frequency of stock-outs in assessed facilities, though we know from qualitative research in Cameroon that households prefer to go to "choukos" because there is a perception that formal health facilities often do not have the required drugs and that they may refer patients to "choukous" to obtain them. Fifth, the study built on upcoming cash assistance programs being delivered through the IRC and the sampling frame was limited to recipients of cash assistance through these programs. Therefore, the findings may not apply to other populations that look different from the population that cash assistance programs typically reach. Finally, for certain types of health care needs and services, the sample size is very small and

ETHICS AND CONSENT
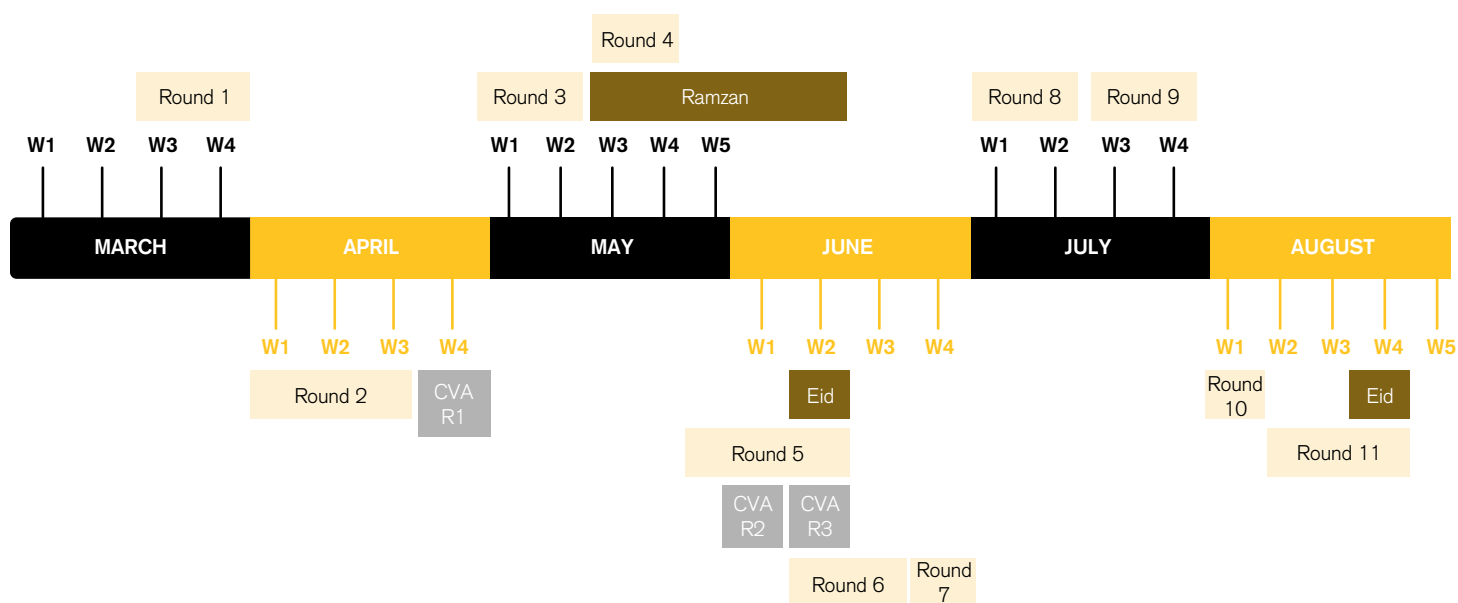
we advise caution in interpretation of data. This includes the overall pregnancy data presented in this report, chronic illness related data for Cameroon and preventive data for both sites in Pakistan.

Methodology aside, there were a number of research implementation and timeline alignment challenges that the research team faced. First, given the complexity of the household survey, the research team had planned to use digital data collection in both locations. This, however, was not feasible in Pakistan and all the data collection was done on paper. To some degree, this did effect the quality of data collection and the research team's ability to run real time checks on collected data. Second, cash implementation did not roll out in either country as planned, i.e. as monthly tranches delivered at regular intervals. Although this was not a significant limitation, it did change the timeline for qualitative data collection. Third, although we strived for an appropriate gender composition of our data collection teams in all locations -- for example, in Peshawar, we had a team of 3 female and 1 male enumerators -- in Peshawar, we still faced challenges where the male enumerator was unable to gather certain pieces of information regarding pregnancy from the households that he covered. This was addressed by ensuring that he was accompanied by a female enumerator once the issue was detected, but it did affect the quality of data collected for some rounds. Finally, in Cameroon, due to research implementation challenges, the research team had to forgo the final round of data collection.

Ethical approval was obtained from the following entities in the US, Pakistan and Cameroon:

1. US: International Rescue Committee's Institutional Review Board on 27th November 2017.

2. Pakistan: Collective for Social Science Research in Pakistan on 12th December 2017

3. Cameroon: National Ethics Committee for Human Health Research (Le Comité National d'Ethique de la Recherche pour la Santé Humaine, CNERSH) on 3rd January 2019

The consent form was translated into Urdu and French and it explained the purpose of the study; the number of rounds of data collection; the voluntary nature of participation in the study, and any risks and benefits to the study participants. Furthermore, it informed the clients that they could drop out at any stage and their participation had no bearing on their eligibility for the cash assistance program. Finally, participants were informed that all data collected was confidential and quantitative information would only be shared in aggregate terms. Prior to starting any data collection, the enumerators read the consent script to the research participants and answered any questions that they had on the information that was shared. Participating households were enrolled in the study after providing written informed consent.

TIMELINE AND PROCEDURES

TIMELINE - **CAMEROON 2019**
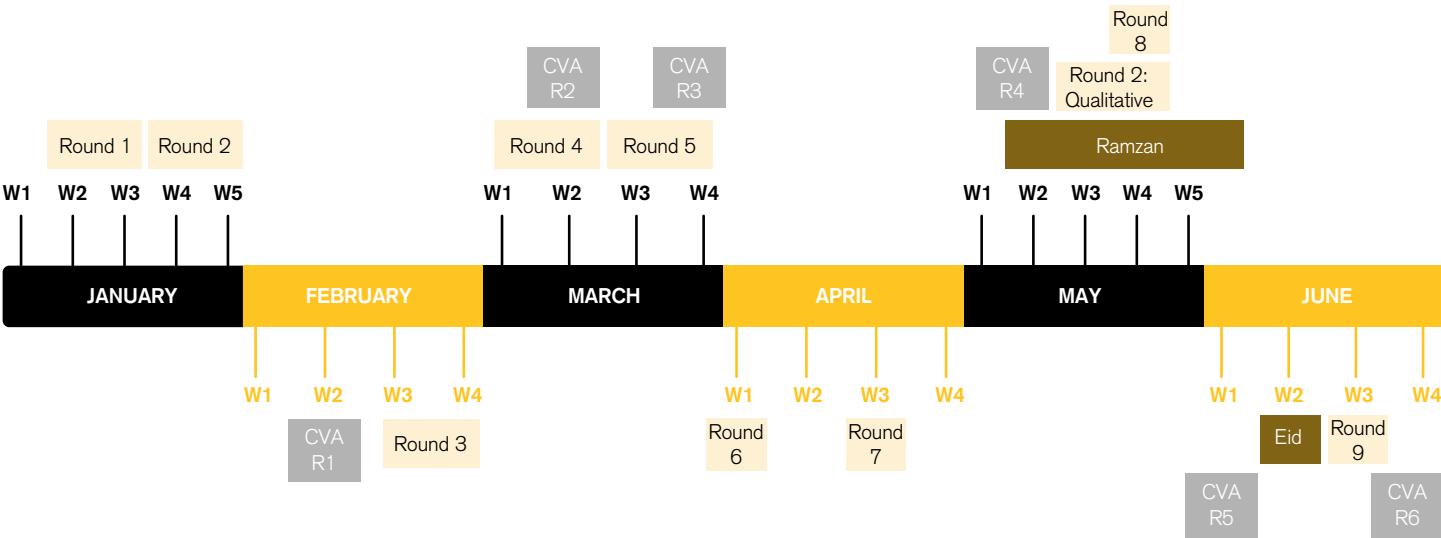
In both countries, the research timeline was aligned with the timeline for the cash assistance program.

In Pakistan, the research took place between March-August 2018. The first cash distribution took place in April 2018 and the second and third distributions took place in June 2018. In Pakistan, a total of 11 rounds of quantitative data collection were completed: two rounds of data collection took place prior to the start of the cash assistance program, while all the rest of the rounds were influenced by the cash program. Five rounds of data collection were completed after the end of the cash assistance program.

In Cameroon, the research took place between January-July 2019. The first cash distribution took place in February 2019; the second and third distributions took place in March 2019; the fourth distribution took place in May 2019; and, the fifth and sixth distributions were in June 2019. In Cameroon, a total of 9 rounds of quantitative data collection were completed: two rounds of data collection took place prior to the start of the cash assistance program, while all the rest of the rounds were influenced by the cash program. In addition to this, two rounds of qualitative data collection were completed: one in January and one in May 2019.

In Pakistan, data was collected on paper, whereas, in Cameroon, data was collected digitally using Kobo Toolbox software on hand-held devices. All qualitative data collection was done on paper. All research instruments were translated into Urdu and French. However, the data collection was conducted in the local language: Pushto for Peshawar and Bannu and Arabic Choa, Kanuri, and Kotoko for Cameroon. During enumerator training, each research instrument was jointly reviewed by the full team and appropriate translation was discussed to ensure a consistent understanding of meaning. Data collection activities took place in each research participant's home.

In both countries, a research manager oversaw the data collection process. In Pakistan, the data collection team consisted of 6 female enumerators and 2 male enumerators (equally split between Bannu and Peshawar), and in Cameroon, the data collection team consisted of 6 male and 1 female enumerator.

DEMOGRAPHICS, ECONOMIC PROFILE AND SPENDING IN THE HOUSEHOLD

Demographics

The demographic data presented in this section for both Pakistan and Cameroon reflects information at baseline (round 1). Balance tests carried out for key variables such as age, gender, household size and income indicated no significant difference between the first and last round of data collection for all tested variables in Pakistan. In Cameroon, we found a significant difference between the first and last round for income and age: income was much lower and there were more people over the age of 35 in the last round of data collection.

Pakistan

The IRC aimed to reach 200 households in Pakistan, 100 each in Peshawar and Bannu. At baseline, the IRC reached a total of 197 households (97 households in Peshawar with an average household size of 7.45 and 100 in Bannu with an average household size of 6.47). Levels of attrition varied by survey round, however, across the 11 rounds of data collection, the lowest total number of households reached was 172 in round 6 of data collection, entirely due to a lower number of households reached in Peshawar. This round of data collection coincided with Eid, when people may have been traveling or were otherwise engaged with celebrating Eid. Although, overall household level attrition was low, the household composition changed significantly during the data collection period, with existing members leaving the household and new individuals joining the household. Given this, most of the data and results are presented as percentages since the denominator is not stable over time.

Approximately 50% of household members in each location were under the age of 18, and 53% of household members were women. Eighty-six percent of the households in Peshawar and 74% of the households in Bannu were male-headed households. Fifty-five percent of households in Peshawar and 57% of households in Bannu had at least 1 child age 5 or under (Table 1). Finally, 1.1% of the total sample in Peshawar and 0.15% in Bannu had health insurance.

FIGURE 1 - **MEDIAN HOUSEHOLD EARNINGS: PAKISTAN**
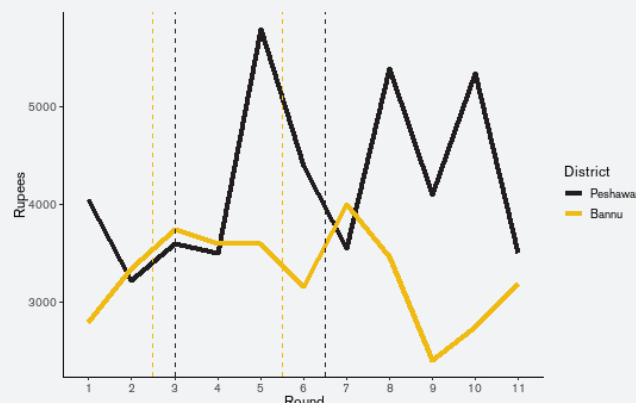
Cameroon

The IRC aimed to reach 200 households in Cameroon, however only 128 households in the unconditional cash assistance program were IDPs or host community members. Therefore, IRC's sample for the research in Cameroon was 128 households.[7] There was no attrition across the 9 rounds of data collection, although similar to Pakistan, we observed changes within the household.

The average household size in Logone-et-Chari department in Cameroon was 7.2, with 88% of households having at least 1 child age 5 or under. Sixty-five percent of the total sample in Cameroon was under the age of 18. The sample had roughly equal numbers of men and women and 61% of the households were female-headed households. Similar to Pakistan, less than 1% of the sample had health insurance.

Income

Pakistan

In Pakistan, more than half of all households (58%) had only 1 income earning member. At baseline, 80% of households reported having at least 1 member engaged in an income generating activity. The vast majority of income earning members were engaged in some form of wage labor. The median income for households in Peshawar

TABLE 1 - **PERCENTAGE OF TOTAL SAMPLE WITHIN A GIVEN AGE BRACKET**

	5 and Under	6 to 12	13 to 17	18 to 35	36 to 54	55+
Peshawar	15%	22%	17%	24%	13%	9%
Bannu	15%	23%	13%	29%	12%	8%
Logone-et-Chari	26%	28%	11%	21%	9%	5%

was between Rs. 3,113-5,800 ($26.32-49.03) and in Bannu was between Rs. 2,400-4,000 ($20.29-33.82) (see Figure 1 and Table 1 in Annex A). The dotted lines represent when the cash assistance was distributed.[8] This median income was lower than the minimum wage and was also lower than the monthly transfer amounts.

Cameroon

In Cameroon, approximately 50% of households had more than 1 income earning member. The majority of income earning members were engaged in self-employment (agriculture or otherwise). The median income for households ranged from XAF 1,001 – 6,825 ($1.70-11.60) and decreased over time, but this also coincided with the harvest period in the region (See Figure 2 and Table 1 in Annex A).

FIGURE 2 - **MEDIAN HOUSEHOLD EARNINGS: CAMEROON**
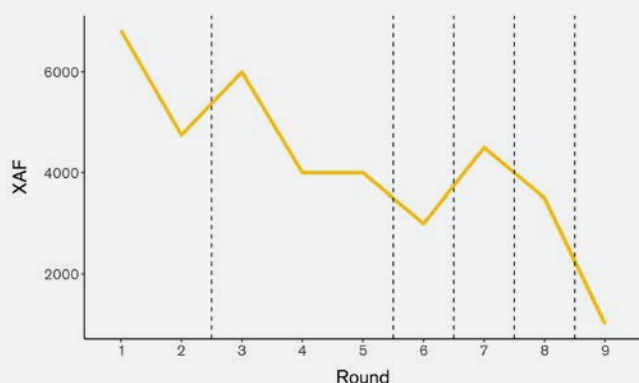
Spending Trends for Non-Health Household Expenditure

In both countries, we captured non-health related household expenditure on: (i) food and beverage items purchased for consumption in the household; (ii) prepared food and beverages purchased and consumed outside the household; (iii) specific hygiene items, such as soap, diapers, detergent, etc; (iv) other items such as rent, utilities, education, entertainment, etc. The expenditure module is included in Annex B and results are available in Table 2 in Annex A. The spending related to food consumption and hygiene items is presented below.

Pakistan

The range of median spending on food in a given two week period was Rs. 2,000 - 5,175 ($16.91 - 43.75) for Peshawar and Rs. 1,500-4,000 ($12.68 – 33.82) for Bannu. As expected, we

Minimum Wage and the Poverty Line in Pakistan and Cameroon

Minimum Wage (Per Adult)
Khyber Pakhtunkhwa Province:
Rs 15,000/month in 2018*

Cameroon:
XAF 36,270/month*

Poverty Line (Per Adult)
Pakistan national standard:
Rs 3,030/month per adult*

Cameroon:
XAF 339,715/year per adult* ≈ 28,309/month per adult

Poverty Line (Per Household)
Pakistan:
Rs 18,180/month

Cameroon:
XAF 56,618 to 84,927/month

based on nationally representative household consumption data
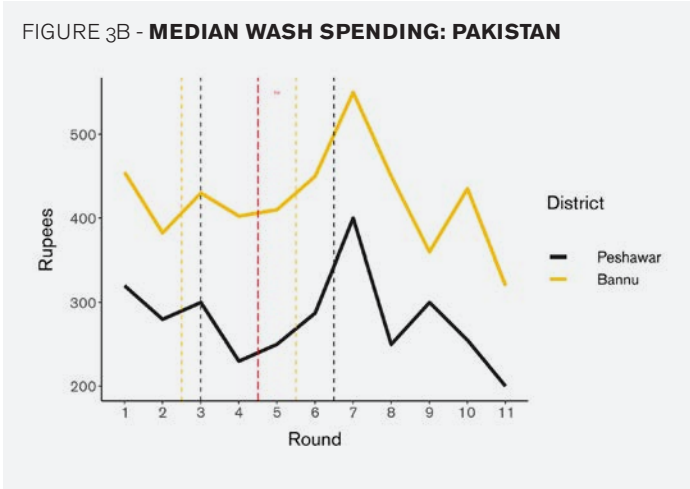
saw increases in median food spending immediately after the cash transfers were made. Median spending decreased once the cash assistance ended and two months after the end of cash assistance, reported spending on food was lower than before

FIGURE 3A - **MEDIAN FOOD SPENDING: PAKISTAN**
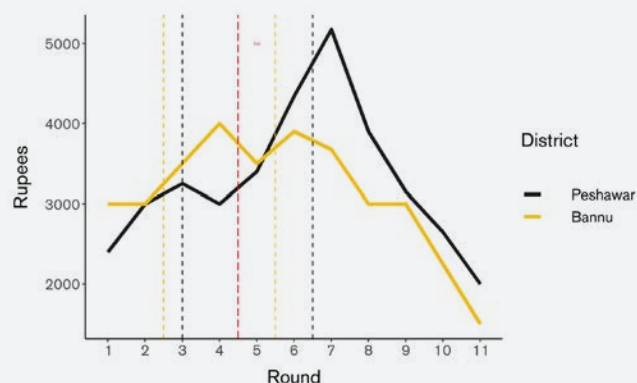
cash assistance began. This decrease could be indicative of lower purchasing power once cash ended or alternatively that households stockpiled essentials when they had access to cash and therefore their purchase needs decreased in the months following cash assistance.

Overall, median spending on water, sanitation, and hygiene (WASH) items was low with a noticeable uptick in spending after the two consecutive cash transfers

FIGURE 3B - **MEDIAN WASH SPENDING: PAKISTAN**

Cameroon

In Cameroon, the range of median spending on food in a given two week period was XAF 12,400-15,000 ($21.08 – 25.50). Similar to Pakistan, we saw increases in spending immediately after the cash transfers had been made. We also saw a levelling off of median spending on food at a value that was XAF1000 higher than the pre-assistance value once the frequency of cash assistance became predictable. In Cameroon, there was no data collection after the cash assistance ended.

FIGURE 4A - **MEDIAN FOOD SPENDING: CAMEROON**
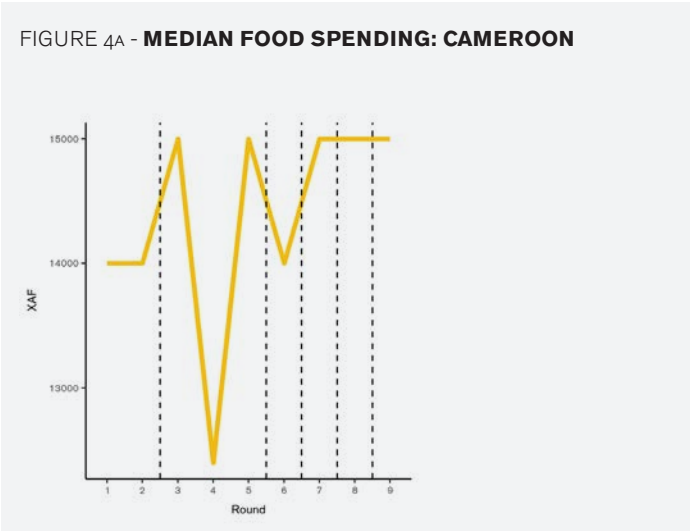
WASH spending in Cameroon decreased over time and we saw no clear relationship between spending on WASH items and the cash assistance.

FIGURE 4B - **MEDIAN WASH SPENDING: CAMEROON**
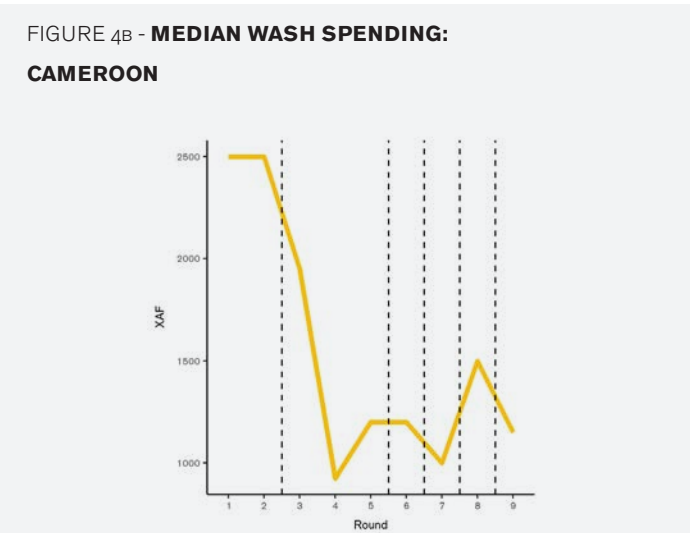
Household Saving and Borrowing Behavior

Pakistan

In Pakistan, we observed that the percentage of households engaging in formal or informal borrowing decreased over time. Notably, we saw that loan repayment by households spiked after the two consecutive tranches of cash assistance (Figures 5a and 5b). We observed no other discernible trends on savings made, savings used or sale of assets in relation to the cash assistance (Tables 3a and 3b in Annex A).

Cameroon

Similar to the trend in Pakistan, in Cameroon, we observed that the percentage of households engaged in formal or informal borrowing decreased over time. We also saw that a greater percentage of households were saving, but were also using the savings made to meet their needs. Similar to Pakistan, loan repayment rates were consistently higher once the cash assistance began, with a noticeable peak after the first round of transfers (Tables 3a and 3b in Annex A). Finally, we observed that a greater percentage of households were giving money to individuals outside of the household (friends, relatives, neighbors) once the cash assistance started (Table 3b in Annex A). We did not observe a discernible trend related to sale of assets in relation to the cash assistance.

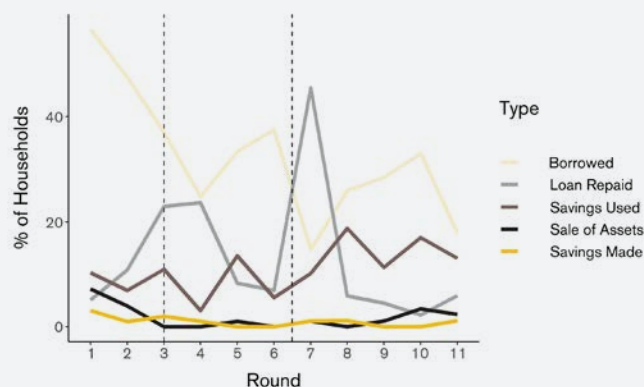FIGURE 5A - **HOUSEHOLD SAVING AND BORROWING IN PESHAWAR**

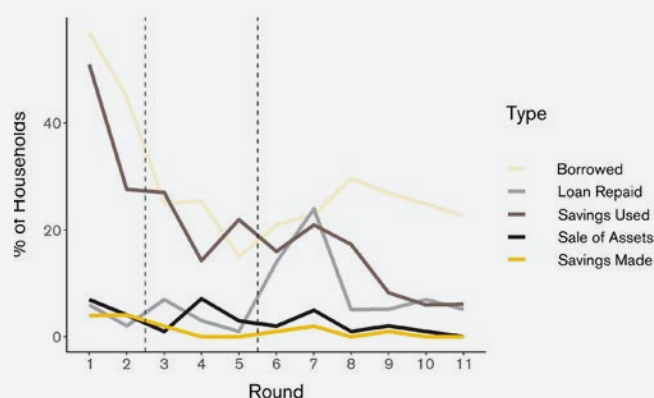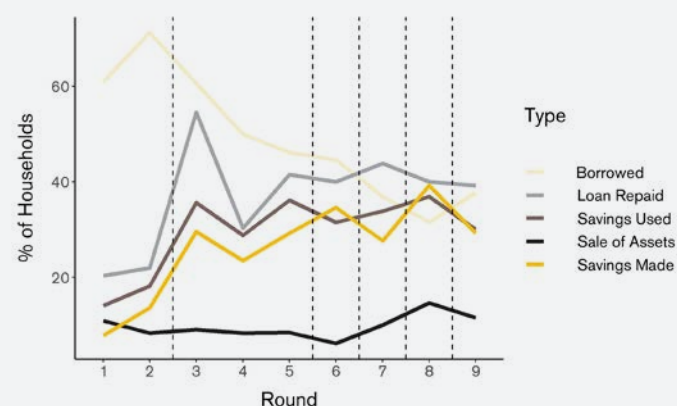

FIGURE 5B - **HOUSEHOLD SAVING AND BORROWING IN BANNU**

FIGURE 5C - **HOUSEHOLD SAVING AND BORROWING IN CAMEROON**

Cash Assistance Transfer Use

Pakistan

At baseline, as a part of the qualitative data collection, respondents were asked a hypothetical question about how they would spend money (of equivalent value to the cash assistance) if they received it without any conditions attached. In Peshawar, a quarter of the respondents (23 out of 94) said that if they received extra cash they would spend it on "health", "medical" expenses or treatment, or "medicine". In Bannu, roughly two-thirds of the sample (72 out of 100) indicated that they would spend on health expenses if they had additional funds.

"I will spend it on my son's treatment"
– Cash assistance beneficiary, Peshawar

"Invest on husband health treatment and start chicken business"
– Cash assistance beneficiary, Peshawar

After the cash assistance program had ended, recipients were asked how they spent the funds from the three rounds of transfers. In Peshawar, although the vast majority of respondents reported spending on food needs and loan repayment, almost half of the respondents (42 out of 88) had used the first transfer to meet some health need. This number decreased for the remaining two transfers to 34 for the second transfer and 27 for the third.

"…took mother in law for medical treatment and house expenses"
– Cash assistance beneficiary, Peshawar, talking about how the first round of cash assistance was spent

"Spent this cash [third transfer] on my daughter's treatment and bought medicine for myself and the remaining cash was used in household"
– Cash assistance beneficiary, Peshawar

Furthermore, 31 respondents said that they had used one or more of the transfers to repay back loans that they had taken out for health needs.

"I took loan for my daughter['s] treatment and to bear my household expenditure. Because the money my husband had earned was not sufficient to fulfill all the requirements"
– Cash assistance beneficiary, Peshawar

Similarly, in Bannu, just over half of the respondents (53 out of 100) had used the first transfer to meet some health need. This number decreased for the remaining two transfers to 32 for the second transfer and 28 for the third.

"Spend [first transfer] on daily home expenses. Also repaid loan which was used on son's health as he had fallen from roof and need thorough treatment"

– Cash assistance beneficiary, Bannu

"Have Cyst problem in uterus. Spent a big amount [third transfer] on medicine, x-rays and transport etc."

– Cash assistance beneficiary, Bannu

Furthermore, 29 respondents said that they had used one or more of the transfers to repay back loans that they had taken out for health needs.

"Yes, repaid loan, taken for medicines of diabetes"

– Cash assistance beneficiary, Bannu

"Yes, original loan was taken for the emergency treatment of son. Also I was [have] in chronic condition.

- Cash assistance beneficiary, Bannu

Cameroon

At baseline, as a part of the qualitative data collection, respondents were asked how they planned to use the cash assistance that they were going to receive. In Logone-et-Chari, half of the respondents interviewed (18 out of 36) said that they planned on using the cash on "health" expenses, in addition to other things like food needs, school fees or their business.

I will buy food and take care of my children's health needs"

– Cash assistance beneficiary, Logone-et-Chari

"I will use it for food, school fees, and health care at reference hospital"

- Cash assistance beneficiary, Logone-et-Chari

In Logone-et-Chari, across the first 3 cash transfers, food was the most common use of the transfer. Yet most households reported using each transfer to cover more than food needs, with additional uses including health, school, debt repayment, non-food household expenses, food or other items to resell, and supporting family and friends who were not receiving the transfer.

"I bought 2 bags of rice for food at 12,000 CFA [XAF]. I bought school uniforms for my 2 kids at 12,000 CFA [XAF]. I also bought shoes for my kids and used the remaining money for treatment at the hospital"

– Female host community member, Logone-et-Chari

"I used half of the money to seek health care due to low blood pressure. I used the other half to buy 2 bags of millet for household consumption. I also shared with around 10 of my neighbors."

– Female IDP, Logone-et-Chari

The purpose of the debt that households reported repaying reflected the uses of the cash transfer, with respondents having taken out loans to cover food, health, household needs, and business start-up expenses.

TABLE 2 - **HEALTH FACILITY ASSESSMENTS IN PAKISTAN AND CAMEROON**

Facility Type	Pakistan		Cameroon
	Bannu	Peshawar	Logone-et-Chari
Public/government	9	4	9
Private	5	2	4
Other*	0	2	7
Total	14	8	20

Facilities that listed their type as "other" reported being from the informal sector ("choukous" and traditional birth attendants), being charity-based, or did not indicate a type.

SUPPLY SIDE

Health Facility Assessments

In order to develop a better understanding of the supply side of health services, the research team conducted a series of rapid health facility assessments within a 25km radius of the intervention area in all three locations taking a sample of public, private and other facilities (pharmacies, traditional practitioners). Overall, information for 22 facilities in Pakistan and 20 in Cameroon was documented.

The rapid health facility assessment captured information on the following:

Number of basic drugs and supplies available: includes insulin, antibiotics, dressing kits, analgesics, iron supplements

Number of basic services available: includes various HIV tests, blood glucose test, hemoglobin tests, X-rays

Number of basic equipment functioning: includes thermometer, stehosope, blood pressure apparatus, IV, examination table, delivery table

Access to facility: registration free, consultation fee, time to referral hosital

Pakistan

Health Facilities: Supplies and Services

In Bannu, 36% of our sample (5 out of 14) was pharmacies and we present the data for pharmacies separately. The remaining, 64% (9 out of 14), were clinics, hospitals, etc. We observed that approximately 78% of facilities (7 out of 9) had more than 75% of the 19 basic drugs and supplies. In Peshawar, 50% of facilities (4 out of 8) had more than 75% of the 19 basic drugs and supplies. In terms of basic services, we found that only 22% of the facilities (2 out of 9) in Bannu had more than 50% of the 18 basic services. Forty-four percent (4 out of 9) had between 26-50%, while the remaining 33% (3 out of 9) facilities had 25% or less. The service supply side for Peshawar indicated that 63% of facilities (5 out of 8) had more than 50% of the 18 basic services, with only 33% (3 out of 9) that had 25% or less (See Table 5 in Annex A for more details).

In Bannu, for the pharmacies in our sample, we saw that all pharmacies (5 out of 5) had more than 50% of the basic drugs available.

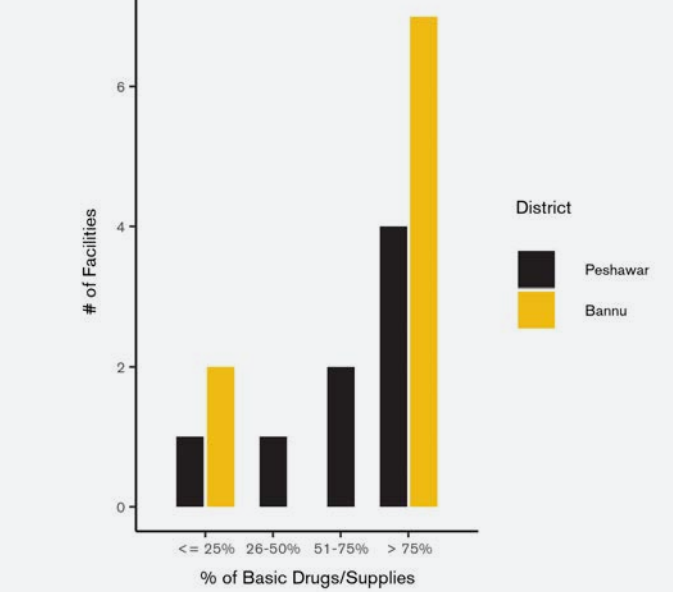FIGURE 6ᴀ - **BASIC DRUGS AND SUPPLIES AVAILABLE IN PAKISTAN**

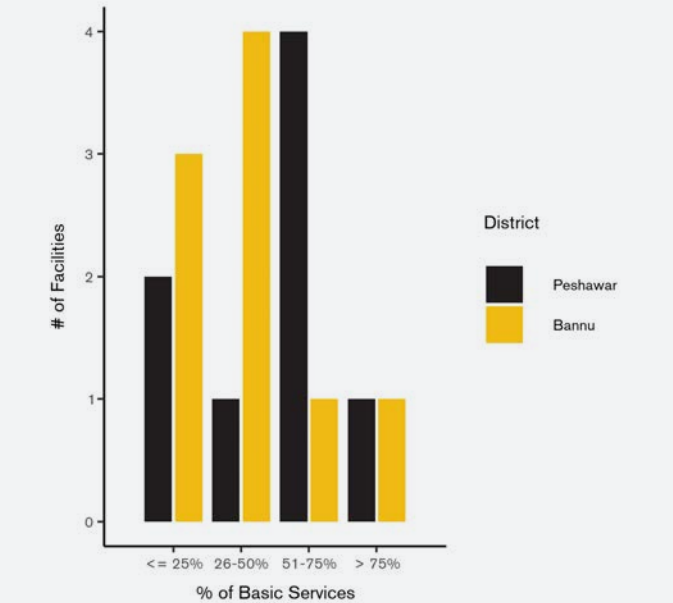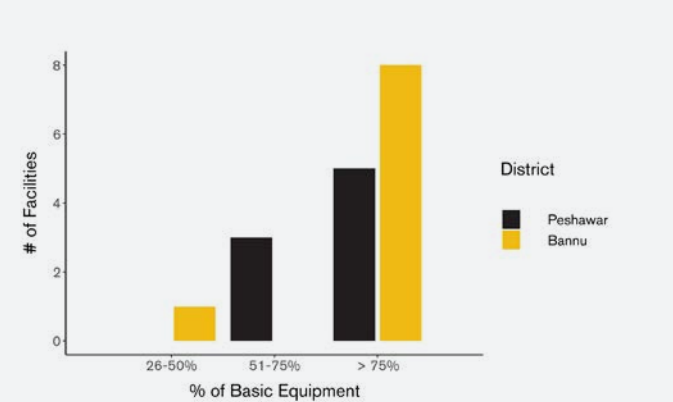FIGURE 6ʙ - **BASIC SERVICES AVAILABLE IN PAKISTAN**

FIGURE 6C - **BASIC EQUIPMENT FUNCTIONING IN PAKISTAN**

Health Facilities: Equipment and Access

Almost all the facilities in Bannu, except one, and Peshawar had at least 7 out of the 14 (50%) basic equipment. In terms of facility access, which we defined as fees, all eight facilities in Peshawar required a registration fee, while only 56% of facilities (4 out of 7) in Bannu required one. Registration fees in Peshawar ranged from Rs. 10-100 ($0.08-0.85), while registration fees in Bannu ranged from Rs. 10-30 ($0.08-0.25). Forty-three percent (3 out of 7) and 63% (5 out of 8) of facilities in Bannu and Peshawar, respectively, had a consultation fee. Fees ranged from Rs.0-20 ($0.00-0.17) in Bannu and from Rs. 20-1500 ($0.17-12.68) in Peshawar.

At baseline, during the qualitative data collection, when asked about challenges they typically faced in seeking health care and accessing health services, 44 out of 94 respondents in Peshawar, and 69 out of 100 respondents in Bannu mentioned things related to money, including: "financial" problems or issues; "costly" or "expensive" services and medicines; and, a lack of "money" to meet costs. Other frequently mentioned things included: "distance to health facility"; "transport"; "low quality medicines"; and, "lack of consultant in hospital", some of which also have financial implications, such as distance to hospital.

"Due to lack of money that is why borrow loan for treatment"
- Cash assistance beneficiary, Peshawar

"Hospital was far away and facing transport problem and high cost medicine"
- Cash assistance beneficiary, Peshawar

"Due to lack of money cannot buy medicines"
- Cash assistance beneficiary, Bannu

"Hospital is on long distance & private taxi is very costly"
- Cash assistance beneficiary, Bannu

Cameroon

Health Facilities: Supplies and Services

In Cameroon, 15 out of the 20 facilities were public and private hospitals, community nurses and community medical centers. Five out of the 20 facilities captured were traditional healers or "choukous." Information for these providers is presented separately.

Due to the prevalence of traditional healers and "choukous" in the area, we asked participants in the qualitative interview whether they

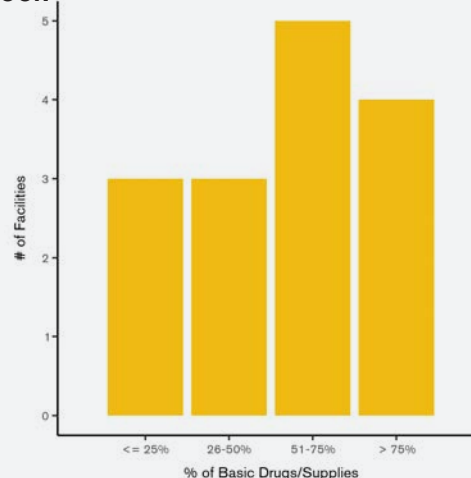FIGURE 7A - **BASIC DRUGS AND SUPPLIES AVAILABLE IN CAMEROON**

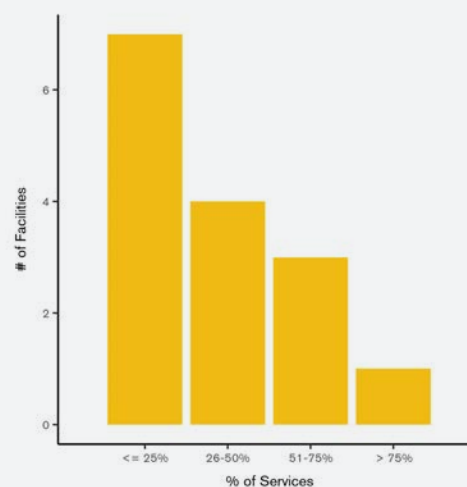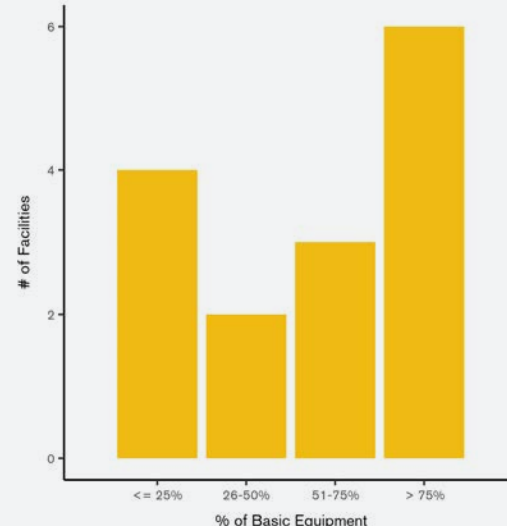FIGURE 7B - **BASIC SERVICES AVAILABLE IN CAMEROON**

FIGURE 7C - **BASIC EQUIPMENT FUNCTIONING IN CAMEROON**

preferred visiting hospitals or "choukous". Among those interviewed, 47% (n = 17) preferred hospitals while 53% (n = 19) preferred "choukous." When asked why community members preferred "choukous" over hospitals, roughly half (56%) of the respondents indicated that "choukous" offered cheap medication and could treat patients at little cost. Another third of participants indicated that "choukous" had a better availability of medication compared to hospitals.

"I prefer hospital. But both hospital and choukou are good for us because at times there are no drugs at the hospital and they recommend you to the choukou. Both of them are working together."

– Female host community member

In Cameroon, 60% of facilities (9 out of 15) had at least 50% of the 19 basic drugs, with 20% (3 out of 15) that had 25% or less. We observed a similar weak supply for services, with only 27% of facilities (4 out of 15) that had at least 50% of the 18 basic services; 47% (7 out of 15) had 25% or less of the basic services available.

In contrast to findings from the qualitative interviews, "choukous" and traditional healers, had a weak supply of basic drugs, services and equipment: although 20% (1 out of 5) had 7 out of 19 basic drugs available, none had any of the basic services available.

Health Facilities: Equipment and Access

In Cameroon, 60% of facilities (9 out of 15) had more than half (7 out of 14) of the basic equipment assessed in functioning condition. In terms of access, we observed that 40% of facilities (6 out of 15) had a registration fee while 67% (10 out of 15) had a consultation fee (See Table 5 in Annex A for more details).

From the qualitative interviews, we found that the most commonly cited challenge in accessing health care was the high cost of care, which was mentioned in 75% (n = 24) of interviews. Difficulty finding transportation, long distance to hospitals, and shortage of health personnel and drugs were each prevalent in 31% (n = 10) of interviews. In cases of financial constraint, 84% of respondents declared that they would borrow money in order to meet their household's health needs.

Availability of Health Services through NGOs for Affected Populations: Data from Secondary Sources

In addition to the primary data collection (health facility assessment), we know from secondary sources[10] that in Pakistan, the government had a uniform fee structure across the province of Khyber Pakhtunkhwa for all populations, including IDPs. Most basic services (for example: blood tests, x-rays, etc) cost between Rs.20-

TABLE 3 - PERCENTAGE OF FACILITIES THAT HAD FREE SERVICES AVAILABLE FOR SPECIFIC POPULATIONS

	Children under 5	Pregnant Women	Elderly	Other free services?[9]
Bannu	78%	67%	67%	57%
Peshawar	25%	75%	88%	88%
Logone-et-Chari	73%	67%	20%	30%

400 ($0.17-3.38), and there was no observed change in cost of services for these populations pre- and post- displacement.

In addition to this, we know that there were other agencies providing health services (primary health care, mental health, first aid, eye camps, etc) in the 2017-2018 time period. These were largely free of cost and available in both Bannu and Peshawar, though the number of actors and services were greater in Peshawar. Though not an exhaustive list, the IRC noted at least 10 actors in Peshawar and 5 in Bannu providing some combination of the above mentioned services. Through our health assessment, IRC found that only 3 facilities in Peshawar reported receiving NGO support, while 8 facilities (including 2 pharmacies) in Bannu reported NGO support.

Eleven facilities from our health facility assessment in Cameroon reported receiving NGO support. Data from secondary sources suggest that, in Cameroon, except vaccination campaigns, which were organized free of cost by the Ministry of Health, all other services were subject to charges.

Furthermore, we know that there were two humanitarian actors who provided medical assistance for refugees, IDPs and other vulnerable populations in the project area: an international NGO, Action Contre la Faim (ACF), and a national NGO, Africa Humanitarian Action (AHA). Until March 2019 and June 2019, ACF and AHA respectively, provided total medical care free of cost through a mobile clinic for pregnant and lactating women and for children under the age of 5 suffering from malnutrition or malaria.

Health Needs and Expenditure

The research team captured information about health service utilization and expenditure associated with 3 different categories of health needs: (i) Preventive (including related to Pregnancy); (ii) Unpredictable, i.e. Illness and Injury, and (iii) Predictable, i.e. Chronic Illness (refer to Annex B for more details). The overall sample size for the following categories was very small and results should be interpreted with caution:
- Preventive health care utilization and expenditures in Pakistan
- Pregnancy in both contexts
- Chronic illness in Cameroon
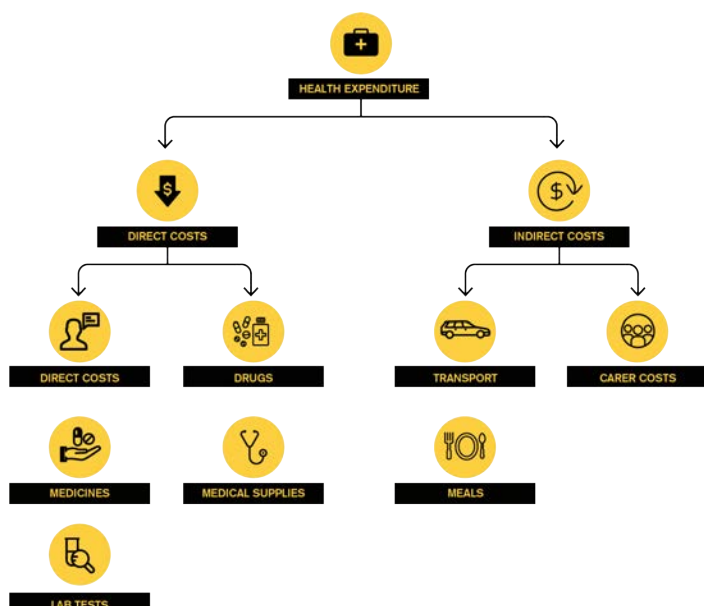
For each category of health needs, after establishing need for service and whether care was sought, the research team captured information about direct and indirect expenditures associated with a visit to a healthcare provider or otherwise. Direct expenditure included costs incurred during visit (consultation, drugs, lab tests, medical supplies, other) and additional costs not related to a visit during the same two-week period. Indirect costs consisted of transportation for self and accompanying household member to health facility, meals while at facility, and other.

Overall, two metrics were used to understand expenditure: first, we examined the total proportion of direct and indirect expenditure across all households to determine the drivers of cost; second, we analyzed the median costs over time for direct and total expenditure at the individual and household level.

Aggregate Health Expenditure and Cash Usage

Peshawar, Pakistan

In Peshawar, at an aggregate level, across all types of health needs, we observed that between 32-85% of households reported requiring health services across rounds. Between 29-75% of households reported seeking care and between 26-73% reported incurring a cost (Table 6 in Annex A). The total aggregate spending on healthcare (across all households and all types of health needs) was between $261.99-1,756.11 across rounds. The total aggregate spending on health needs was 35.4% of the aggregate reported income for the relevant 3 month period of cash assistance and was 20.8% of the aggregate transfer amount (i.e. of three tranches of cash assistance). Finally, we observed that between 3.41-45% of households across rounds reported incurring health expenses that were 40% or more of their non-food expenditure (i.e. qualified them as incurring catastrophic spending on health expenses) during any

given bi-weekly period (Table 7 in Annex A). Although the range for catastrophic spending[11] across rounds is huge, this is indicative of the fact that households don't incur catastrophic spending due to healthcare expenses in every reporting period. When viewed on aggregate, 15.8% of households experienced catastrophic spending on health expenses.

Bannu, Pakistan

In Bannu, at an aggregate level, across all types of health needs, we observed that between 63-89% of households reported requiring health services across rounds. Between 7-69% of households reported seeking care and between 6-65% reported incurring a cost (Table 6 in Annex A). The total aggregate spending on healthcare (across all households and all types of health needs) was between $91.13-8,375.72 across rounds.[12] The total aggregate spending on health needs was 66.4% of the aggregate reported income for the relevant 3 month period of cash assistance and was 30% of the aggregate transfer amount (i.e. of three tranches of cash assistance).[13] Finally, we observed that between 4-32.32% of households across rounds reported incurring health expenses that were 40% of their non-food expenditure (i.e. qualified them as incurring catastrophic spending on health expenses). When viewed on aggregate, 12.4% of households experienced catastrophic spending on health expenses.

Logone-et-Chari, Cameroon

At an aggregate level, across all types of health needs, we observed that between 45-82% of households reported requiring health services across rounds. Between 39-77% of households reported seeking care and between 21-35% reported incurring a cost (Table 6 in Annex A). The total aggregate spending on healthcare (across all households and all types of health needs) was between $378.93-2,394.97 across rounds.[14] The total aggregate spending

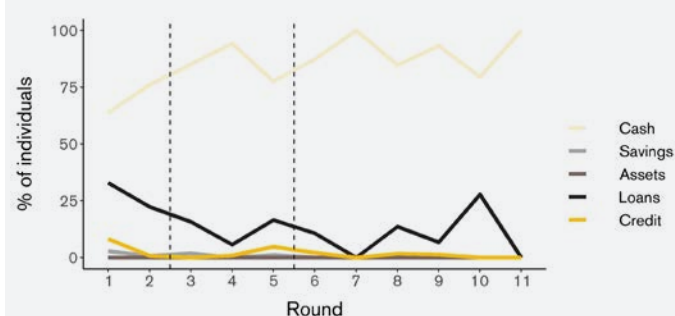FIGURE 8A - **EXPENDITURE METHOD FOR ALL HEALTH SERVICES: PESHAWAR**

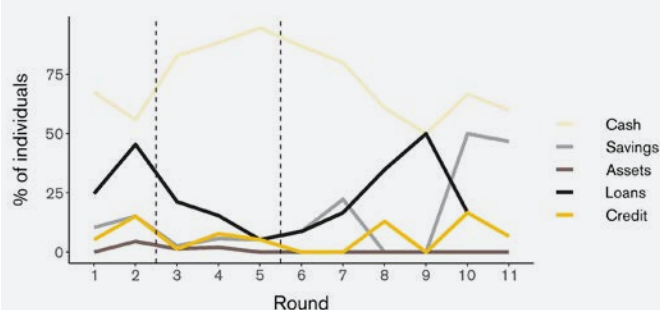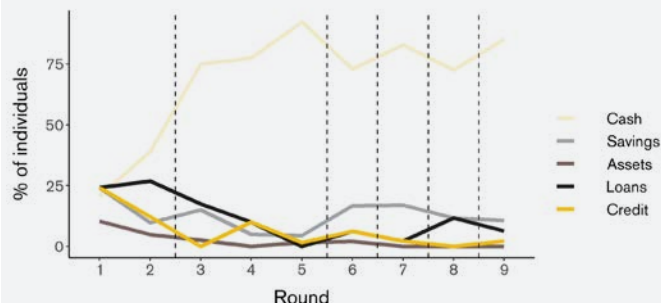FIGURE 8B - **EXPENDITURE METHOD FOR ALL HEALTH SERVICES: BANNU**

FIGURE 8C - **EXPENDITURE METHOD FOR ALL HEALTH SERVICES: LOGONE-ET-CHARI**

on health needs was 107.2% of the aggregate reported income for the relevant 3.5 month period after the cash assistance started and was 10% of the aggregate transfer amount (i.e. of five tranches of cash assistance). Finally, we observed that between 10.94-18.75% of households in any given round reported incurring health expenses that were 40% of their non-food expenditure (i.e. qualified them as incurring catastrophic spending on health expenses). When viewed on aggregate, 11.7% of households experienced catastrophic spending on health expenses.

Across all three sites, we observed that once the cash assistance started, there was an increase in the use of cash to make health related payments and a decrease in loan usage for health payments (Refer to Table 8 in Annex A).

Key Findings

- Most households in which someone sought care tended to incur a cost in Bannu and Peshawar

- Aggregate spending on health needs was greater than aggregate bi-weekly income in Logone-et-Chari, Cameroon

- Households used loans to cover health expenditure

- Cash use increased and loan use decreased for health expenditures during cash assistance

Preventive Health Needs

Peshawar, Pakistan

In Peshawar, across all rounds, we saw that 1% (or less) of the population sought preventive health care services. In total, across 11 rounds of data collection, we only observed 40 instances of preventive health care utilization. These services primarily included vaccinations, though there were a few instances of family planning, post-natal care and voluntary counseling. Individuals primarily reported seeking care at the hospital or clinic, though there were a few cases of individuals visiting a traditional healer. Out of these 40 instances, individuals only incurred a direct cost in 3 cases, but 10 individuals reported incurring indirect costs. The median total cost for individuals who sought care (and for households in which anyone sought care) was between Rs. 100-380 ($0.85-3.21), suggesting that typically it was only one member per household that was seeking preventive care..

Pregnant or Lactating Women in Household:

Between 3-5% of the sample was pregnant or lactating women, depending on the round of data collection. Overall, only between 0.4-1% of the total sample were women who were pregnant during the data collection period. The data suggest that, typically, there was one pregnant or lactating woman per household, with 2-3 households that had multiple pregnant or lactating women. During the recall period captured by our study, there were 15 reported deliveries and the majority of women sought care in a public facility. The remaining delivered either at home or at a private facility. For those women who sought delivery services the median direct expenditure was between Rs. 0-3,000 ($0-25.36) and the total median expenditure for delivery services for those who sought care was between Rs. 0 – 3,350

($0-28.32). Fifteen women reported seeking antenatal care, and primarily at a public or private facility. The median direct expenditure for antenatal care visits for those who sought care was between Rs. 0-3,488 ($0-29.50) and the median total expenditure was between R. 200-3,508 ($1.69-29.65). The median direct expenditure figures for both delivery services and antenatal care for households in which anyone sought care were similar, reinforcing that typically there was only one woman per household that was currently pregnant (See Tables 12a and 12b in Annex A).

Bannu, Pakistan

In Bannu, across 11 rounds of data collection, we only observed 18 instances (1.1% or less for any given round) of preventive health care utilization, with 6 rounds in which no individual reported seeking preventive care. Only 5 individuals reported incurring an expense in the entire study period.

Pregnant or Lactating Women in Household:

In Bannu, between 1.6-3.7% of the sample were pregnant or lactating women, depending on the round of data collection. The data suggest that, typically, there was only one pregnant or lactating woman per household. During the recall period captured by our study, there were no reported deliveries. During the study period, 13 women reported receiving antenatal care services, primarily in public facilities. The median total cost for individuals who sought care (and for households in which anyone sought care) was between Rs. 100-380 ($0.85-3.21), suggesting that typically it was only one member per household that was seeking preventive care.

Logone-et-Chari, Cameroon

In Logone-et-Chari, in three rounds of data collection, we observed spikes (>10% of sample) in utilization of preventive care. These were all associated with national vaccination campaign days and

individuals utilizing these services primarily reported visiting hospitals or to a lesser degree clinics to seek care. Individuals utilizing these immunization services, did not report incurring costs for these services. We also know from secondary sources that immunization services were provided free of cost by the government. Other preventive health services utilized with some frequency across rounds include: (i) family planning; (ii) postnatal care; (iii) voluntary counseling and testing; (iv) delivery, and (v) circumcision.

Overall, immunization aside, although individuals access preventive health care services at low rates (<3% of sample in all rounds), the individual and household median direct and total expenditure on preventive health care for the sample stays close to zero. We see no clear trends in relation to the cash assistance. For all services – with the exception of vaccinations -- that individuals reported utilizing, both non-zero and zero direct costs were reported, suggesting that some individuals did have to pay for preventive care.

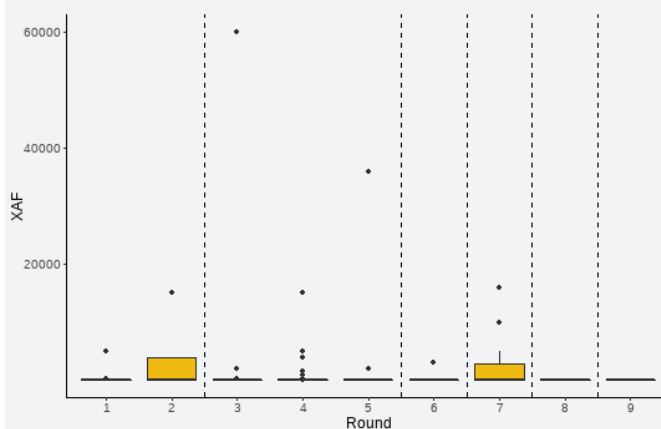FIGURE 10A - **DIRECT EXPENDITURE FOR PREVENTIVE CARE VISITS IN LOGONE-ET-CHARI**

FIGURE 10B - **INDIRECT EXPENDITURE FOR PREVENTIVE CARE VISITS IN LOGONE-ET-CHARI**
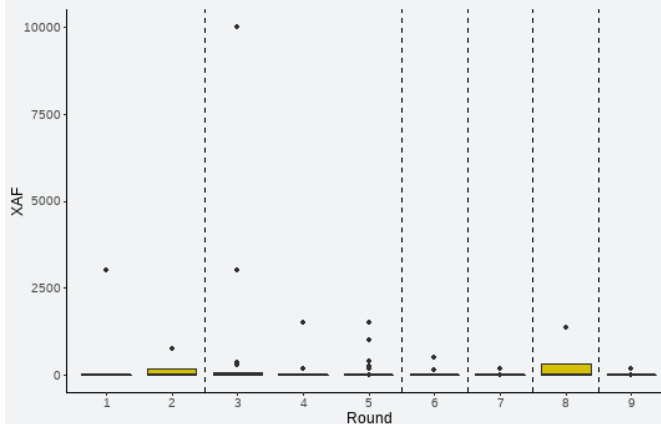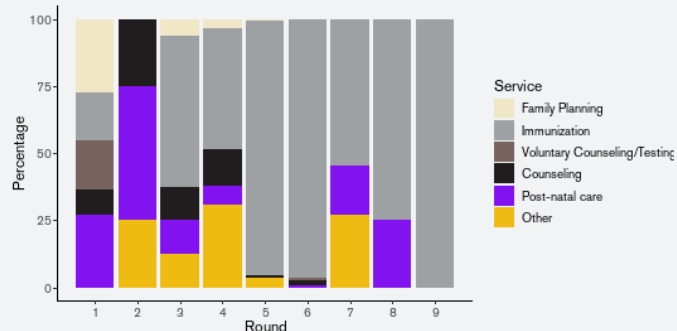

FIGURE 9 - **PREVENTIVE HEALTH SERVICES SOUGHT IN LOGONE-ET-CHARI**

Findings from the qualitative data highlight possible mechanisms behind the low demand for non-vaccination preventive care. The following quotes represent common themes found from participants' responses when asked why they don't seek preventive health services.

"We don't do that. You first have to fall ill before spending your money. We don't want even if it is free."

– Female host community member

"There is ignorance of the availability of preventive health care services at the Integrated Health Center in Biamo. Hospitals are not sharing enough information on preventive health care. They only have preventive care for children and not for adults in our community.

– Female host community member

"We must only go to the hospital when we are sick and not just for nothing."

– Male host community member

The lack of preventive health care seeking appears to be three-pronged: informational, behavioral and possibly related to availability of services. First, preventive services were not well advertised, thus community members may not know what services are available to them, and at what cost. Second, preventive care seeking was not a behavioral norm; community members viewed health care as a service only relevant for those who were ill, and thus did not seek preventive care since they considered themselves in good health. Third, services may only have been available for certain populations and not all populations.

Pregnant or Lactating Women in Household:

Roughly 8% of the sample in Logone-et-Chari were women who were pregnant or lactating. Of these, 30% of the women were currently pregnant and 70% were lactating. The data suggest that, typically, there was one pregnant woman per household, with 2-3 households that had multiple pregnant or lactating women. During the recall period captured by our study, there were 23 reported deliveries. Of these, there were 4 reported cases of either a miscarriage or death of the baby shortly after birth. Approximately 60.9% (14 out of 23) of women who sought care for delivery reported going to a public facility and the remainder (9 out of 23) reported delivering at home. The median total spending on delivery services (in rounds where there was a reported delivery) per individual who delivered (and per household in which anyone delivered) ranged from 1,000-6,000 francs ($1.70-10.20). Our primary data collection indicated that only 50% of facilities provided free healthcare services for pregnant women, but data from secondary sources suggested that there were 2 humanitarian organizations providing free health care services for pregnant and lactating women. Despite these free services, both, pregnant women delivering at a public facility and those delivering at home, reported incurring a cost for delivery services.

We saw antenatal care usage across all rounds and only at public facilities (a total of 63 visits were reported). The median spending on antenatal care for those who sought care was 0 for 7 out of the 9 rounds. Those who were spending money, spend primarily on: visit fees, drugs, and lab tests.
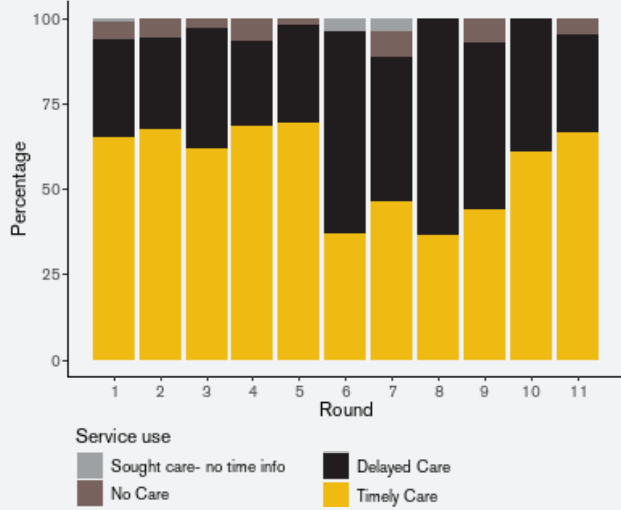
Unpredictable Health Needs: Illness and Injury

For illness and injury, for each individual within the household, the IRC asked whether the individual had experienced an illness or injury in the last 2 weeks. Individuals who were injured or ill, could seek care or not seek care, and individuals who did seek care, could either seek care immediately or wait to seek care. Anyone who did seek care could incur a cost. Details such as: (i) reasons for not seeking care or delaying care; (ii) type of service provider; (iii) number of visits; (iv) distance to service provider; (v) cost incurred, and (vi) method of payment, were all captured for each household member as a part of the illness and injury module (refer to Annex B for more details). Individuals could experience more than one illness or injury during the 2 week recall period. For most of this analysis, we used visit as the unit of analysis rather than the individual. For example, an individual may have sought care for an illness and an injury during the two-week period, thus each visit was counted as a separate data point.
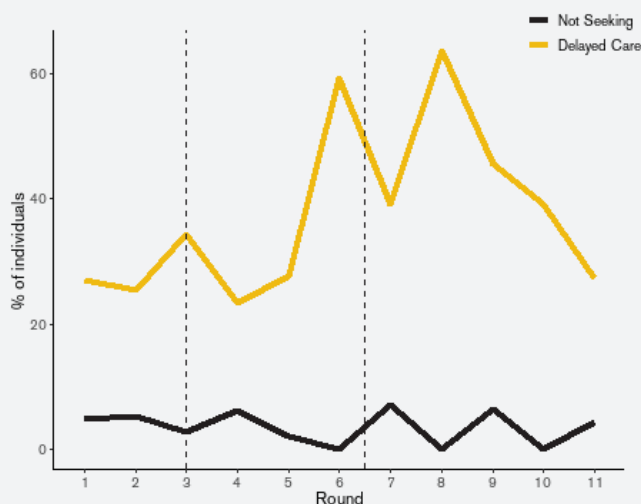
Peshawar, Pakistan

The overall percentage of individuals that experienced unpredictable health needs in Peshawar decreased over the study period (Table 10a and 10b in Annex A). This is potentially attributable to a change in season (with higher levels of people reporting a "Fever" or "Cough" in February and March) and may also be a result of over-reporting in the initial rounds if households are conflating IRC's service provision with the research study. For both illness and injury, the vast majority of people who reported any illness or injury reported seeking care, primarily at a hospital or a clinic, and reported incurring a cost for seeking care.

FIGURE 11 - **CARE-SEEKING FOR ILLNESS AND INJURY IN PESHAWAR**

11a and 11b in Annex A for more details). The median spending on direct expenses in households where anyone sought care for illness or injury was Rs. 590-1100 ($4.99-9.30) and the median total expense was Rs. 700-1125 ($5.92-9.51) (Refer to Tables 12a and 12b in Annex A for more details). The expenditure is largely driven by direct costs across all rounds.

In Peshawar, we did not observe any clear patterns through the study period that suggested more people were seeking care because of the cash assistance. However, we observed peaks in delayed care prior to the start of the cash assistance, right before the second and third tranches were delivered, and once cash assistance stopped. This pattern suggests that cash may be facilitating timely care seeking behavior (Figure 12 and see Table 13a for more details).

FIGURE 13 - **TOTAL EXPENDITURE BREAKDOWN FOR ILLNESS AND INJURY IN PESHAWAR**
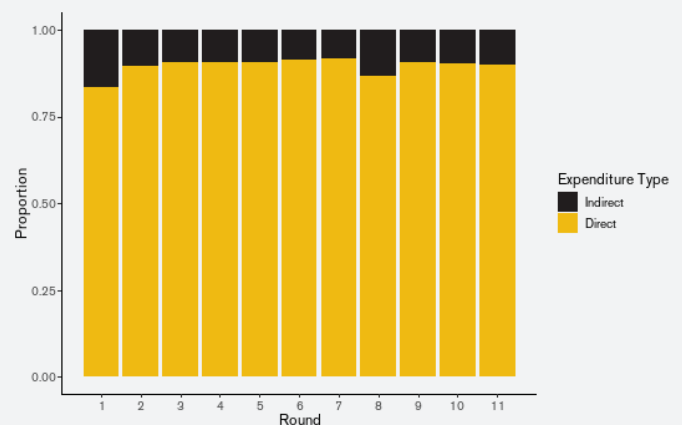
Bannu, Pakistan

The overall percentage of individuals experiencing unpredictable health needs in Bannu decreased over the study period (Table 10a in Annex). This is potentially attributable to a change in season (with higher levels of people reporting a "Fever" or "Cough" in February and March) and may also be a result of over-reporting in the initial rounds if households are conflating IRC's service provision with the research study.

FIGURE 12 - **DELAYED CARE/NO CARE FOR ILLNESS AND INJURY IN PESHAWAR**

FIGURE 14 - **CARE-SEEKING FOR ILLNESS AND INJURY IN BANNU**
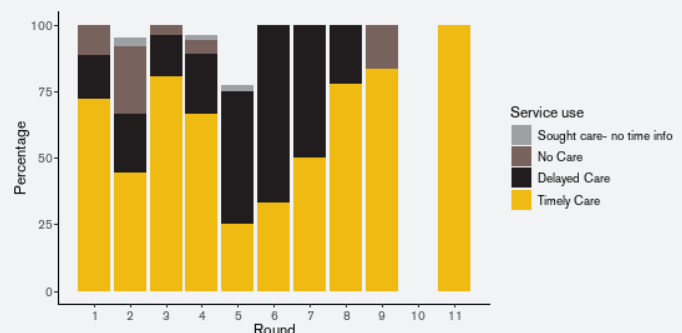
Note: The percentages don't add up to 100% in rounds 2, 4, and 5. Some illnesses were accidentally reported as chronic (such as colds or flu), and had to be moved into the illness database. Since the questions for chronic illness are slightly different, none of these cases had the relevant data to match the illness questions.

Overall, the median direct expenditure for illness-related visits was between Rs.350-725 ($2.96-$6.13) across rounds, while the total expenditure was between Rs.400-800 ($3.38-6.76) (Refer to Tables

FIGURE 15 - **DELAYED CARE/NO CARE FOR ILLNESS AND INJURY IN BANNU**
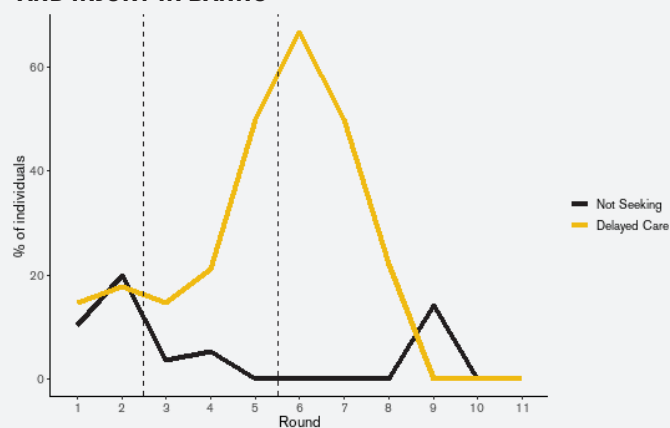

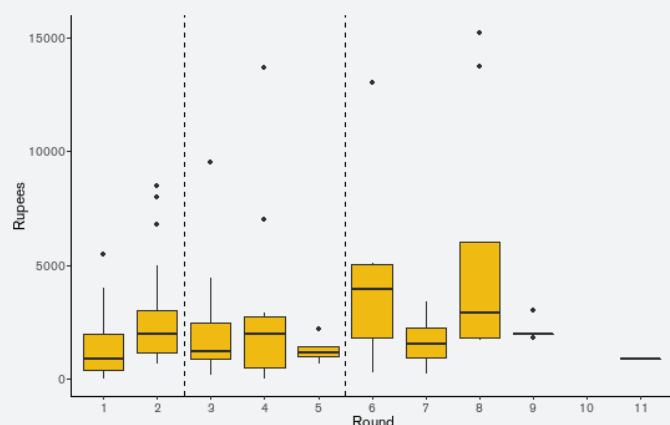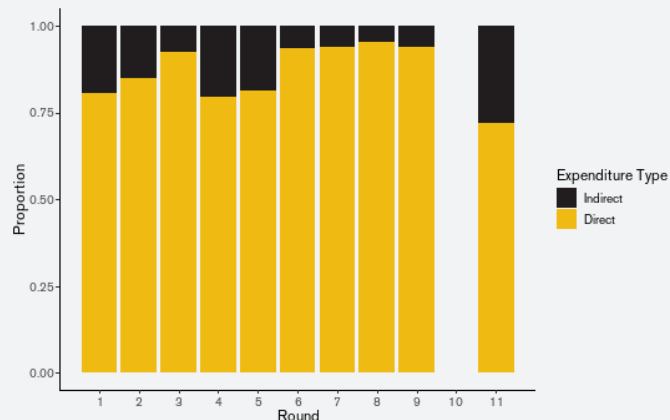FIGURE 16 - **DIRECT EXPENDITURE FOR ILLNESS AND INJURY VISITS IN BANNU**

FIGURE 17 - **TOTAL EXPENDITURE BREAKDOWN FOR ILLNESS AND INJURY IN BANNU**

For both illness and injury, the vast majority of people reported seeking care (whether timely or delayed), primarily at a hospital or clinic (see Table 14 in Annex A), and reported incurring a cost for seeking care.

In Bannu, we observed that during the initial rounds of data collection (when there was no cash assistance), there was a greater percentage of illnesses or injuries for which people reported not seeking care. This decreased during the cash assistance period. Furthermore, we observed a increase in the percentage of illnesses or injuries for which people reported seeking delayed care in the 5 week period between the first and second cash transfers. However, notably, the number of reported cases for illness/injury in this period is low and this period coincides with Ramzan and Eid, which could also be driving the delay in seeking care (see Figure 15 and Table 13 in Annex A for more details).

Overall, the median direct expenditure for illness-related visits was between Rs.900-3,950 ($7.61-$33.39) and the total direct expenditure was Rs. 900-4,550 ($7.61-38.47) across rounds (Refer to Tables 11a and 11b in Annex A for more details). The median spending on total expenses for illness and injury at the household level was between Rs. 1,100-4,550 ($9.30-38.47) (See Table 12b in Annex A).

The expenditure was largely driven by direct costs across all rounds.

Logone-et-Chari, Cameroon

Across all 9 rounds, between 7-14% of the sample reported an unpredictable health need (either illness or injury). The data suggest that, typically, there was more than one member within a household that was either ill or injured in any given round of data collection. The most commonly reported illnesses and injuries included: fever, cough, diarrhea, and headaches.

Individuals reported spending on unpredictable health needs across all rounds of data collection and the median spending on direct expenditures per illness-related visit was between 1,000-2,000 francs ($1.70-3.40) and the total expenditure per individual who sought care was between 1,000-2,400 francs ($1.70-4.08). At the household level, the median spending on direct expenditure ranged from 1,050-3,450 francs ($1.79-5.87) and total expenditure ranges from 1,200-3,450 francs ($2.04-5.87) for households in which anyone sought care.

The vast majority of illnesses and injuries were treated at a hospital or by a community nurse (Refer to Table 14 in Annex A for more details). A very small percentage of the sample were treated by a traditional healer. We observed that the percentage of illnesses and injuries for which people did not seek care decreased over time as the cash

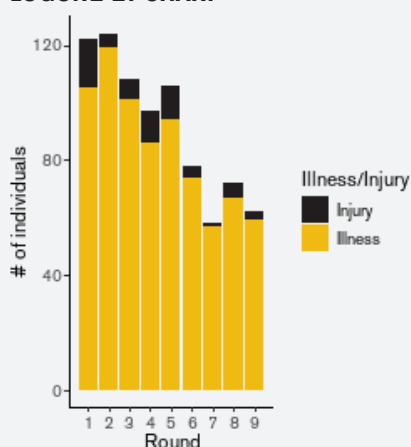## FIGURE 18 - **ILLNESS AND INJURY BREAKDOWN IN LOGONE-ET-CHARI**

FIGURE 19 - **DIRECT EXPENDITURE FOR ILLNESS AND INJURY VISITS IN LOGONE-ET-CHARI**
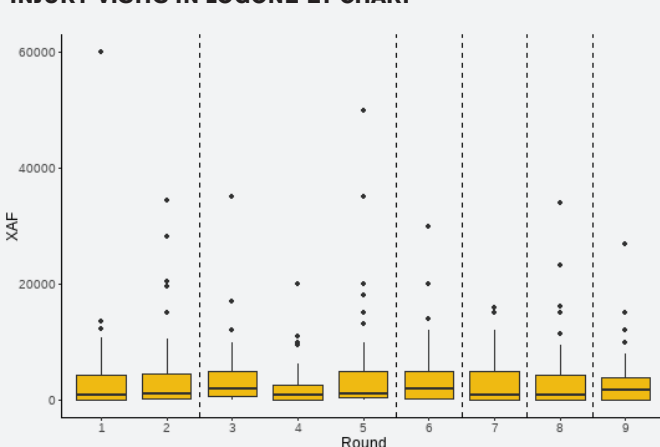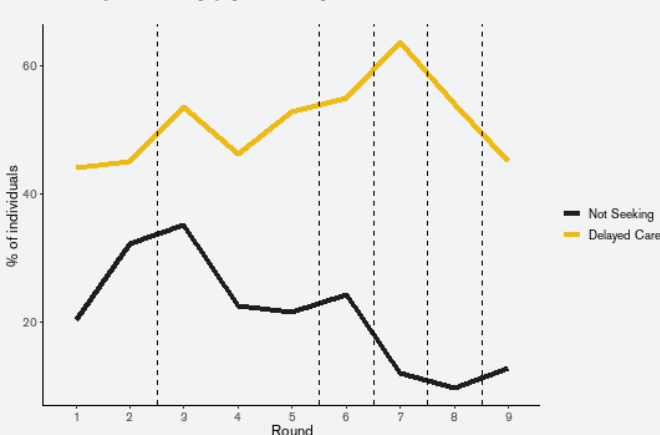

FIGURE 20 - **DELAYED CARE/NO CARE FOR ILLNESS AND INJURY IN LOGONE-ET-CHARI**

assistance started. However, we also observed an increase in delayed care, suggesting that on the one hand more people were seek care, but on the other hand, they may have been waiting more than 24 hours before doing so (Table 13 in Annex A).

A combination of a 'lack of money' and 'high cost of care' was the most commonly cited reason for not seeking care, delaying care or not completing care. Other cited reasons included: 'self-medication'; 'long distance to provider'; 'illness/injury not considered serious enough', and 'prescribed drugs not available'.

Predictable Health Needs: Chronic Illness

We defined chronic illness as a predictable health need, which means that basic care such as medication, dietary regiments, or routine appointments can generally be anticipated by the individual and is already incorporated into the individual's daily life. Given that such needs can be predictable, households can budget for medication and required appointments. However, individuals with chronic illnesses can also experience unexpected complications that may require additional medical supplies or hospital visits. Due to the possibility of complications, participants with chronic illnesses were asked whether they sought routine care or care for complications during each round of data collection.

Participants were asked to indicate which chronic illness(es) they have from a set list and a fill-in-the-blank option. The set list of illnesses included hypertension, diabetes, cardiac disorder, arthritis, ulcers, hepatitis, and cancer. Since onset and diagnosis of a chronic illness can occur at any time, and the composition of households can change, households were asked about any changes to the health status of all household members during each round of data collection. It is important to note that the CfW program in Pakistan specifically targeted households with members who have chronic illnesses, while only chronic illness of the head of household was a targeting criteria for the program in Cameroon. This may explain some, but not all of the prevalence difference between Pakistan and Cameroon.

During each round of data collection, household members with chronic illnesses were asked whether they were supposed to have a routine visit to a health care provider or if they experienced complications related to the illness within the last two weeks. Individuals could have more than one required visit or experience multiple, but separate complications within the recall period. In both cases, household members could either seek care or not seek care. However, those who didn't have required visits or experience complications could still seek care, though very few usually did. Household members with multiple

conditions could choose to seek care for one condition but not another. Regardless of how soon care was sought, all individuals who eventually sought care could incur a cost.

Since care can vary by condition, we used each required visit or complication as the unit of analysis rather than the individual or illness itself. For example, an individual may have two required visits during the two-week period, thus each visit was counted as a separate data point.

Peshawar, Pakistan

In Peshawar, at baseline, 154 individuals (21.3% of total sample) reported having a predictable health need. This section focuses specifically on chronic illness, a subset of predictable health needs. A total of 101 individuals (14.0% of sample) reported having a chronic illness or a critical medical condition (Table 9a in Annex A). Data aggregated at the household level indicated that the vast majority of households (between 70.1-84.1%) in the sample had at least one chronically ill member, with some households with more than one member with a chronic illness or which had members with co-morbidities (Table 9b in Annex A). These numbers were not stable across rounds as existing household members left the household and new members joined.

The most commonly reported condition was hypertension (n=50 individuals), followed by diabetes (n=21), hepatitis (n=18), other (n=13), arthritis (n=12), cardiac disorders (n=9), and cancer (n=1). Self-reported conditions from the "other" category included: asthma; back problems; kidney complications; tumors; epilepsy, and dermatological conditions.

In Peshawar, the percentage of required visits decreased from 59.12% in Round 1 to 20.16% in Round 11. It is possible that there was over-reporting of care needed in earlier rounds if research participants were conflating the research study with IRC's service provision. Forty-six percent of these visits were attended in Round

1. Adherence to routine visits drastically dropped off over time, with only 17.05% of routine visits attended in Round 11. Individuals were asked why they didn't seek care for both routine visits and complications. In Peshawar, a lack of money or high cost of care were the main reasons that individuals gave for not seeking care, followed by self-medication.

Care was primarily sought from hospitals, clinics or pharmacies. Initially, visits and complications for which care was sought usually occurred in a hospital (60.9%) or a clinic (37.5%). Over time, the percentage of visits to pharmacies increased and eventually became the most common facility in the final round (77.3%, compared to 0% for clinics and 22.7% for hospitals). Very few visits or complications were treated by traditional healers (Table 14 in Annex A).

Visit-related costs were the main driver of expense in Peshawar for chronic illness. Across all but two rounds, additional drug costs made up the second largest portion of direct expenditure.

The median direct expenditure for chronic illness related visits in Peshawar ranged from Rs. 275-1,000 ($2.32-8.45) across rounds,

FIGURE 22 - **DIRECT EXPENDITURE BREAKDOWN FOR CHRONIC ILLNESS IN PESHAWAR**
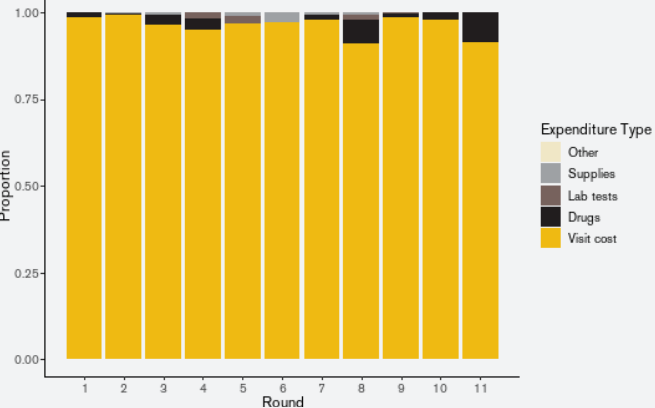

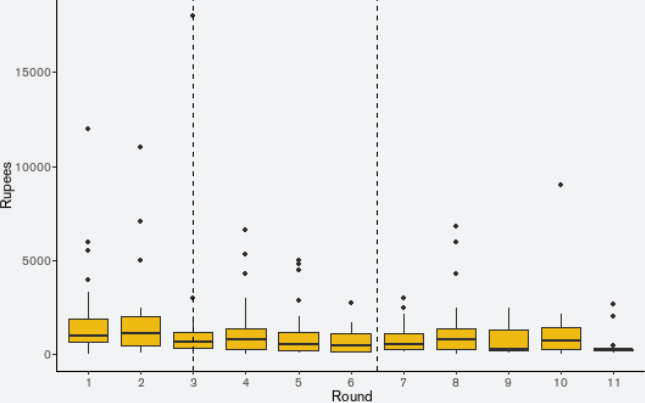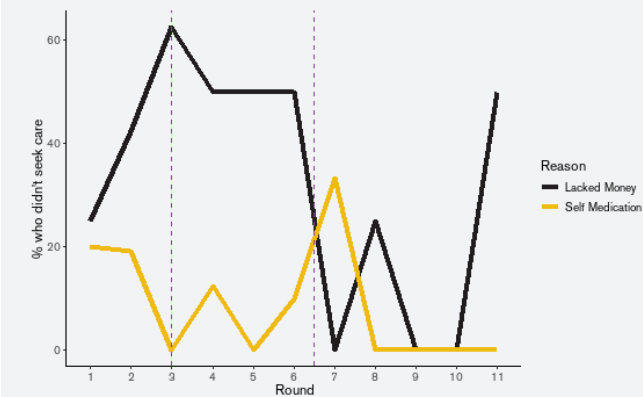FIGURE 21 - **REASONS FOR NOT SEEKING CARE FOR CHRONIC ILLNESS IN PESHAWAR**

FIGURE 23 - **DIRECT EXPENDITURE FOR CHRONIC ILLNESS VISITS IN PESHAWAR**

while the total expenditure was between Rs. 275-1,400 ($2.32-11.84). The median direct expenditure per household in which anyone sought care was between Rs. 550-1,850 ($4.65-15.64) and total expenditure was between Rs. 600-1,900 ($5.07-16.06).

Similar to other contexts, indirect expenditure in Peshawar was also driven by transportation costs for self to and from facilities. A smaller portion of indirect expenditure in Peshawar consisted of meals costs.

FIGURE 24 - **INDIRECT EXPENDITURE BREAKDOWN FOR CHRONIC ILLNESS IN PESHAWAR**
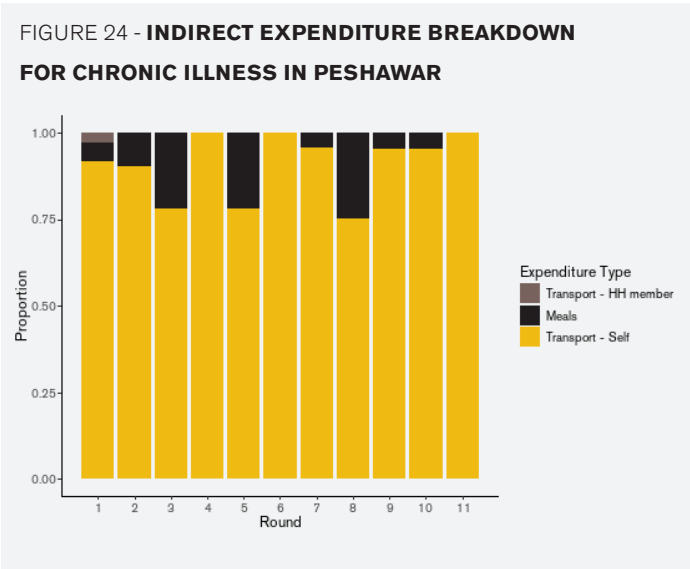
Bannu, Pakistan

In Bannu, at baseline, 88 individuals (13.6% of total sample) reported having a predictable health need. This section focuses specifically on chronic illness, a subset of predictable health needs. A total of 48 individuals (7.4% of sample) reported having a chronic illness or a critical medical condition. This figure varied across rounds because of existing household members leaving the household and new members entering (Table 9a in Annex A). Data aggregated at the household level indicated that at least 8% of households had more than one member who had a chronic illness or a critical medical condition (Table 9b in Annex A).

The most commonly reported condition was other (n=21 individuals), followed by hypertension (n=13), arthritis (n=8), cardiac disorders (n=8), diabetes (n=3), hepatitis (n=3), and ulcers (n=1). Self-reported conditions from the "other" category included: anemia, asthma and breathing problems, kidney complications, tumors, stomach or neck problems and dermatological conditions.

In Bannu, the percentage of required visits varied across rounds from 84.5% in Round 1 to 94.1% in Round 11. In rounds 5, 6 and 8, close to a 100% of the chronically ill population reported requiring a visit. However, although approximately 55% of the population was

receiving the care they were supposed to get in round 1, adherence to routine visits drastically dropped off over time, with only 20.6% of routine visits attended in Round 11. It is possible that there was over-reporting of care needed in earlier rounds if research participants were conflating the research study with IRC's service provision.

FIGURE 25 - **REASONS FOR NOT SEEKING CARE FOR CHRONIC ILLNESS IN BANNU**
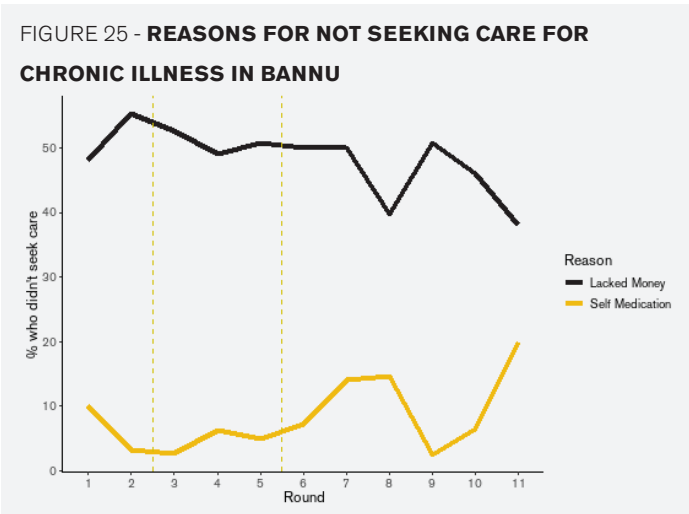
Individuals were asked why they didn't seek care for both routine visits and complications. In Bannu, a lack of money or high cost of care were the main reasons that individuals gave for not seeking care, followed by self-medication.

Care was primarily sought from hospitals, clinics, or pharmacies (Table 14 in Annex A). Additional drug costs and visit related costs were the main drivers of expense in Bannu for chronic illness. Across most rounds, additional drug costs made up the largest portion of direct expenditure.

The median direct expenditure for chronic illness related visits in ranged from Rs. 1,250-3,150 ($10.57-26.63) and the total cost ranged from Rs. 1,370-3,500 ($11.58-29.59). The median direct expenditure per household in which anyone sought care was between Rs. 1,250-3,500 ($10.57-29.59) and the total expenditure was between Rs. 1,370-3,700 ($11.58-31.28).

FIGURE 26 - **DIRECT EXPENDITURE BREAKDOWN FOR CHRONIC ILLNESS IN BANNU**

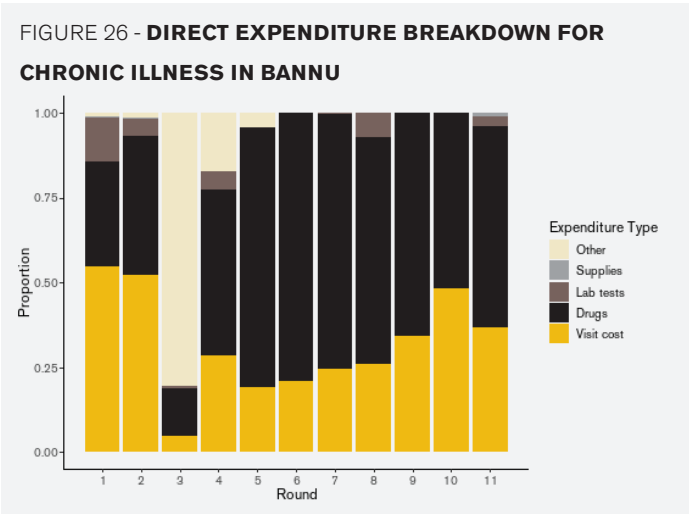FIGURE 27 - **DIRECT EXPENDITURE FOR CHRONIC ILLNESS VISITS IN BANNU**

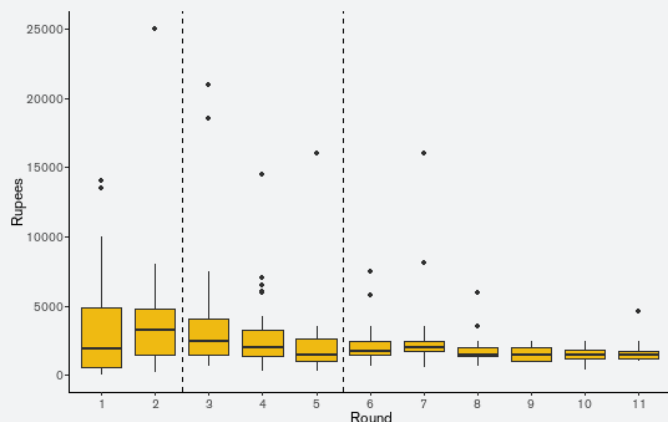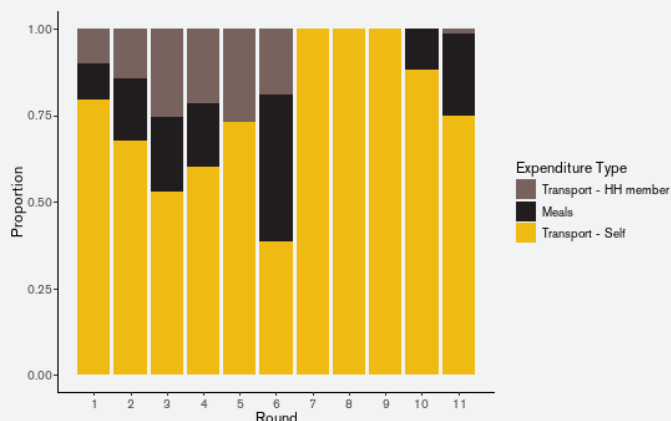FIGURE 27 - **DIRECT EXPENDITURE FOR CHRONIC ILLNESS VISITS IN BANNU**

FIGURE 28 - **INDIRECT EXPENDITURE BREAKDOWN FOR CHRONIC ILLNESS IN BANNU**

Similar to other contexts, indirect expenditure in Bannu was also driven by transportation costs for self to and from facilities. A smaller portion of indirect expenditure in Bannu consisted of meals costs and transport for other household members.

Logone-et-Chari, Cameroon

In Logone-et-Chari, at baseline, 150 individuals (16% of the total sample) reported having a predictable health need. Predictable health needs captured the following categories: (i) Permanent physical disability; (ii) Mental disability; (iii) Visual, hearing or speech impairment; (iv) Pregnant or Lactating women; and, (v) Chronic illness or critical medical condition. Roughly half of these individuals were pregnant or lactating women and information regarding this population has been captured elsewhere in this report.

This section focuses specifically on chronic illness. In Logone-et-Chari, a total of 18 individuals (~2% of sample) reported having a chronic illness across 17 households, suggesting that most households only had 1 chronically ill member. "Other" conditions were most common (n = 9 individuals), followed by hypertension (n = 5), diabetes (n = 2), cardiac disorders (n = 1), and cancer (n = 1). Self-reported "other" conditions included: asthma; stomach problems; rheumatism, and hemorrhoids.

Those who reported seeking care, primarily reported visiting hospitals (between 25-100% of usage across rounds). In contrast to the results from Pakistan, few people in Logone-et-Chari frequented clinics or pharmacies. Rather, community nurses (0-37% use across rounds) or traditional healers (0-50% use across rounds) treated a sizeable percentage of chronic conditions.

FIGURE 29 - **TOTAL EXPENDITURE BREAKDOWN FOR CHRONIC ILLNESS IN LOGONE-ET-CHARI**
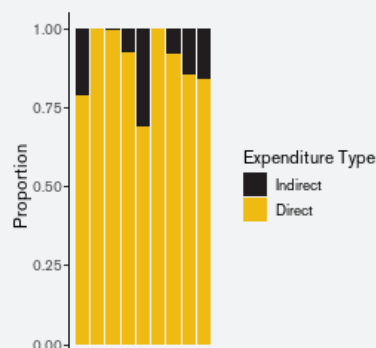
FIGURE 30 - **DIRECT EXPENDITURE BREAKDOWN FOR CHRONIC ILLNESS IN LOGONE-ET-CHARI**
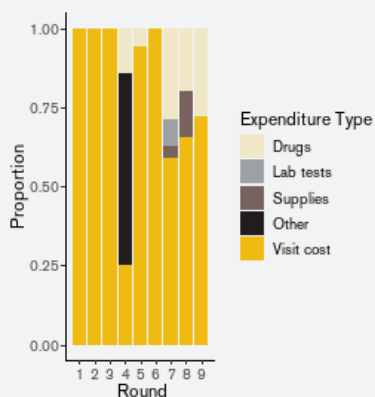

FIGURE 31 - **INDIRECT EXPENDITURE BREAKDOWN FOR CHRONIC ILLNESS IN LOGONE-ET-CHARI**
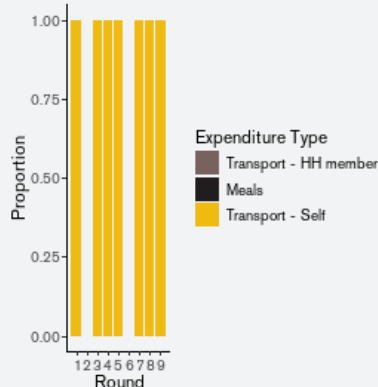

FIGURE 32 - **INDIRECT EXPENDITURE FOR CHRONIC ILLNESS VISITS IN LOGONE-ET-CHARI**
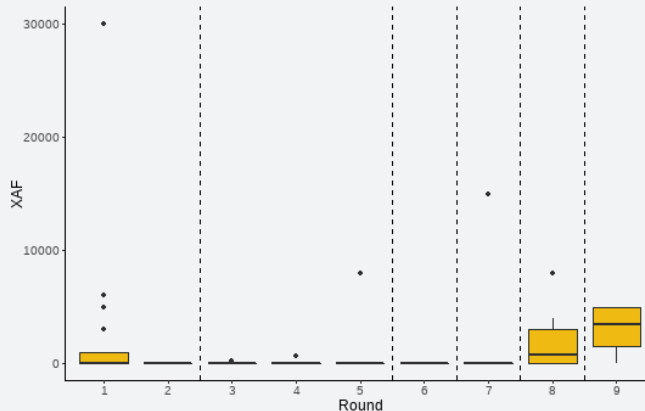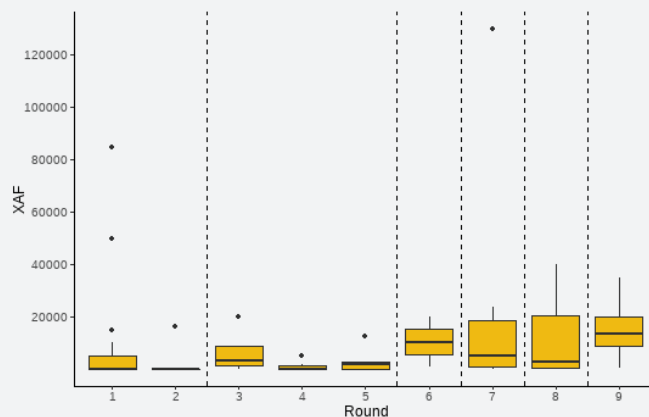

FIGURE 33 - **DIRECT EXPENDITURE FOR CHRONIC ILLNESS VISITS IN LOGONE-ET-CHARI**

The total cost for chronic illness was driven by direct costs and within that visit costs made up the bulk of the expense, though additional spending on drugs also increased over time.

The median spending in Logone-et-Chari on direct expenditures for chronic illness related visits ranged from 0-13,500 francs ($0.00 to $22.95), with median spending being 0 only in the first 2 rounds of data collection. Since few people had a chronic condition, and not everyone sought care at a given time point, the median should be considered unstable and we caution interpretation. Median total expenditure per household in which any member sought care ranged from 0-17,000 francs ($0.00-28.90). At the 95th percentile,

we observed cases where total household expenditure was as high as 145,000 francs ($246.50).

Similar to the other two contexts, indirect expenditure was driven by transportation costs for self to and from facilities. In Cameroon, this was the only kind of indirect expenditure experienced.

Conclusions and Recommendations

This research study takes a first step towards deepening our understanding of usage of health services and products for predictable and unpredictable health needs and the related cost burden on individuals and households of health expenses across three different conflict-affected contexts in Pakistan and Cameroon. In doing so, it touches on a number of gaps highlighted through the research agenda-setting exercise undertaken by the GHC. Notably, it speaks to the following: (i) the reality of "free" health services in humanitarian contexts; (ii) the role of cash in meeting health needs and first-order or intermediate health outcomes, such as access and utilization; (iii) inclusion of health costs in the MEB for recipients of cash assistance, and (iv) catastrophic health expenditure incurred by households.

The assumption of free services doesn't hold up in our study settings. There is often an assumption that in humanitarian settings, people affected by crises, should have or do have access to health services free of cost. Although our supply side mapping indicated some availability of free services for certain populations in all three locations, there were no facilities that provided the entire range of primary healthcare services for free. Our expenditure data also showed that, across all three sites, households utilized health care services for predictable and unpredictable health needs (though to varying degrees) and incurred a cost for doing so. For example, in all three locations, we noted that there were providers (hospitals, NGOs) that provided free health care services for pregnant women. In our sample, pregnant women sought health care services (for antenatal care and delivery) and despite the availability of "free" services, incurred direct costs related to the visit and indirect costs, such as transportation to the facility. As noted above, the one exception to this was antenatal care for 7 out of 9 rounds in Cameroon.

One possible explanation for this could be that perhaps healthcare services are more readily available for free at the immediate onset of an emergency and since all our contexts are protracted crises (ongoing since 2014 and 2015), services are less readily available as humanitarian actors have left. A second explanation may also be that healthcare services are more readily available in camp settings (or settlements), but in locations where IDPs are living in communities with host populations, there are fewer dedicated services available to them. It is also possible that although facilities officially offer free services, in reality underpaid healthcare workers charge informal fees. Alternatively, clients may perceive the free services to be of lower quality, so they prefer to go to other facilities when they have the means to do so. Finally, it is possible that there is little overlap between the profile of households that are targeted and selected through cash assistance programs versus those targeted by free health programs, or that there is a lack of coordination between actors supporting the same population with different services.

Cash is used to pay for health expenditure. In most instances when households reported seeking care, they also reported incurring a cost related to it.[16] During the cash assistance period, this cost was anywhere from 9.7% to 30% of the aggregate cash transfer value. We also found that when households had access to cash (i.e. because of the cash assistance program) they used the cash in hand to pay for health services and in the same period, loan usage for health payments also decreased. We saw the reverse happening in the absence of the cash assistance. Although we know that this finding does not speak to achieving health outcomes, and that health outcomes are ultimately dependent on a number of factors and require a robust supply side of quality services, it does speak to the fact that households are incurring debt to meet health needs and that cash may be used to alleviate this constraint.

Cash may be facilitating timely access or influencing care-seeking behavior. More specifically for unpredictable health needs, such as illness and injury, we observed that individuals reported seeking healthcare services and incurred a cost for seeking services. In Peshawar, we did not observe any clear pattern that suggested that people are seeking care because of the cash assistance, however, we did observe peaks in delayed care prior to the start of the cash assistance and when there was a gap in the transfers. In Bannu and Cameroon, on the other hand, we observed that the percentage of people not seeking care decreased over time as the cash assistance started. These results suggest that cash assistance is likely influencing care seeking behavior and may be facilitating timely access for individuals. Across the board in all three contexts, one of the most commonly cited reasons for not seeking care was "lack of money" or "high cost of care".

The results from this study point to a number of recommendations for cash and health actors aiming to design cash programs to enable households to access the required care and/or to avoid negative coping strategies due to a high cost burden of health care.

1. **Donors, practitioners, and the relevant clusters and coordinating bodies (such as the health cluster and the cash working groups) should include health to the ingredient list for the Minimum Expenditure Basket that is typically used to determine the cash transfer value in many humanitarian settings where health is identified as a priority need during needs assessments.** Across the

board, we observed that households report unpredictable health needs, sought care for these needs and incurred a cost to meet them. We also saw that 'lack of money' or 'high cost of care' was cited as a reason for not seeking or delaying care. And, finally, we observed that households' use of cash to pay for services increased and use of loans to pay for services decreased during the cash assistance period. This suggests that cash can play a role in reducing the burden of health costs and health related debt and that the ingredients for the MEB that is used to determine the cash transfer value in many humanitarian contexts should have some allowance for health needs so as to avoid households resorting to negative coping mechanisms to meet health needs. In practice, humanitarian actors seldom receive funding that enables them to deliver cash assistance of sufficient value to cover everything included in the expenditure basket (and often the transfer value funded is just sufficient to cover food needs). Still, it is important to capture health as an ingredient in the MEB during the program design phase so that humanitarian actors can sufficiently advocate for these needs to be met. As discussed in the report, this is not meant as a substitute for availability of high quality services, but just as a way to enable households to meet health needs without resorting to negative coping mechanisms.

2. **Researchers and donors should prioritize additional research to understand the root cause of low demand for preventive health care services.** From the current research, it is not feasible for us to conclusively determine whether the low levels of utilization and spending on preventive health care services is due to: (i) a lack of information or knowledge; (ii) a lack in the supply side (availability of services or availability of quality services), or (iii) low demand because it is not a priority for households in a resource constrained environment. We do know that, in Cameroon, households participate in vaccinations campaigns that are led by the government and are available free of cost. We also know that women access antenatal care in all locations and incur a cost for doing so. However, we did not investigate demand for all preventive health care services as a part of this research. Additional research is necessary to understand the root cause of the low levels of utilization and spending on preventive health care services.

3. **Donors and practitioners should design and test programs that stimulate demand for preventive health care services.** Aside from pregnancy related care and immunization (specifically in Cameroon), we observe little use of preventive health care services. This suggests that there is little demand for these services and that unconditional cash assistance at the levels provided as a part of these programs was insufficient to stimulate demand for these services. As mentioned above, this might be indicative of an information or knowledge gap or may speak to a lack of available services. However, it may also be a result of limited resources. There is a need for further research that explores whether increasing the total value of cash assistance would be sufficient to increase demand and uptake of preventive services, or whether alternative types of programming, such as targeted voucher assistance or cash assistance combined with social and behavioral change programming, would be more effective.

4. **Explore additional support options, cash or otherwise, to ensure services for pregnant women are free.** Although pregnancy services are available free of cost for pregnant women in all locations, pregnant women still incur a cost related to these services (particularly delivery). This cost is not limited to indirect costs and also includes direct costs. Given this and in order to abide by the guidelines put forward by GHC, there is a need to explore what kind of additional support pregnant women might require. Again, this could simply be a higher cash transfer value to enable them to meet expenditure or it could be more targeted support for particular kinds of services or to facilitate access (transport, etc.).

5. Donors, health practitioners and the health cluster should **ensure coordination among humanitarian actors to make sure that there are in fact still free high quality services available and accessible to displaced populations** even during protracted crises or for populations residing in urban settings with host communities. Furthermore, they should ensure coordination in targeting of vulnerable populations such **that people in need are getting all services in an integrated manner**.

Endnotes

[1] OIM-DTM, Round 18, April. 2019

[2] OIM-DTM, Round 19, August. 2019

[3] Solidarité Internationale, Rapport d'évaluation Extrême Nord – Cameroun, 18 Décembre 2018

[4] The dependency ratio is the number of dependents in the household, i.e. non-income earners, divided by the number of income earners in the household

[5] In practice the distribution timeline varied per district and per country depending on the operating environment and other logistical factors

[6] In reality, 11 rounds of data collection were completed in Pakistan and 9 rounds were completed in Cameroon.

[7] The research grant secured by the IRC focused specifically on internally displaced populations and host community members. Therefore, refugees were not included in the sample.

[8] The income reported does not include the cash transfers that the households received as a part of IRC programming.

[9] Other free services included: delivery, emergency drugs and services, vaccination, treatment for malnutrition, and dental.

[10] Secondary sources included publicly available information through the United Nations Office for the Coordination of Humanitarian Affairs and on-the-ground knowledge acquired by IRC field staff.

[11] Wagstaff et al., 2018, define catastrophic payments as "out-of-pocket payments that are especially large relative to a family's total income or consumption". They further note that this can be measured in multiple ways, but "The idea, is, in effect, to measure the incidence of financial hardship caused by health payments—ie, the number of households with health spending that is large relative to their ability to pay." They present the data both with total consumption in the denominator (setting the threshold at 10%) and with non-food consumption in the denominator (setting the threshold at 40%).In the text of this report, we present catastrophic spending with non-food consumption in the denominator (setting the threshold at 40%).

[12] The upper-end of the range is being driven by one outlier where an individual incurred a Rs. 717,000 ($6,061.52) cost for brain surgery. When we take out this outlier, the range is $91.13-$2,314.20

[13] These calculations do not include the outlier value of Rs. 717,000 ($6,061.52).

[14] The upper-end of the range is being driven by one outlier where an individual went to the hospital 14 times for an injury and incurred a total cost of 935,000 francs ($1,589.50). When we take out this outlier, the range is $378.93-863.03.

[15] Except for vaccination services in Cameroon

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