# Programmatic Guidelines:
# Cash and Voucher Assistance in Sexual and Reproductive Health Programming in Emergencies

UNFPA

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# Introduction

The United Nations Population Fund (UNFPA) is the sexual and reproductive health (SRH) agency of the United Nations, working to eliminate maternal mortality, gender-based violence (GBV) against women and the unmet need for family planning. With the International Rescue Committee, UNFPA co-leads the Global Health Cluster SRH Task Team, which aims to ensure that SRH priorities are systematically addressed in all phases of humanitarian response and that SRH coordination is consistently included in cluster coordination at both the global and country levels.

In 1994, the International Conference on Population and Development (ICPD) in Cairo recognized for the first time SRH as a human right and clearly stated that this right does not cease during an emergency. The ICPD Programme of Action defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (A/CONF.171/13/Rev.1).

Following the ICPD, in 1995 the Inter-Agency Working Group on Reproductive Health in Crises formed, ultimately developing a set of minimum reproductive health interventions to be initiated at the outset of a humanitarian crisis that are known as the Minimum Initial Service Package (MISP) for SRH in Crisis Situations.

Cash and voucher assistance (CVA) can be a valuable tool in supporting the implementation of the MISP and contributing to comprehensive SRH services in crises. In line with the UNFPA Guidelines for Cash and Voucher Assistance, UNFPA's Commitments to Scaling Up Cash & Voucher Assistance, and other organizational guidelines, global tools and standards, CVA can help to lower financial barriers to SRH or GBV services or to the purchase of necessary individual SRH supplies and items. CVA can also be a key way to alleviate barriers to universal health coverage, a key principle in SRH programming that means that everyone can access a full range of quality health services when and where they need them, without financial hardship. However, supply-side challenges like availability, acceptability and appropriateness require broader SRH programme interventions rather than CVA.

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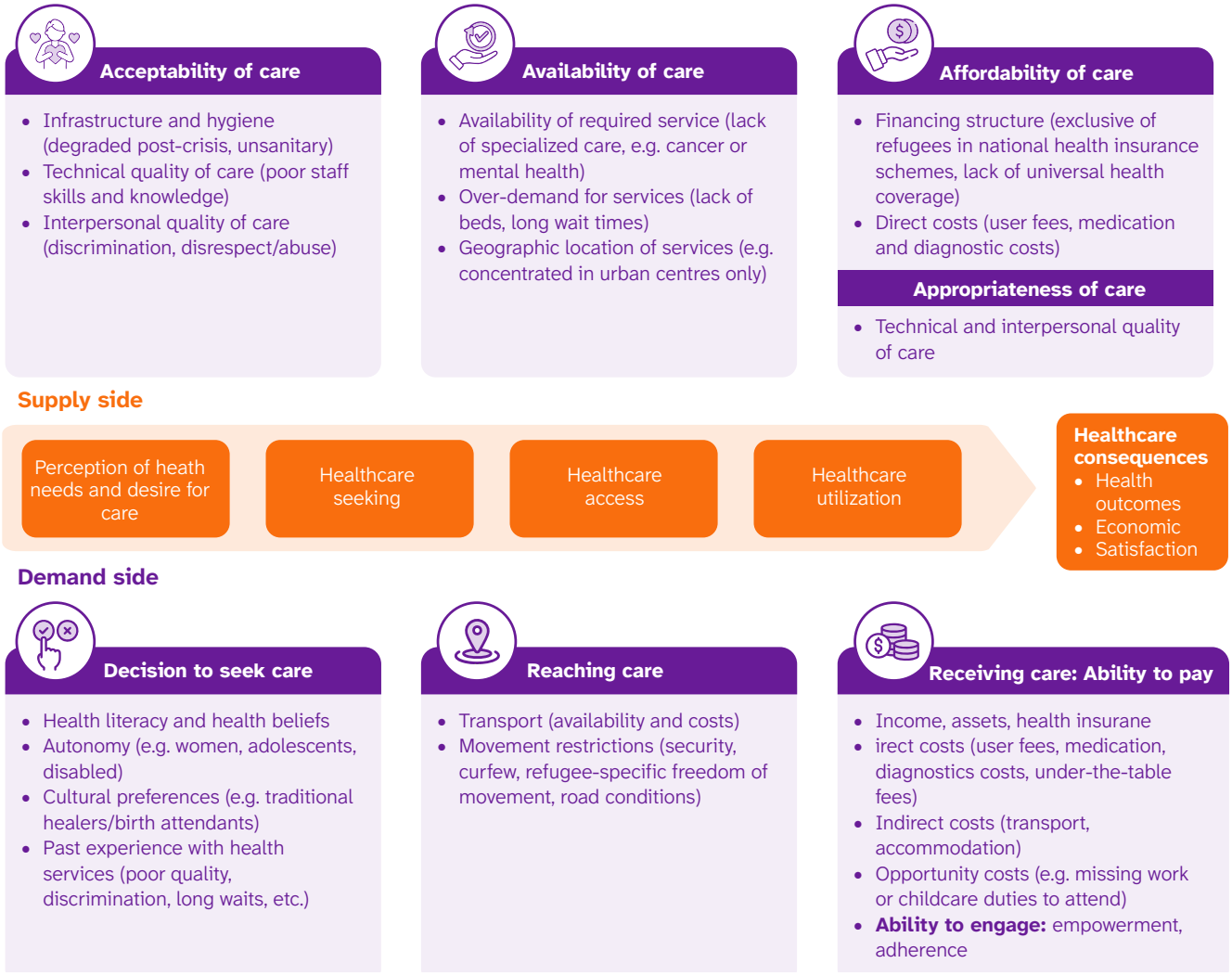
**Figure 1. Health service utilization and common barriers[1]**




In practice, CVA can support the implementation of the MISP and contribute to universal health coverage by providing women, girls of reproductive age and other key individuals with financial support to mitigate obstacles to accessing and utilizing life-saving and preventative SRH services and treatment such as antenatal and postnatal care visits, facility-based deliveries, and screenings like ultrasonography.

CVA can help cover out-of-pocket costs to accessing services by providing an individual with funds to cover the cost of transportation to a health service, and other costs such as food when staying at a health facility, lodging near health facilities and childcare. With this, CVA can subsidize the cost of the service itself when the service is not free, or if public facilities are overburdened, forcing women to instead pay for care in private facilities.

CVA can also be used to address financial barriers to purchasing menstrual hygiene items and, in emergencies, pharmaceuticals, medical items, and devices including essential medicines and contraceptives.[2] CVA has also been used by UNFPA to incentivize antenatal and postnatal care visits, facility-based deliveries for pregnant women, family planning and antiretroviral (ARV) treatment for people living with HIV, by providing CVA following a recipient's uptake of those services.

CVA should never be a stand-alone intervention. It should complement, not replace, health system strengthening interventions, and be well-integrated within UNFPA's core programming. Like any other modality of assistance or service delivery, CVA should support UNFPA's mandate, strategy and specific humanitarian programme objectives in a country

1 UNHCR, 'The role of cash assistance in financing access to health care in refugee settings and other persons of concern to UNHCR' (Geneva, 2020).

2 UNFPA, 'Policy and Procedures for Emergency Response' (2024), section 95.5, states that for contexts classified as level 1, 2 and 3 emergencies, "Goods purchased by affected communities under Cash and Voucher assistance projects are exempt from UNFPA procurement policies and procedures."

or region. CVA aligned to UNFPA's mandate is enshrined in the UNFPA Priority Emergency Response Interventions (PERIs), which detail a number of specific CVA interventions to contribute to SRH objectives based on UNFPA country office experience.

This document does not cover in detail how to choose between *direct support to providers* (for example, paying pharmacies to cover the medications of a target group) or providing CVA to individuals to pay providers, though it provides ample examples to contribute to reflection on the subject. This may be a choice based on value for money and the specificities of each local context, but this guideline assumes that the choice has already been made to provide CVA directly to affected persons. According to the Global Health Cluster,

> "health systems that rely on direct out-of-pocket payment by patients when they are ill as a main source of funding tend to be inequitable and ineffective due to several market failure issues. The optimal response option to address household health expenditures, when health services are available with adequate capacity and quality but user fees are applied, is through provider payment mechanisms. CTP [cash transfer programming] for health should always be considered complementary to such supply-side health financing strategies, and not aim to replace these."[3]

This guidance note aims to support UNFPA staff and personnel, implementing and government partners, and the broader SRH and CVA communities of practice, in their use of CVA within SRH programming in emergencies, in line with the MISP and comprehensive SRH care. This guidance note should be read alongside other resources on CVA design, implementation and monitoring, as it focuses on points specific to using CVA to achieve SRH objectives, and does not offer comprehensive guidance on setting up CVA programming.

# CVA within SRHiE programming

This section outlines how CVA can support SRH programming in emergencies (SRHiE), distinguishing between integrating CVA within the MISP and comprehensive SRH services. The MISP is a package of crucial, life-saving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis. As such, UNFPA strives to embed the MISP within national preparedness plans and ensure its implementation as a minimum standard in all acute emergencies. The final objective of the MISP is to transition to comprehensive SRH services integrated into primary healthcare as soon as possible.

In this light, contextual SRH objectives should guide CVA programme design, with implementing actors selecting options based on humanitarian needs, programmatic and health system priorities, and this guidance aims to provide a menu of options from which they may choose for both MISP and comprehensive SRH programming. In contexts where infrastructure allows, CVA can extend beyond MISP, while in other contexts, it may be necessary to focus solely on MISP objectives in alignment with the overall country programme and SRH objectives. This guidance complements, rather than replaces, SRH technical guidance by highlighting CVA's added value, including its role in transitioning from MISP to comprehensive SRH care.

## CVA to contribute to MISP/SRHiE objectives and activities

CVA within SRHiE should support the service delivery activities of the MISP. The following table lists the MISP objectives in which CVA may be an appropriate tool, and suggests possible applications. The objectives are extracted from the MISP and focus on the provision of SRH services that can prevent death, disease and disability that may result from unintended pregnancy, obstetric complications, GBV, HIV and other reproductive health issues.

3 Global Health Cluster and WHO Cash Task Team, 'Working Paper for Considering Cash Transfer Programming for Health in Humanitarian Contexts' (2018).

| Using CVA to contribute to the MISP | |
|---|---|
| **Relevant MISP objective** | **Potential applications of CVA** |
| **Objective 2: Prevent sexual violence and respond to the needs of survivors of sexual violence**<br>• *Make clinical care and referral to other supportive services available for survivors of sexual violence.*<br>• *Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.* | Access (transportation, accompaniment, fees etc.) to basic health services such as the clinical management of rape and other required health services, **only** as unrestricted, unconditional cash within GBV case management.<br>For more information, see:<br>• UNFPA Guidance: How to Design and Set Up Cash Assistance in GBV Case Management<br>• Programming brief. Women and girls choose: Cash assistance in GBV case management saves lives<br>• UNFPA/Johns Hopkins University research from Jordan, Colombia, Indonesia and Honduras |
| **Objective 3: Prevent the transmission of and reduce morbidity and mortality due to HIV and other sexually transmitted infections (STIs)**<br>• *Guarantee the availability of free lubricated male condoms and, where applicable (e.g. already used by the population), ensure provision of female condoms.*<br>• *Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an antiretroviral therapy program prior to the emergency, including women who were enrolled in prevention of mother-to-child transmission programs.*<br>• *Provide post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure.*<br>• *Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV.*<br>• *Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs.* | Access to ARVs or other treatments by covering transportation costs for accessing services for all areas under Objective 3; in emergencies, cost of items where applicable (e.g. contraception, STI medication etc.); dependent care and accommodation as appropriate.<br>For more information, see:<br>• Scaling-up CVA for People Living with HIV<br>• Cash assistance for female sex workers during the COVID-19 pandemic: Indonesia (2021) |
| **Objective 4: Prevent excess maternal and newborn morbidity and mortality**<br>• *Ensure availability and accessibility of clean and safe delivery, essential newborn care, and life-saving emergency obstetric and newborn care (EmONC) services*<br>• *Establish a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital* | Access to facility-based or skilled birth attendance, such as transportation, laboratory and, in emergencies, medication costs for obstetric or neonatal complications; costs related to required obstetric or neonatal laboratory testing; support for families during prolonged hospital stays due to complications, or care for families with newborns in special care or kangaroo mother care; additional costs of delivery (if any); post-partum sanitary supplies; in emergencies, contraceptives (if at a cost); and pregnant women and baby kits.<br>Incentivize the use of services, e.g. facility-based deliveries.<br>For more information, see:<br>• Expanding the evidence base on cash, protection, GBV and health in humanitarian settings: Cash to increase facility-based deliveries in the Philippines<br>• Cash assistance to access sexual and reproductive health services and reduce maternal deaths in the Philippines<br>• Vouchers for fresh food and uptake of sexual and reproductive health services for pregnant women: Cox's Bazaar, Bangladesh |

| | |
|---|---|
| **Objective 5: Prevent unintended pregnancies**<br>• *Ensure availability of a range of long-acting reversible and short-acting contraceptive methods [including male and female (where already used) condoms and emergency contraception] at primary healthcare facilities to meet demand*<br>• *Provide information, including existing information, education, and communications materials, and contraceptive counselling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination*<br>• *Ensure the community is aware of the availability of contraceptives for women, adolescents, and men* | Access to voluntary family planning methods and services, including transport and in emergencies, supplies,[4] in order to complement other interventions to effectively enhance access to family planning (along with awareness-raising interventions as appropriate).<br>Ensure that the use of contraceptives is voluntary, fully informed, and free from coercion and discrimination. Cash may be used to cover costs related to contraceptives, but not used to incentivize use, as this could be inadvertently coercive to low-income individuals. Act with particular care, working based on a completed CVA risk matrix when engaging with groups that have historically been subject to coercive family planning practices, such as certain ethnic groups or Indigenous peoples, persons with disabilities, and persons living with HIV/AIDS.[5] |

## CVA for additional and comprehensive SRH services

Comprehensive SRH services are provided in humanitarian settings such as protracted emergencies, as well as during the recovery phase of a crisis. UNFPA recommends planning for a gradual scale up to comprehensive SRH services once the MISP has been implemented during the acute emergency response. There are a number of ways in which CVA can contribute to comprehensive SRH services, as well as activities and services that are complementary to the MISP, as outlined below.

| Using CVA to contribute to comprehensive SRH services | |
|---|---|
| **Relevant comprehensive SRH activity** | **Potential applications of CVA** |
| Support access to and/or incentivize antenatal care (ANC) and postnatal care (PNC) visits | Cover costs related to access (e.g. transportation, accompaniment, fees, etc.).<br>Support ANC and PNC service costs if not free of charge (e.g. ultrasonography).<br>In emergencies, pay for medication during pregnancy or post-partum (e.g. folic acid, antibiotics, analgesics).<br>For more information, see:<br>• Vouchers for fresh food and uptake of sexual and reproductive health services for pregnant women: Cox's Bazaar, Bangladesh<br>• Expanding the evidence base on cash, protection, GBV and health in humanitarian settings: Cash to increase facility-based deliveries in the Philippines |
| Improved menstrual health and hygiene | Cover the costs of quality menstrual products such as absorbent sanitary pads, soap, painkillers and spasmolytics, in order to address period poverty in line with UNFPA's approach to menstrual health promotion by enabling women and adolescent girls to purchase the menstrual hygiene products they need.<br>Conditional CVA can also be used as an incentive to encourage women and adolescent girls to attend menstrual health and hygiene management (MHM) awareness sessions as part of a broader MHM approach. |

4 UNFPA's 'Policy and Procedures for Emergency Response' (2024), section 95.5, states that for contexts classified as levels 1, 2 and 3 emergencies, "Goods purchased by affected communities under Cash and Voucher assistance projects are exempt from UNFPA procurement policies and procedures."

5 UNFPA personnel: see the UNFPA CVA Risk Matrix (updated 2024).

| | |
|---|---|
| Continue the supply and provision of cancer prevention and management (for cancers related to reproductive health, such as cervical cancer and breast cancer), in order to avoid women's sudden cessation of treatment during an emergency | Cover the costs of transportation, accompaniment, fees and services related to cancer prevention (vaccination, screening, diagnostics) and treatment for cancers related to reproductive health, ensuring continuity of existing treatments and initiation of new ones as needed.<br>This could include support for:<br>a. surgical and radiology services<br>b. diagnostic procedures such as biopsies, pathology and histopathology<br>c. preventative vaccination programmes (e.g. for cervical cancer)<br>d. cervical and breast cancer screening per national protocols |
| Support access to obstetric fistula care and related costs | CVA to cover for access (transportation, stay, accompaniment, fees, etc.).<br>Support service fees for screening, repair and rehabilitation, transport, dependent care, additional costs related to the service.<br>Support supplies needed as part of fistula repair (e.g. urinary catheter). |
| Support mental health services for pregnant and lactating women | Complementary costs if mental and psychological support is needed during pregnancy and post-partum e.g. during post-partum depression. |
| Support for out-of-school education sessions on SRH, MHM and family planning | Conditional CVA can be used to encourage adolescents and youth to attend out-of-school education sessions on SRH, MHM and family planning. |

**Lebanon** and **Jordan** (cash transfers), and **Bangladesh**, **Moldova**, and **Myanmar** (vouchers, including blockchain-based vouchers in Bangladesh), have provided CVA to women and girls of reproductive age to enable them to purchase quality MHM items. In all three countries, participating women and girls received CVA after attending MHM awareness sessions. Monitoring showed that CVA helped to reduce their reliance on negative coping methods like girls missing school, women missing work or using unsafe materials to manage their menstruation.

In the **Philippines**, UNFPA launched a programme to engage vulnerable adolescent girls and adolescent transgender individuals from urban poor communities in SRH education and services such as HIV, STI and family planning services. Participants in out-of-school learning sessions on adolescent SRH received a small conditional cash transfer after attending the sessions, where they learned about how to make informed choices for their SRH. Monitoring showed that the programme contributed to improved knowledge and informed decision-making, and promoted healthier behaviours, including increased medical check-ups and HIV/AIDS counselling.

## Preparedness and anticipatory action linked to SRH

There is a growing evidence base on the effectiveness of using cash in anticipatory action, through which cash assistance is provided to individuals to help them prepare for and meet their ongoing SRH needs before and immediately after a crisis and ensure continuity of care. This is complemented by a wealth of evidence on the value of cash for women's SRH and GBV and protection, which has been driven in large part by UNFPA. Given this, cash assistance can be a valuable form of anticipatory action for women and girls in disaster-prone areas.[6]

6 UNFPA personnel: for more information on CVA for preparedness and in anticipatory action, see the UNFPA 'Minimum preparedness actions and guidance: Anticipatory action for women and girls' annexed to the Policy and Procedures for Emergency Response.

Under the Central Emergency Response Fund Anticipatory Action framework, **Bangladesh**, **Nepal** and the **Philippines** have prepared to provide cash assistance to pregnant women in disaster-prone areas before disasters like floods or cyclones. Upon activation of a trigger, pre-identified women receive cash to ensure continuous access to maternal health services and to meet other immediate SRH needs in the event of evacuation or displacement. It was implemented in Nepal in 2022 and 2024, and in Bangladesh in July 2024 following the anticipatory action trigger activations for floods.

# How to design CVA within SRH programming

The use of cash and/or vouchers to contribute to the fulfilment of any SRH objective must align with organizational guidelines for CVA. First, identify the SRH objectives and desired outcomes for the cash or voucher assistance, and select appropriate monitoring indicators to track impact and risks.

This includes:

- Taking into account gender/GBV risks, gender and social norms, and women's preferences, particularly when determining the target recipients, delivery mechanism and suitability of CVA within the predetermined time frame for the intervention.
- Monitoring of safe access to CVA to ensure satisfaction and impact, and that GBV and protection risks are mitigated.
- Establishing robust accountability mechanisms, including for protection from sexual exploitation and abuse (PSEA), through complaints and feedback mechanisms such as hotlines, whistle-blowing protocols, multichannel feedback with recipients, in-person channels through local partners, etc.
- Using pre-agreed data protection protocols for sharing and storing data with both public and private sector partners (e.g. mobile companies, banks), being sure to conduct code of conduct/PSEA training for all partners and establish signed agreements and a zero-tolerance policy before implementation.

The following flow chart, taken from the UNFPA Guidelines for CVA, illustrates the major steps of designing and implementing a CVA intervention. When designing CVA for SRH objectives, many of these steps will be determined by the SRH programme itself (objectives, stakeholder engagement etc.), while others are common for CVA across all programme areas. As such, the focus of this guidance is on specific considerations for CVA within SRH programming.

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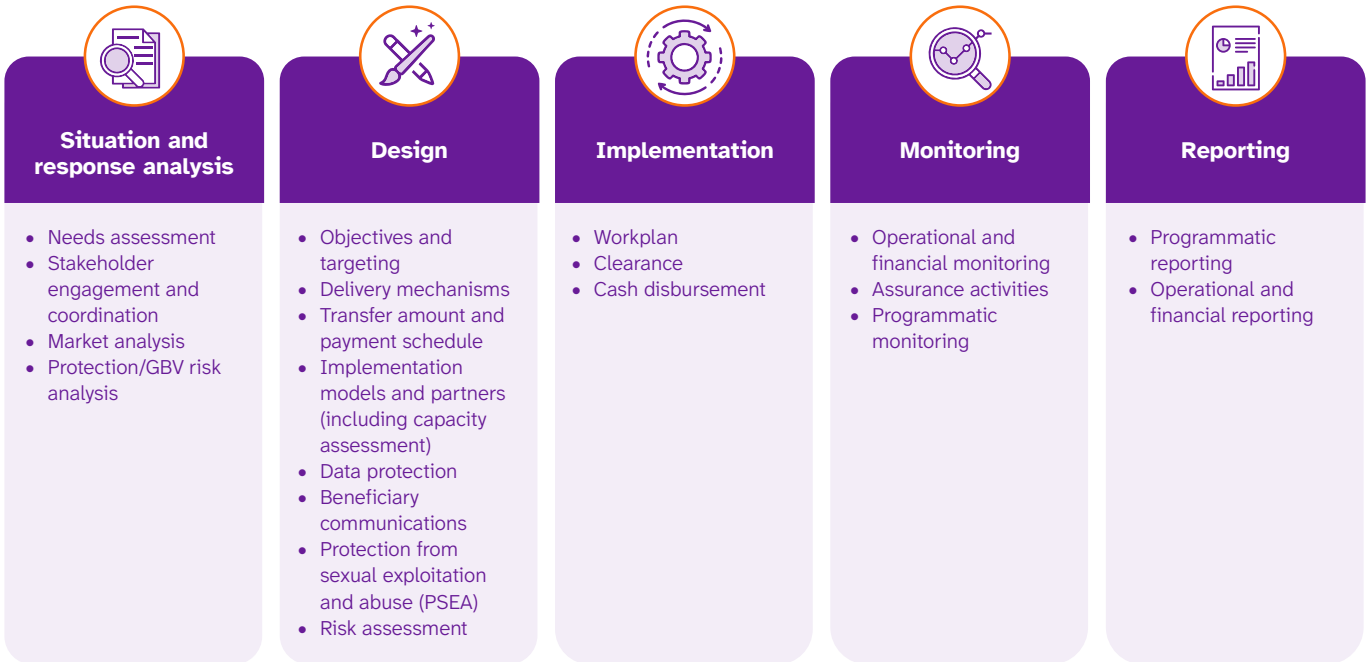
**Figure 2. CVA flow chart**[7]




### *A note on assessments*

As discussed in the UNFPA Guidelines for CVA, the assessments referenced in the above flow chart can be carried out by UNFPA or an implementing partner (IP). Frequently, they can be coordinated with other SRH, health and cash actors, such as the Cash Working Group (CWG), during the design of a CVA intervention in order to obtain the information and assessments necessary to determine feasibility of CVA and subsequent design of the CVA intervention. The national CWG will cover many of the general assessments (including political and market feasibility, operational infrastructure, and payment/financial service provider mapping).

## Determining if CVA is appropriate

To determine if CVA is an appropriate tool to meet the identified SRH needs in a given context, **the key questions are whether SRH services and items are available and accessible with appropriate pricing and of adequate quality, and if there are financial issues preventing access to those services and items** (e.g. costs of transport, direct costs and other costs). The country office should identify if there are particular groups of women and girls with intersecting vulnerabilities (e.g. ethnic minorities, youth) who have less access to some or all SRH services. Then, coordinate with SRH, health, CVA, quality assurance, supplies and other relevant colleagues to obtain the relevant information and assessments necessary to answer this question.

If SRH services and items are available, accessible and of adequate quality, and if CVA would contribute to lowering existing financial barriers to accessing those SRH services or items, then CVA can be considered within the SRH programme.

It is important to engage with other external stakeholders, including the relevant government, local authorities, donors, other United Nations agencies and non-governmental organizations providing services to UNFPA's target populations in order to assess the openness to and operational feasibility of using CVA to meet SRH needs during a crisis. This coordination will also help to identify ways through which the transfers could be delivered, and help raise awareness among other agencies and the government or national authorities regarding UNFPA's use of CVA in relation to its mandate on GBV and SRH.

7 UNFPA Guidelines for CVA (2021).

Further guidance on determining whether CVA is feasible and appropriate can be found in the CALP Network Programme Quality Toolbox, or in individual agencies' CVA guidelines.[8]

## Risk identification and mitigation

Upon determining that CVA is appropriate to meet the identified SRH needs, assess whether it is safe to use in your context and whether the benefits of the intervention would outweigh any potential risks. To do so:

- Identify the risks for CVA in SRH in your country's context.
- Consider whether the risk is acceptable and what potential mitigation measures are available, and discuss them with IPs, recipients and colleagues.[9]

Remember that risk assessment is an ongoing process throughout the programme cycle, including the participation of affected women, girls and diverse groups, UNFPA's IPs, and other relevant partners for triangulation of information. GBV and protection risk analyses from the GBV Area of Responsibility (AoR) and Protection Cluster should be referenced and can serve to highlight potential risks of CVA in SRH programming. If the risks are too significant and cannot be mitigated, it is not advised to proceed with CVA.

It is important to note that overlooking this step can create further GBV and protection risks for women and girls. See the UNFPA/GBV AoR Toolkit for GBV Risk Mitigation in Cash and Voucher Assistance for guidance on how to do this throughout the CVA programme cycle.

## Prioritization of recipients based on SRH programme objectives

CVA actors often discuss "targeting" of recipients of cash or vouchers, which typically refers to identifying the households that are considered most vulnerable. UNFPA's approach is to integrate CVA within existing SRH and GBV programming, so the term "prioritization" is more appropriate than "targeting". For SRH, this would mean a general focus on women of reproductive age, or adolescent girls, pregnant and post-partum women, women and girls with disabilities, or individuals from key populations such as people who sell or exchange sex and persons living with HIV/AIDS.

Since CVA is always aimed at reducing financial barriers to access, final selection of recipients should be based on financial need. This may be assessed at the individual level, if time and access allow. Financial need may also be extrapolated from humanitarian assessments and information. For example, if local IPs attest that all pregnant women in a rural conflict zone would need to pay for transport to an urban delivery facility, UNFPA could aim to cover all pregnant women in that particular geographic area and budget accordingly. Country office resources and potential donor funds should also be taken into account.

In 2022, **Bangladesh** provided in-hand and mobile cash assistance to pregnant women in flood-affected areas to cover transportation and other related costs for obstetric emergencies. Cash was also given to those pregnant women who delivered in health facilities.

8 UNFPA personnel: refer to UNFPA Guidelines for CVA, section I, 'Situation and response analysis', and section II, 'Design'.

9 UNFPA personnel: use the UNFPA CVA Risk Matrix (updated 2024).

## Choosing a cash or voucher modality

UNFPA has committed to prioritizing unrestricted and unconditional cash transfers to recipients wherever feasible and appropriate, to maximize flexibility and choice for recipients, unless political barriers, markets, recipient preferences or programme quality dictate otherwise. **Urgent SRH needs are best addressed through cash assistance** rather than vouchers, as cash assistance is unrestricted, with recipients able to spend it at their discretion on whatever items or services they choose to prioritize.

In contrast, vouchers are restricted and can only be redeemed at specific vendors and/or for specific items or services. When there is some doubt in a given context about the quality of items or the acceptability or appropriateness of care in certain facilities, vouchers may be used to ensure that access is only provided to high-quality SRH items or services. Establishing a solid network of service providers and having robust service provider agreements in place are key for voucher-based assistance, which by definition require UNFPA or its IP(s) to contract suppliers. In some UNFPA settings, vouchers can help to "protect" certain SRH expenditures, such as when women and girls have expressed a preference for vouchers (rather than cash) for menstrual hygiene items, so that they know that they will be able to prioritize those purchases among other competing household needs.

In the **Syrian Arab Republic**, UNFPA has provided CVA to pregnant women in their last trimester to increase access to obstetric health facilities at time of delivery. UNFPA adopted a mixed modality approach. For women in urban areas, a transport voucher system was set up with a taxi company, helping to ensure that the recipients would be able to use the assistance to help access a safe obstetric facility. In remote rural settings where taxis are not available, cash was provided instead to cover transportation costs. The transfer value of the cash assistance was set according to the distance from the community to the closest free 24/7 obstetric facility, and also takes into account the cost of a return trip in a private vehicle. For both the cash and vouchers, the assistance was provided in advance of the pregnant woman's delivery.

Consult recipients to identify their preferred form of assistance. Engage with various age groups to understand their preferences for cash, vouchers or in-kind support. For example, adolescent girls in certain cultures may prefer receiving in-kind items for menstrual hygiene or family planning due to social norms, while adult women might favour cash or vouchers. Use focus group discussions to identify specific SRH needs and assess risks, opportunities and delivery mechanisms. Also consult SRH providers, health officials and key stakeholders to verify this information.

### *Most common CVA delivery mechanisms*

- **Cash** can be delivered through payment service providers (PSPs, also known as financial service providers or FSPs) in the form of bank transfers, mobile money, cheques, cash over the counter, debit cards, or cash in hand through a cash custodian in rare instances.[10]
- **Vouchers** can be issued in paper, mobile or electronic form, ideally where purchase transactions are authenticated in the system at the time of purchase. UNFPA should, to the extent possible, leverage voucher management systems that are deployed by other United Nations partners or IPs. UNFPA offices should always attempt to minimize the use of paper vouchers, using them only as a last resort.

10 UNFPA personnel: refer to the UNFPA Policy and Procedures on Management of Cash Disbursements (2019) and Policy and Procedures for Preparation, Management and Monitoring of Workplans (2022).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## Conditionality

Conditions are prerequisite activities or obligations that a CVA recipient must fulfil in order to receive assistance. Cash or vouchers are conditional if receiving them is contingent/conditional upon participation in an awareness session, check-up or facility-based delivery. For example, pregnant and lactating women participating in a conditional CVA intervention might receive cash assistance after attending antenatal or postnatal care or delivering their baby in a designated health facility.

Requiring conditions to receive CVA may help achieve specific SRH objectives related to access and awareness by increasing utilization and acceptability of health services. However, whether this directly translates into improved health outcomes is a function of the quality of the health services that target recipients can access.[11]

In 2021, the **Philippines** provided cash incentives to pregnant and lactating women contingent upon their attendance to antenatal and postnatal care and delivery in registered health facilities, with amounts ranging from USD 4 to USD 46. A UNFPA evaluation with Johns Hopkins University found that cash recipients were significantly more likely to have facility-based deliveries (86.4 per cent versus 58.7 per cent), and planned to do so for future pregnancies.

When using conditions for CVA, be sure to allocate time and resources to monitor the fulfilment of the condition and clearly link it to the CVA disbursement. Also be prepared to remove conditions if they prove too burdensome for CVA recipients in humanitarian settings.

**Unconditional CVA should be prioritized in situations requiring immediate or emergency access to services or to cover direct/indirect SRH care costs.** Imposing conditions may not be appropriate, feasible or dignifying in these cases.

In 2020, **Indonesia** launched an unconditional cash assistance programme for people living with HIV and female sex workers to improve access to services and sustain adherence to ARV treatment during COVID-19. Cash was provided through mobile wallets for attending ARV treatment visits and accessing other health services, including tuberculosis treatment and maternal care. In a second phase, conditionality was introduced for the ARV programme, whereby cash was provided upon verification of ARV treatment visits and pick-up of medication.

## Deciding how to deliver – possible implementation models

UNFPA[12] refers to four implementation models that can be used to deliver CVA, which have been tested and refined since the issuance of the UNFPA Guidelines for CVA based on field experience:

1. Working through a government social protection system, using its delivery mechanism(s).
2. Using another United Nations agency as a service provider, using their delivery mechanism(s).
3. Through the IP's delivery mechanism(s) as defined in the IP agreement, through PSP(s) in the case of cash or vendors in the case of vouchers.
4. UNFPA direct implementation, directly contracting a PSP for cash delivery.

Field offices should assess whether the government or other agencies like WFP, UNHCR or UNICEF are already implementing CVA. This information should be available through the CWG or directly from the other United Nations

11 UNHCR, *Cash-based Interventions for Health Programmes in Refugee Settings: A Review* (Geneva, 2019).

12 UNFPA personnel: refer to the UNFPA Guidelines for CVA (2021).

agencies. The choice of implementation model depends on factors such as cost-effectiveness, capacity of the implementer (technical, operational and financial), timeliness and coverage (geographical or of different target groups), with the primary considerations being security and data protection, mitigation of financial and programmatic risks, and responsiveness to the needs of women and girls.

## Partnerships and coordination

UNFPA field experience has shown that it is often difficult for women and girls to prioritize their own protection and health needs in household spending decisions, given that household needs are rarely completely covered by income or other humanitarian assistance during and after emergencies. Furthermore, multipurpose cash assistance given by other agencies usually does not cover women and girls' (especially adolescent girls) individual protection and health needs. Evidence has shown that typically only a small portion of the minimum expenditure basket (MEB) is calculated for the health costs of a whole household (1–2 per cent of the MEB in some cases), far from the 10 per cent recommended by the Global Health Cluster.[13] With this, it typically does not cover the cost of pregnant women's access to health facilities for check-ups and delivery or other life-saving or catastrophic SRH needs.

UNFPA's CVA for SRH targeted to individual women, girls and other key populations should be complementary to large multipurpose cash interventions by other agencies, helping to ensure that the specific SRH needs of UNFPA's target populations can be addressed alongside broader household health needs. Coordination with other humanitarian actors delivering multipurpose cash to households is therefore central, including explaining the objectives and complementarity of UNFPA's CVA within SRH programming to existing multipurpose cash interventions.[14] Assistance provided in a coordinated manner means that the pregnant woman, adolescent girl or other recipient (e.g. trans individual) can prioritize the sectoral cash for SRH transfer for their own personal needs as intended. Where there is no multipurpose cash being provided, sectoral cash for SRH can be coordinated with other types of assistance to households provided, whether through CVA or in-kind.

It is also important to advocate for the inclusion of pregnant and lactating women, girls, and marginalized groups in other agencies' CVA, such as multipurpose cash, as well as in other assistance more generally. In some contexts, it may also be strategic to advocate for more of the SRH-related needs of women and girls to be included into the MEB and multipurpose cash assistance calculation, for example if sectoral cash for health will not be allowed or funded. To do so, a UNFPA CVA focal point should regularly engage in technical discussions with the CWG and with other sectors/clusters as appropriate.

UNFPA can work with United Nations sister agencies and key cash actors such as WFP, IOM, UNICEF or UNHCR in order to identify households that are already eligible for or receiving multipurpose cash that include members of UNFPA's target population (e.g. households with pregnant and lactating women, or households with adolescent girls) and provide specific SRH or protection "top-ups". These transfers can be disbursed directly via a PSP, or through a United Nations sister agency or IP, alongside the multipurpose cash, and in some cases can be provided on separate digital wallets on the same card or mobile account.

In response to the armed conflict in 2023 and 2024, UNFPA **Ukraine** worked with IOM to identify eligible pregnant and lactating women already receiving multipurpose cash assistance from IOM, in order to provide them with USD 200 cash to address their SRH needs. The funds were transferred directly to their bank accounts, with IOM handling the cash disbursement, while UNFPA managed recipient information and payment processing.

13 Global Health Cluster and WHO Cash Task Team, 'Technical note on the inclusion of health expenditures in the minimum expenditure basket and subsequent multi-purpose cash transfer' (2020).

14 UNFPA personnel: please see the guidance note on *Aligning UNFPA's CVA with the UNFPA Mandate* for further information.

### *Market analysis from the MEB can help to determine CVA for SRH transfer values*

The transfer value for multipurpose cash is calculated based on the cost of the MEB, which is the average amount of money needed for the average household to cover the cost of its basic needs. This may include a small amount for general household health expenditures. It generally does not include an amount for a woman's or girl's individual health needs. UNFPA does not rely on the MEB to determine transfer values for this reason. However, some aspects of the analysis conducted by/in the CWG to determine a MEB may be useful to determine the cost of some SRH items, fees or services. User fees for a particular service or item will require additional information from UNFPA, its partners or other actors, who can then calculate a transfer value based on the cost of what the CVA intervention aims to cover.

## Transfer value, timing and frequency

Each individual woman and girl has different needs in terms of SRH items and services. As such, CVA for SRH necessitates flexibility in the timing and amount of cash or vouchers.

The transfer value is the amount (usually a currency value) provided directly to a CVA recipient. Transfer values (along with number and frequency of transfers) are calculated based on the intervention's objectives. When determining the transfer value for CVA to enable access to services, the decision on the size of transfer value should be guided by UNFPA's or its IP's service mapping and estimate of related costs. In the case of providing CVA to cover the costs of items such as MHM items or other dignity items, a list of prices on the local market(s) could come from UNFPA, Water, Sanitation and Hygiene (WASH) and Health Clusters, or others depending on the context. UNFPA does not need to engage in a comprehensive market analysis, but can triangulate information from these relevant sources. In case none of these are available, the quality assurance officer or supplies officer, along with the SRH or humanitarian team, can conduct a rapid price analysis of local markets.

To cover direct costs such as user fees, the transfer value would be based on the costs of the user fees. In line with the objective of universal health coverage, coverage of user fees or other direct costs should only be implemented on a case-by-case basis and in line with donor regulations (for example, to cover access to private sector care in case of public sector collapse).

Coordination with the Health and WASH Clusters, SRH Working Group, and the CWG can support the design of UNFPA's CVA for SRH transfer values. Engaging in these forums is also important in order to avoid duplication with other actors, ensure visibility for UNFPA's CVA, and advocate for the inclusion of SRH needs and items in inter-agency assessments.

If customizing transfer amounts for each individual is not practical for the country office (for example, because it would carry too high of an administrative burden), it is possible to agree on one standardized amount that is sufficiently large enough to cover the estimated costs of an array of SRH needs in a single transfer. Alternatively, create a small menu of standard transfer amounts that can be selected on a case-by-case basis, with each tailored to the estimated cost of meeting a specific SRH need. A standardized amount could be distributed as a one-off or in multiple disbursements, depending on the intervention.

Flexibility in the timing of CVA disbursement is crucial to ensure timely delivery of cash to recipients for necessary care. Timing should align with when SRH-related expenses occur, maximizing impact and prioritization for SRH purposes. Context and the type of health expenditure should guide timing decisions.

The frequency of needs, whether recurring (i.e. access to a service multiple times over a set period of time) or one-off, should influence the decision on how frequently to disburse CVA to a single recipient. One-off expenses like safe delivery in a hospital differ from recurring needs such as ANC, PNC, monthly menstrual hygiene products, consumable SRH items and transport to postnatal care.

| CVA delivery window and duration | | | |
|---|---|---|---|
| **CVA for SRH objective** | **Delivery time** | **Transfer amount** | **Duration** |
| *Expenditures incurred while accessing emergency SRH care, including user fees (should be context-specific and align with donor regulations), transportation, food, lodging, accompaniment, dependent care, etc.* | 24 hours | Individualized amount (e.g. based on user fee for a specific service and/or the cost of transportation to a health facility)<br>OR<br>Standardized amount based on context-specific estimated costs of transport, accommodation, additional cost for dependents, etc. A standard amount is determined and provided based on costs in the local area/public sector, and that amount is given to each recipient regardless of their actual individual costs. | One-off |
| *Costs of transportation or accompaniment to regular/ planned SRH services (such as ARV treatments, facility-based delivery, family planning services, obstetric fistula repair, prevention and screening, antenatal and postnatal visits, etc.)* | 1–2 weeks | Individualized amount (e.g. based on user fee for a specific service and/or the cost of transportation to a health facility)<br>OR<br>Standardized amount based on context-specific estimated costs of transport, accommodation, additional cost for dependents, etc. A standard amount is determined and provided based on costs in the local area/public sector, and that amount is given to each recipient regardless of their actual individual costs. | One-off or recurrent |
| *Costs or fees of diagnostics (lab tests) or, in emergencies, prescription medicines from a pharmacy* | 1 week | Amount based on the cost of the item prescribed or the utilized service, as cash or as a commodity voucher (e.g. a voucher for a specific lab test). In the case of a commodity voucher, the price is pre-set with the clinic, lab or pharmacy; this amount would often be individualized, but could be standardized. | One-off or recurrent (monthly or quarterly, e.g. for contraceptive pills, injectables, etc.) |

| | | | |
|---|---|---|---|
| *Incentives for education or the uptake of SRH services, such as upon verified attendance to an information session, check-up, or other programme activity (e.g. attending two ANC check-ups and one PNC check-up to be eligible to receive CVA, or attending one information session prior to receiving CVA)* | Within 1 month, or depending on the schedule of services | Amount should cover costs related to the objective of participation in the given activity (e.g. CVA to cover a month's supply of menstrual hygiene products after attending an MHM session), or an agreed-upon "incentive" amount that is typically less than other types of cash assistance but which can still contribute to the coverage of additional costs borne by participant related to attendance in the activity (e.g. transportation to and from the activity). | One-off or recurrent |
| *Menstrual health and hygiene items and painkillers* | Monthly, as soon as possible | Standardized amount based on the estimated prices of the menstrual hygiene products (e.g. three packs of sanitary pads) from the local market. | Recurrent (typically monthly, e.g. each month for 2–3 months following a disaster) |

## Financial and operational considerations

Financial and fiduciary risks should be part of any CVA risk analysis prior to implementation.[15] CVA for SRH at UNFPA has typically been carried out by UNFPA IPs with SRH expertise, or through a United Nations sister agency as a service provider, but can also be carried out directly by UNFPA if relevant staff are available. When considering CVA as part of an IP's workplan, it is important to ensure that they are considered a low-risk partner (through microassessments), are trusted by the country office and have some experience with CVA.[16] Country offices may consider working with a moderate-risk partner during an emergency if they are able to support them in areas needed to build their capacity.

A PSP assessment should be carried out to inform UNFPA's choice of PSP (such as bank, mobile operator etc.), with UNFPA sometimes able to "piggyback" on current long-term agreements or agreements of PSPs already negotiated by other United Nations agencies, in line with the Guidance for Collaborative Procurement for Humanitarian Cash Transfers and Common UN Procurement at the Country Level.[17] This aims to mitigate actual or perceived risk of fraud and associated reputational risk (e.g. money-laundering, excessive PSP fees and skimming – cash/vouchers that do not reach the end recipient).

15 UNFPA personnel: refer to the UNFPA CVA Risk Matrix (updated 2024).

16 UNFPA personnel: see further in the Policy and Procedures for Preparation, Management and Monitoring of Workplans (2022).

17 UNFPA personnel: see further in the Policy and Procedures on Management of Cash Disbursements (2019).

# Monitoring CVA in SRH

Like any other CVA, monitoring of CVA in SRH interventions should aim to assess intended outcomes, results and outputs while ensuring the "do no harm" principle and generating evidence. During the project's design phase, the monitoring framework for CVA should be designed to align with sectoral and programmatic objectives, incorporating indicators and questions that are relevant to the context, CVA modality and delivery mechanism.

Monitoring should assess whether access to SRH services or items was achieved, increased or provided, rather than simply counting the number of CVA recipients. In addition, it is useful to monitor indicators related to the adequacy of the transfer value, recipients' ability to access the CVA, the performance of the delivery mechanism, the efficacy of registration/distribution, and safety. If it is possible to triangulate with monitoring of utilization, this can be helpful to determine if the addition of CVA is contributing to any pull or push factor towards specific facilities, which could potentially impact overcrowding or quality of care. CVA should never be assessed in a vacuum, but as part of the broader SRH programme. Referring back to the tables above, "Using CVA to contribute to the MISP" and "Using CVA to contribute to comprehensive SRH services" are good starting points for designing indicators based on the intended outcomes of each CVA for SRH intervention.

Certain delivery mechanisms may require special consideration in process monitoring. Physical delivery mechanisms (e.g. paper vouchers, cash, prepaid cards) require consolidation of distribution lists, lost/ruined assistance and unredeemed vouchers. Monitoring of electronic delivery mechanisms necessitates indicators related to online transactions and reconciliation, access to technology and ability to use it, ability to report problems, and Know Your Customer (KYC) rules, as appropriate. Country offices should consult with their operations and finance colleagues for support.[18]

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18 UNFPA personnel: Reach out to the Finance Branch (DMS), Legal Unit (Personal Data Protection), or Quality Management Unit (DMS) if you have questions.

# Acronyms

| | |
|---|---|
| **ANC** | Antenatal care |
| **AoR** | Area of Responsibility |
| **ARV** | Antiretroviral |
| **CVA** | Cash and voucher assistance |
| **CWG** | Cash Working Group |
| **EmONC** | Emergency obstetric and newborn care |
| **GBV** | Gender-based violence |
| **HIV** | Human immunodeficiency virus |
| **ICPD** | International Conference on Population and Development |
| **IP** | Implementing partner |
| **MEB** | Minimum expenditure basket |
| **MHM** | Menstrual health and hygiene management |
| **MISP** | Minimum Initial Service Package for SRH in Crisis Situations |
| **PDM** | Post-distribution monitoring |
| **PEP** | Post-exposure prophylaxis |
| **PNC** | Postnatal care |
| **PrEP** | Pre-exposure prophylaxis |
| **PSEA** | Protection from sexual exploitation and abuse |
| **PSP** | Payment service provider |
| **SRH** | Sexual and reproductive health |
| **SRHiE** | Sexual and reproductive health in emergencies |
| **STI** | Sexually transmitted infection |
| **UNFPA** | United Nations Population Fund |
| **WASH** | Water, sanitation and hygiene |

**Programmatic Guidelines:**
Cash and Voucher Assistance in Sexual and Reproductive Health Programming in Emergencies

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