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Research agenda-setting on cash programming for health and nutrition in humanitarian settings

Aniek Woodward^{1*} , Andre Griekspoor^{2*}, Shannon Doocy³, Paul Spiegel³ and Kevin Savage⁴

Abstract

Background: While the evidence base for cash transfer programming (CTP) in humanitarian contexts is more established for food security, it is very limited for health and nutrition. The aim of this study was to develop a research agenda on CTP for health and nutrition in humanitarian settings.

Methods: This exercise adopted a qualitative descriptive approach using four stages over a 13-month period (October 2016 to November 2017). Data was collected using two methods: an online survey and face-to-face group session. The advisory group was asked to judge questions based on four criteria (answerability/feasibility, fills important knowledge gap, maximum potential for improving health or nutrition outcomes, effect on equity) using a 5-point scale. Content analysis was used to identify and rank research categories.

Results: One hundred eighty-nine research questions were developed in the consultation stage ($n = 40$ online survey; $n = 30$ group session), which were categorised into nine overarching research areas (with 22 sub-categories): modalities (41% of the identified questions), followed by outcomes and impact (31%), intermediate outcomes (27%), initial considerations (19%), effectiveness (19%), pathways (14%), methodologies and indicators (13%), types of diseases or health issues (6%), and context (5%). Triangulation with other evidence reviews confirmed the need for further research in these areas.

Conclusions: Nine overarching and ranked categories for research on CTP for health and nutrition in humanitarian contexts, validated by existing reviews, are proposed by this study. The research agenda, with examples of questions, could serve as guidance for researchers, policy-makers, implementers, and funders when selecting which of the many gaps in the current evidence base on this topic to start addressing first.

Keywords: Research agenda, Priority setting, Cash transfer programming, Health, Nutrition, Humanitarian settings

Background

Cash transfer programming (CTP), the provision of cash or vouchers directly to those in need (CaLP 2016), accounts for a small but rapidly increasing proportion of humanitarian assistance (Global Humanitarian Assistance 2017). It implies a shift from delivering goods and services to supporting people to purchase these through local economies and systems. While being increasingly adopted, its limits are acknowledged and ‘investment in public goods, including protection, education, and health

is still needed’ to effectively respond to emergencies (Agenda for Humanity 2016).

It is important that the options for cash-based assistance for health be supported by research. In stable contexts, there is some evidence that CTP can address financial barriers to meet health and nutrition needs and improve utilisation of priority services (Bastagli et al. 2016; Bassani et al. 2013; Manley et al. 2012). There is agreement amongst humanitarian health partners to seek opportunities to include CTP in the health sector response analyses, alongside other responses to support access to quality essential health services and complementary to supply side health financing (Agenda for Humanity 2016; ODI 2015). While the evidence base for

* Correspondence: a.woodward@kit.nl; griekspoor@who.int

¹Independent Researcher, Rotterdam, the Netherlands

²World Health Organization, Emergency Operations, WHO Health Emergencies Programme, Geneva, Switzerland

Full list of author information is available at the end of the article

CTP in humanitarian contexts is more established for food security (ODI 2015), it is very limited for health (The World Bank 2016; Pega et al. 2015; Harrison et al. 2013; UNHCR 2015a; Gentilini 2016) and nutrition (Gentilini 2016; Fenn 2015; de Groot et al. 2015).

Research priority setting is a useful way to guide the focus and investments of researchers, donors, policy-makers, and implementers (Viergever et al. 2010). Resources to invest in humanitarian research are still scarce, even as donors and actors are increasing their commitments to research-based evidence. Identification of research areas and prioritisation is needed to ensure that limited resources for humanitarian research are used to address the most important questions that could not be answered in more stable environments. As a result, the international community is investing through collaborations such as the Research for Health in Humanitarian Crises Evidence Reviews (Blanchet et al. 2015), Consortium for Research on Food Assistance for Nutritional Impact (REFANI) (Fenn 2015), the Cash Learning Partnership (CALP) work in summarising the current state of CTP (CALP 2018), and global cluster efforts such as this one, to identify and validate research agendas to guide investments. To the best of our knowledge, there is no consensus on a research agenda on the use of CTP for health and nutrition in humanitarian contexts at the global level. For this reason, a research agenda-setting exercise was commissioned by the World Health Organization (WHO) and the Global Health Cluster (GHC) as part of the work plan of the GHC Task Team (TT) on Cash. This paper describes the process of research

agenda development and the resulting research areas that were prioritised.

Methods

This study adopted a qualitative descriptive approach using four stages. Data was collected using two methods: an online survey and face-to-face group session. An overview of the stages, methods, purpose, and timeline is found in Table 1.

Under stage 3, there was a change of strategy from prioritisation of research questions (by use of criteria applied by the Advisory Group (AG)) to ranking by counting of research categories (using content analysis) due to an insufficient response rate.

A flowchart of this exercise, including its participants at each stage, is displayed in Fig. 1.

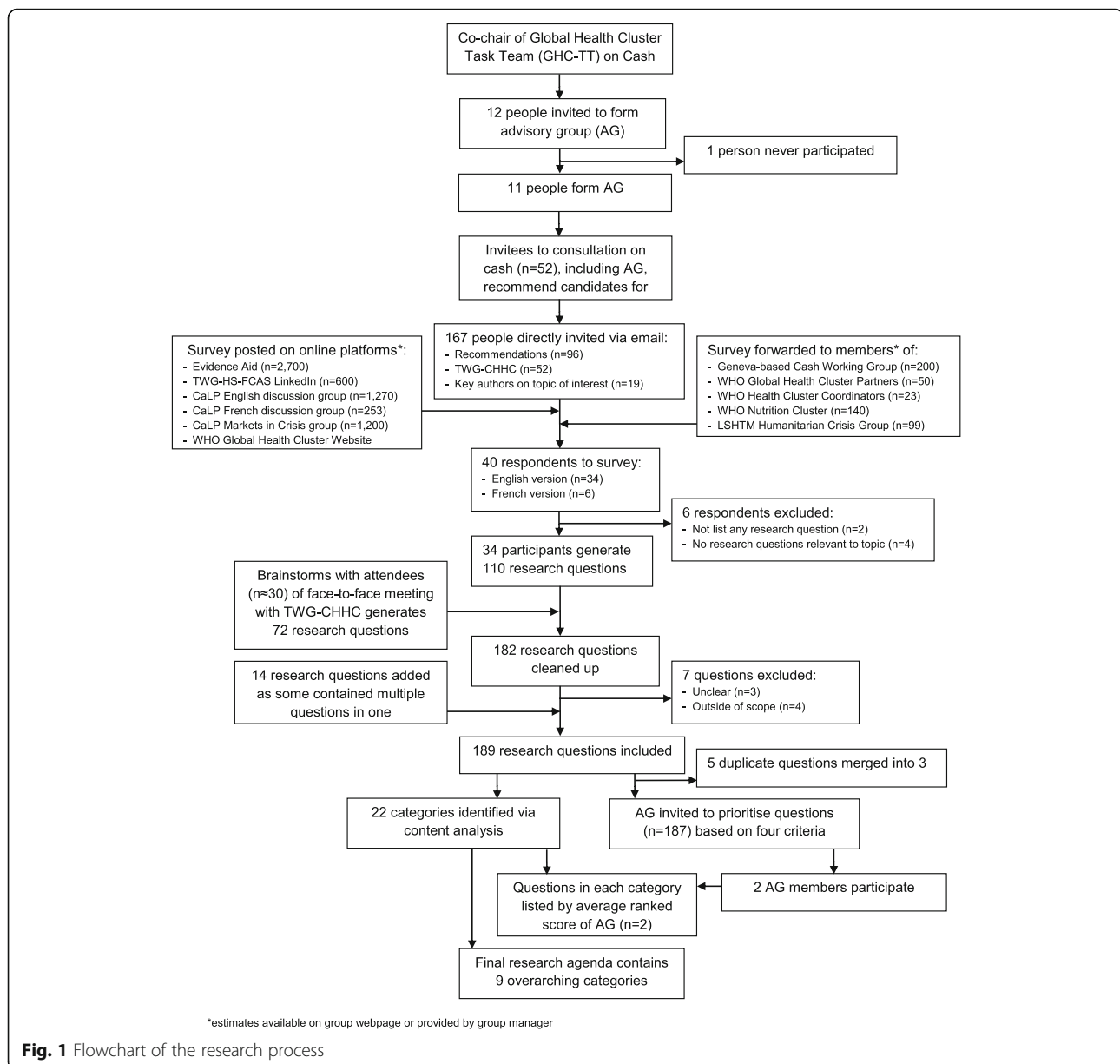
Ethical approval from the WHO Research Ethics Review Committee was sought. This committee determined that a full review of the project was not required because it did not fall into the category of human subjects. Anonymity and confidentiality of participants were ensured throughout the study. Each stage is described in more detail below.

Stage 1: establishment of advisory group and development of methodological approach

An AG was set up to guide the methodological approach. The co-chair of the GHC-TT purposively selected members ($n = 11$) for the AG based on their global level knowledge about cash for health and nutrition or experience in humanitarian research priority setting. Most were currently working for international non-governmental organisations

Table 1 Overview of study's stages, including purpose, approach and time-line

Stage	Purpose	Approach	Time-line
1. Establishment of advisory group and development of methodological approach	To guide the methodological approach	Members from the advisory group discussed methodology and criteria for prioritisation via Skype and email.	Three 60–90 min Skype discussions (October 2016–February 2017); 30-min face-to-face meeting during consultation on cash (4 November 2016); email feedback (October 2016–June 2017).
2. Consultation on research questions (a) Online survey (b) Face-to-face group session	To identify key research questions on this topic	(a) Sample of global stakeholders was invited to complete the survey. (b) Attendees of a consultation session on cash were asked to list research questions.	(a) 10-min survey was open for 3 weeks (28 March to 19 April 2017) (b) 1 h face-to-face session on 4 November 2016
3. Clarification and prioritisation of research questions and categories	To refine and rank research questions and categories	Members of the advisory group were asked to prioritise research questions based on four criteria. Content analysis was used to develop and rank research categories.	About 1.5 h during 1 month (11 May to 11 June 2017)
4. Triangulation of findings with past evidence reviews	To check whether identified categories (a) have not yet been addressed by primary research and (b) whether existing literature reviews recommend research on similar or differing topics.	Published and unpublished literature reviews were identified (through recommendations by authors, searching the CALP library, and checking reference lists of selected papers) and discussed in relation to identified research categories.	October–November 2017



(NGOs) ($n = 6$), followed by research institutions ($n = 5$) and membership organisation ($n = 1$). All were from high-income countries. Four meetings were held with the AG (three via Skype and one face-to-face), and the AG were asked to provide feedback on several occasions during the research process. About half of the AG members were present at each Skype meeting; those unable to attend were provided a written update and the opportunity to provide feedback. A checklist for health research priority setting was used to facilitate discussions on the scope and methodological approach (Viergever et al. 2010).

Advice of the AG was to consider the relationship between CTP for health and/or nutrition in all types of humanitarian settings in LMICs and limit research ideas to

the next 5 years. There was an agreement to use a similar methodological approach to the Child Health and Nutrition Research Initiative (CHNRI) (Rudan et al. 2006; Rudan et al. 2008), described as a common and comprehensive way to develop health research priorities at the global level (Viergever et al. 2010; Rudan 2016) and previously used in the humanitarian field (Tol et al. 2011; Morof et al. 2014; Prudhon et al. 2016).

Stage 2: consultation on research questions

Two methods were used to generate research questions on cash for health and nutrition in humanitarian settings and are described here.

Group session at cash for health in humanitarian contexts taskforce

Initial research questions were identified during a session at a face-to-face meeting with the GHC-TT on Cash in November 2016. After an explanation of the project, attendees were asked to answer the following question: “*What do you think are the main research needs on cash transfer programming for health in humanitarian crises in LMICs?*” They were advised to (a) list their ideas individually before discussing in groups, (b) write ideas in the form of a question or statement, and (c) list as many ideas as possible within 10 min. Each group was moderated by an AG member who consolidated their group’s notes and presented to the larger group.

Online survey

An online survey was then used as the principal method to widely consult on research needs. The approach is a relatively efficient way to gather the opinions of stakeholders who are spread geographically (Heiervang and Goodman 2011; Evans and Mathur 2005) and has previously been used to identify research priorities in emergencies and unstable contexts (Tol et al. 2011; Evidence Aid Priority Setting Group 2013; Woodward et al. 2016).

The survey and its cover text (including study rationale, purpose of online survey, link to survey, deadline, whether to further circulate) were piloted amongst the AG (50% responded), which led to minor revisions. The final English survey (Additional file 1) and cover text were translated into French. The survey required approximately 10 min to complete, was administered using Bristol Online Surveys (Bristol Online Surveys 2017), and was open for a 3-week period in March/April 2017. Participants were asked to list at least one research question (and up to five).

All people with self-identified knowledge of and/or experience in cash programming in the health and nutrition in humanitarian settings were eligible to participate. The target sample size was ≥ 50 respondents, including a mixture of males and females, different types of stakeholders (donors, policy-makers, academics, international, and local implementers), and geographical regions (people based in different continents and countries, including humanitarian settings).

Convenience and snowball sampling were used. Invitees to a consultation on cash (WHO 2017) ($n = 52$) were contacted via email and requested to recommend individuals from their network who belong to the target population. This list of recommended candidates ($n = 96$, duplicates removed) was supplemented with contact details of key authors on cash programming (for health) available from the published literature ($n = 19$). All ($n = 167$) were directly approached via email to participate in

the survey. In addition, coordinators of the Geneva-based Cash Working Group,¹ WHO Global Health, Health, and Nutrition Clusters,² and the London School of Hygiene & Tropical Medicine (LSHTM) Health in Humanitarian Crisis Group³ were asked to circulate the survey and cover text amongst their members via email. Furthermore, a brief description of the study and a link to the survey were posted on the WHO Global Health Cluster website and relevant platforms (i.e. Thematic Working Group on Health Systems in Fragile and Conflict Affected States (TWG-HS-FCAS)⁴ LinkedIn site, Evidence Aid,⁵ CaLP’ English and French discussion groups,⁶ and Markets in Crisis D-Group⁷).

Stage 3: clarification and ranking of research questions and categories

The AG was requested to prioritise the clarified results of the survey and consultation based on four criteria (Table 2) using a 5-point scale (strongly agree, somewhat agree, do not know, somewhat disagree, strongly disagree).

Data analysis

Research questions were analysed with the support of NVivo 10.2.2. © QSR International. Content analysis was used to identify patterns across the data and quantify results (Vaismoradi et al. 2013; Silverman 2010). Questions were initially coded and further refined, ordered, reordered, and categorised into research topical areas until an initial coding framework was identified. A discussion between the researcher (AW) and co-chair of the GHC-TT on cash (AG) resulted in further refinement of the framework. This final matrix was then applied to all research questions. Questions were coded with at least one category (and up to four). The number of instances categories were covered by research questions was counted.

Stage 4: triangulation of findings with past evidence reviews

Finally, categories of research topical areas identified through content analysis were compared against the

Table 2 Final agreed criteria for prioritisation

1. Answerability/feasibility: it will be feasible to answer this research question in a humanitarian context.
2. Fills important knowledge gap: this research question will fill an important gap in knowledge that is required for translation to humanitarian policy and practice.
3. Maximum potential for improving health or nutrition outcomes: An answer to this research question will have a potential to improve health or nutrition outcomes or access to and/or utilisation of services, in humanitarian settings.
4. Effect on equity: an answer to this research question will help to improve the conditions of marginalised groups in humanitarian settings.

small existing literature on CTP for health and nutrition in humanitarian and stable settings. The aim of this exercise was to assess if identified topical areas or research questions (a) have not yet been addressed by primary research and (b) whether existing literature reviews also acknowledge the need for more evidence in the topical area. For this purpose, we used published and unpublished literature reviews (Bastagli et al. 2016; Pega et al. 2015; Gentilini 2016; Fenn 2015; Doocy and Tappis 2016) known to the authors. Additionally, the CALP resources library was hand-searched using relevant search terms ('review', 'review' AND 'health' OR 'nutrition'). Reference lists of included sources published between 2015 and 2017 were checked to identify further reviews.

Results

Participant characteristics

Approximately 30 people participated in the research question brainstorms in six smaller groups during a face-to-face meeting with the GHC-TT on Cash in November 2016. These were a mixture of men and women from different backgrounds (international NGOs, academic, donor). In total, 72 research needs were generated in this 20-min process.

The online survey was completed by 40 respondents ($n = 34$ in English; $n = 6$ in French; 50% male, 50% female); six were excluded because they did not list any research questions ($n = 2$) or provide any questions relevant to the topic of interest ($n = 4$). A large number heard about the survey via email (79%) and smaller numbers via online platforms (15%) (e.g. LinkedIn, CaLP discussion groups, GHC website) and GHC-TT on Cash (6%). Respondents worked in 19 countries. The majority worked in high-income countries (67%), especially Switzerland (18%) and the USA (15%), and a minority (37%) in LMICs, particularly African countries (21%). Most were employed by an international NGO ($n = 18$), followed by donors ($n = 7$), UN agencies ($n = 6$), national NGO ($n = 1$), academic institution ($n = 1$), and membership organisation ($n = 1$). The focus of their occupation was global for many ($n = 25$, 73%) and regional ($n = 5$) or national ($n = 4$) for others. A total of 110 research questions were generated from the online survey.

Research needs ($n = 182$) were cleaned (i.e. to ensure all needs were in question format, correct any typographical errors and write abbreviations in full). Seven questions were removed as they were unclear or outside of the scope of this exercise. Some questions contained two or more questions in one and were split, which resulted in the addition of 14 questions (total = 189). Three duplicate questions were merged before prioritisation (final $n = 187$). On average, three questions were formulated by each included participant.

Two of 11 AG members completed the prioritisation which was considered insufficient to develop a ranked research agenda; instead, content analysis of all research questions ($n = 189$) was used to rank, with prioritisation of the two AG members utilised to categorise questions into research topical areas.

Identified research categories with consulted questions

Table 3 provides an overview of the 22 categories identified via content analysis and the number and proportion of research questions covered by each. All categories include a research question as illustration. Questions selected as examples most clearly reflect the relevant category (more questions are found in Additional file 2). These 22 categories could be further combined into nine overarching categories. Figure 2 presents a visualisation of our understanding of how sub-categories relate to overarching categories (displayed in bold), and whether and how categories are interconnected.

Initial considerations include questions that require research prior to the implementation of CTP, such as those about the health system, population health status, and preferences of affected households. *Modalities* covers questions about the different types of cash transfer programming (e.g. conditional transfers and unconditional transfers; restricted transfers/vouchers and unrestricted transfers/multipurpose grants (MPGs)/cash), how they compare with one another and direct support to health and nutrition services and goods. *Pathways* encompasses questions on how CTP influences *intermediate outcomes, outcomes, and impact*, as well as routes to *effectiveness*. Outcomes and impact has a feedback loop with intermediate outcomes because, for example, social protection and financial protection reduce financial access barriers and may encourage beneficiaries to seek care or access goods, which will positively affect health and nutrition outcomes. Effectiveness includes questions around (cost) effectiveness of CTP, and variations in the amount of cash, in influencing both intermediate and longer-term outcomes. *Context* refers to questions on where CTP takes place such as stage and type of the emergency. *Methodologies and indicators* involves questions on how and what to measure, and *types of diseases or health issues* suggest what health or nutrition issues require focus.

Table 4 shows the counts of research questions covered by the nine overarching categories. The top three categories are modalities (41%), outcomes and impact (31%), and intermediate outcomes (27%). Questions were on average coded 1.74 times, meaning most addressed more than one overarching research category.

Triangulation of research categories with available evidence

The main categories of research areas were linked to the existing evidence to explore similarities and differences

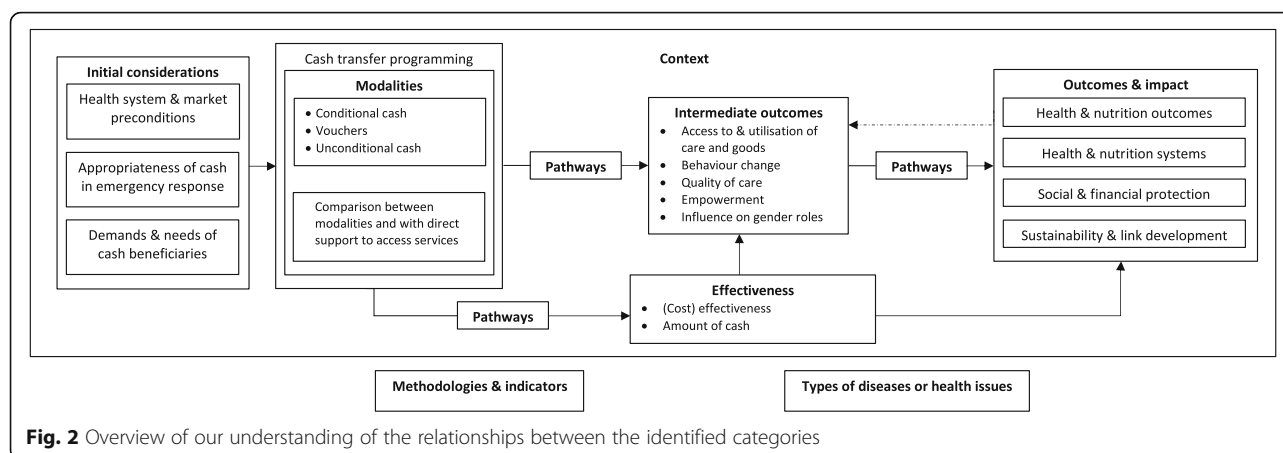
Table 3 Number of consulted research questions for each category, including examples of research questions

Categories of research areas	Number of times covered in research questions (%) ^a	Examples of research questions
Health and nutrition outcomes	44 (23%)	How can CTP best be designed so that they will have a positive effect on child nutritional status?
Comparison modalities	36 (19%)	How can use of CTP instead of delivering in-kind improve health and nutrition indicators in LMICS?
Unconditional cash	36 (19%)	Does the inclusion of an average health cost in the Minimum Expenditure Basket improve the health of beneficiaries?
(Cost) effectiveness	32 (17%)	How does the effectiveness of different cash modalities and payment mechanisms to tackle nutrition/health issues compare?
Access to and utilisation of care and goods	29 (15%)	What effect do cash transfers have on accessing and utilising health services?
Pathways	27 (14%)	How do cash transfers work to protect undernutrition in humanitarian crisis?
Methodologies and indicators	24 (13%)	What are appropriate methodologies to research cash for health in humanitarian crises?
Demands and needs of cash beneficiaries	16 (8%)	Do people affected by conflict prefer cash or in-kind support for the treatment of their children or family members?
Appropriateness of cash in response	16 (8%)	What is the appropriate place for cash-based assistance as one response option to deliver health programming?
Conditional cash	12 (6%)	Does labelling a cash grant for nutrition have the same impact as a conditional cash grant for nutrition?
Types of diseases or health issues	12 (6%)	How do various types of cash transfers affect nutrition, HIV, and maternal health?
Vouchers	11 (6%)	What is the evidence that cash or vouchers may incentivise care or utilisation?
Behaviour change	11 (6%)	Can CTP be used to incentivise health outcomes and/or health behaviours?
Context	9 (5%)	In what type of contexts are different cash transfer modalities likely to work?
Social and financial protection	9 (5%)	How can social protection nets be developed for health or nutrition?
Sustainability and link development	9 (5%)	What are the longer-term effects of cash transfers on undernutrition?
Quality of care	7 (4%)	How can quality of care be guaranteed during CTP?
Health and nutrition systems	6 (3%)	How do different cash modalities strengthen the health system and contribute to longer term equitable health financing?
Health system and market preconditions	6 (3%)	What health system preconditions are necessary for the implementation of cash for health and nutrition programming?
Amount of cash	3 (2%)	How does the amount of the cash transfer affect its impact upon undernutrition?
Influence on gender roles	3 (2%)	Do cash transfers positively or negatively affect gender roles?
Empowerment	2 (1%)	How do cash transfers compare to specific patient free health vouchers in terms of empowerment of patients?
Total	189 (100%) ^a	

^aEach research question could be coded with multiple categories (and up to four). In total, 360 codes were assigned to 189 research questions. On average, each question was coded 1.91 times

in research priorities (see [Methods](#), stage 4). Key results and conclusions of 47 sources, predominantly literature reviews, were compared with our findings (see [Additional file 3](#)). Of these, 24 were focused specifically on humanitarian settings;

however, reviews with a global focus or on developing or LMICs were also included to get a wider picture of the evidence base. Of the 21 sources in humanitarian settings, nine concentrated on health or nutrition.



Our analysis did not find a substantial existing evidence base for CTP for health and nutrition in humanitarian contexts for any of the categories identified in stage 3, while several sources confirmed the need to conduct further research on most of the categories. These will be further elaborated under the discussion.

Discussion

The research categories identified through this agenda-setting exercise are compared to existing evidence reviews in this section. Overarching categories covered most by consulted research questions are discussed first and those the least last.

Modalities

Research questions in this category considered the different modalities of cash, how they compare with each other and how they compare with the direct provision

Table 4 Number of consulted research questions for each overarching category of research area

Overarching categories	Number of times covered in research questions (%) ^a
Modalities	77 (41%)
Outcomes and impact	58 (31%)
Intermediate outcomes	51 (27%)
Initial considerations	36 (19%)
Effectiveness	35 (19%)
Pathways	27 (14%)
Methodologies and indicators	24 (13%)
Types of diseases or health issues	12 (6%)
Context	9 (5%)
Total	189 (100%) ^a

^aEach research question could be coded with multiple overarching categories (and up to four). In total, 329 codes were assigned to 189 research questions. On average, each question was coded 1.74 times

or support to health and nutrition services and goods. The largest groups of questions focused on the comparison of modalities (19%) and on one particular modality, UCT (19%), which is aligned with literature review findings. In general, more rigorous evaluations are needed comparing the effectiveness of different cash-based approaches and transfer modalities in humanitarian situations (Doocy and Tappis 2016; Mishra and Battistin 2017). A recent review found most evidence on CTP is drawn from CCTs and more research is necessary on UCTs (Bastagli et al. 2016). Likewise, the need for high-quality studies on the effects of UCTs for assistance in humanitarian disasters on health services and outcomes was raised (Pega et al. 2015); multi-sector cash programming, a topic related to UCTs, also requires further exploration (Austin 2014). More research was advocated for on the variations of cash plus complementary interventions and the impact of cash compared to vouchers (Roelen et al. 2017; Harvey and Bailey 2011). Frameworks for both demand and supply side monetary and non-monetary interventions can be used to explore how CTP can be integrated in a broader response strategy alongside other interventions and within a health financing policy (Jacobs et al. 2011). There is robust evidence that vouchers increase utilisation of health goods and services; however, it is unclear if voucher programmes are more efficient than other health financing strategies (Meyer et al. 2011).

Outcomes and impact

Nearly a third of research questions (31%) concerned the outcomes and impact of CTP. This includes health and nutrition outcomes such as mortality, morbidity, and/or nutrition status (23%); social protection and financial protection (5%); and health systems (8%). The evidence of the impact of UCTs (Boccia et al. 2011; Adato and Bassett 2008; Lucas et al. 2008), CCTs (Boccia et al. 2011; Adato and Bassett 2008; Gaarder et al.

2010; Lagarde et al. 2009; Fiszbein and Schady 2009), and vouchers (Meyer et al. 2011) on health outcomes is mixed and of moderate quality, making it difficult to draw reliable conclusions. The evidence base for the impact of CTP on nutrition outcomes was regarded limited (Bastagli et al. 2016; Pega et al. 2015; Gentilini 2016; de Groot et al. 2015; Bailey and Hedlund 2012), particularly for anthropometric measures (Bastagli et al. 2016; Pega et al. 2015; Mishra and Battistin 2017) and medium to longer-term impact (Fenn 2015). Dependence on the availability, cost, and quality of services and social norms that influence attitudes to healthcare (UNICEF-ESARO/Transfer Project 2015) might explain why it is challenging to establish a solid evidence base on the relationship between cash and health and nutrition outcomes. In humanitarian settings, this is further complicated by reduced accessibility and quality of services, meaning complementary interventions to address the supply and quality of healthcare are likely needed (Bailey and Hedlund 2012), which again makes it more difficult to establish cause and effect. Moreover, other determinants such as income, education, water, and sanitation and food security also influence health outcomes (WHO 2012), necessitating an understanding of contextual factors and causal pathways of cash transfers. Findings from relevant reviews support the need for more research in social protection and financial protection and sustainability of outcomes (Arnold et al. 2011; Maunder et al. 2016; Farrington et al. 2007).

Intermediate outcomes

Many of the identified research questions (27%) focused on clarifying the relationship between CTP and intermediate outcomes such as access and utilisation of health services/goods (15%), behaviour change (6%), quality of care (4%), influence on gender roles (2%), and empowerment (1%). Some of these outcomes may be more closely linked to the final outcomes than others. There is some evidence that cash transfers positively affect access to and utilisation of health care (Bastagli et al. 2016; Lagarde et al. 2009; Arnold et al. 2011), particularly preventative services for children and pregnant women. Evidence for increased utilisation of health services is more established for vouchers (Meyer et al. 2011) and CCTs (Bastagli et al. 2016; Lagarde et al. 2009) than for UCTs (Bastagli et al. 2016; Pega et al. 2015); however, most studies reporting on 'intermediate outcomes' are outside of humanitarian contexts and care needs to be taken when extrapolating their conclusions. The potential effects of conditionality, such as financial and administrative costs for monitoring compliance with the conditions, or that their use may unfairly penalise families who cannot comply with the conditions for reasons beyond their control (WHO. 2012; UNICEF 2016).

need to be better understood in humanitarian contexts where access to services is constrained and resources are limited. Previous reviews have also identified research gaps on the relationship between CCTs and health-related behaviours and attitudes (Gaarder et al. 2011) and vouchers and quality of care (Meyer et al. 2011), which indicates the need for more research on behaviour change and quality of care as was observed in this study taking into account how crises are likely to have different effects compared to stable settings. Gender has been identified an important area of analysis in relation to CTP (Bastagli et al. 2016; Fenn 2015; Berg and Seferis 2015; Brady 2010; Yoong et al. 2012), and outcomes are rarely disaggregated by sex (Bastagli et al. 2016; Browne 2014; Hagen-Zanker et al. 2017). Evidence related to empowerment is regarded 'thin' and in need of 'bolstering' (p227) in a social protection review of literature from LMICs (Bastagli et al. 2016).

Initial considerations

This category concerns questions with respect to analysis and decision-making in humanitarian contexts that would inform the choice of using CTP, such as about the demands and needs of cash by beneficiaries (8%), appropriateness of cash in emergency response (8%), and health system and market preconditions (3%). A recent survey by CALP found that 53% of practitioners believed evidence is available to use CTP appropriately across humanitarian sectors (CALP 2018). This means nearly half of the practitioners believed there are gaps in the evidence on the appropriateness of cash, which confirms the need for further research on this topic. Numerous practical guidance documents emphasise the importance of initial analysis and assessment of the context in guiding the choice of cash transfers (Harvey and Bailey 2011; Creti and Jaspars 2006; UNHCR 2015b; CaLP 2017; UNHCR 2015c) and determining if their use is appropriate. This was reflected in CaLP's significant global review of cash transfer programming in emergencies (CALP 2018) which particularly highlighted the need for further investigation on which operational models are most appropriate in different contexts and how to make these choices. Such contextual distinction is also crucial to further research in order to allow careful analysis, recognise limitations, and make appropriate generalisation of findings.

Effectiveness

Nearly a fifth of research questions fell under effectiveness (19%). This overarching category mostly comprises questions from the category '(cost) effectiveness of CTP' (17%), which includes questions on the cost-effectiveness of CTP in general (e.g. *How do cash transfers for health influence service costs and cost-*

effectiveness?) and for specific types of transfers (e.g. *How cost-effective are multi-purpose grants?*); questions on general effectiveness (e.g. *How effective is cash as an incentive for health seeking behaviour?*) as well as comparative effectiveness (e.g. *What is the relative effectiveness of cash transfers, compared with in-kind transfers?* or *Is a package of interventions more effective than an individual cash-for-health intervention?*). Moreover, some of these questions on (cost) effectiveness had a link with intermediate outcomes (e.g. *How effective is cash as an incentive for health seeking behaviour?*) and others with eventual outcomes and impact (e.g. *What is the cost-effectiveness of conditional/unconditional cash transfers with regard to impact on nutrition/health?*). Additionally, a small amount of questions could be categorised under ‘amount of cash’ (2%). Relevant literature reviews have similarly identified a need for increased understanding of the effectiveness of CTP (Doocy and Tappis 2016; Bellows et al. 2011) and its cost (effectiveness) (ODI 2015; Gentilini 2016; Fenn 2015; Doocy and Tappis 2016; Austin 2014; Boccia et al. 2011; Gaarder et al. 2010; Bailey and Hedlund 2012; Maunder et al. 2016; Bellows et al. 2011; Venton and Bailey 2015; Glassman et al. 2013). The current evidence on the impact of the size (Bastagli et al. 2016; Fenn 2015; Lagarde et al. 2009; Farrington et al. 2007) and/or frequency (Fenn 2015) of cash transfers was also found lacking. Additionally, existing reviews recognised a demand for further exploration of the (cost) efficiency (ODI 2015; Austin 2014; Meyer et al. 2011; Venton and Bailey 2015; Bailey and Annex 2014), cost benefit (Arnold et al. 2011), and value for money of cash and vouchers (ODI 2015; Venton and Bailey 2015; Bailey and Annex 2014), which were areas of research that did not come across strongly in findings from our consultation.

Pathways

This category encompasses questions on how CTP influences intermediate outcomes (e.g. *How can cash-based interventions have an effect on health behaviour change?*), outcomes and impact (e.g. *How do unconditional cash transfers impact health and nutritional status?*), as well as routes to effectiveness (e.g. *How do cash transfers for health influence service costs and cost-effectiveness?*). The need for more evidence on the causal mechanisms through which cash transfers work to improve health and nutrition has been raised previously on many occasions (Bassani et al. 2013; Fenn 2015; de Groot et al. 2015; Roelen et al. 2017; Bailey and Hedlund 2012; UNICEF-ESARO/Transfer Project 2015; Yoong et al. 2012; Glassman et al. 2013; Leroy et al. 2009; Sridhar and Duffield 2006). Authors of a systematic review found it difficult ‘to attribute these positive effects [of CCTs on health] to the cash incentives as other

components may also contribute’ (Lagarde et al. 2009). Along the same lines, writers of another systematic review concluded it was challenging to ‘attribute the health effects of conditional financial incentive programmes to the monetary component because, theoretically, conditionality may be confounding this effect...’ (p10–11) (Bassani et al. 2013). Clearly, analyses that aim to disentangle the ways in which cash affects health and nutrition should be a priority for future research. Existing theoretical frameworks (de Groot et al. 2015; Gaarder et al. 2010; Bailey and Hedlund 2012) could be tested and, if required, further refined.

Methodologies and indicators

Participants raised a fair amount of questions (13%) about the ‘best’, most ‘appropriate’, or ‘useful’ methods, designs, tools, or indicators for measuring, monitoring, or evaluating CTP for health and nutrition. Recent literature reviews have provided more details of the type of approaches, designs, and methods needed to strengthen the evidence base for cash transfers generally, all of which are applicable to research cash transfers with respect to health and nutrition. More rigorous process (Roelen et al. 2017) and impact evaluations (Manley et al. 2012; Glassman et al. 2013), and causal and response analyses (Bailey and Hedlund 2012) are required to achieve a better understanding of the pathways. Disaggregated analyses according to individual- and household-level characteristics as well as research testing specific design details of cash transfer components, such as variations in the details of conditionality design and implementation have been highlighted necessary (Bastagli et al. 2016). Gender and social analyses are regarded important to improve the understanding about the gender dynamics of cash transfers (Brady 2010). Contextual and protection risk analyses (e.g. age, gender, and diversity implications and outcomes) are needed to increase knowledge of protection outcomes of CBIs (Berg and Seferis 2015). A systematic review on the effects of UCT on health in humanitarian disasters highlighted that, if possible, future studies should apply RCT designs as well as conceal allocation and reduce the risk of contamination by, for example, sampling geographically disconnected clusters (Pega et al. 2015). Practical tools to analyse efficiency and cost-effectiveness of value for money of CTP in emergencies was an identified gap in the literature (Venton and Bailey 2015). Additionally, a lack of a common global approach to report humanitarian expenditure on cash, voucher, and in-kind assistance was mentioned (Spencer et al. 2016). Such improvements are critical to improving decision making, analysis, and choices, an area in need of further study discussed earlier.

Types of diseases or health issues

For some research questions (6%), respondents specified the types of health or nutrition issues that require further exploration. Maternal and child health was most commonly cited ($n = 5$), followed by mental and psychosocial health ($n = 4$), WASH and diarrhoea ($n = 1$), HIV ($n = 1$), Ebola and cholera ($n = 1$), and chronic disease ($n = 1$). Literature reviews also mentioned specific diseases and health concerns requiring investigating, including HIV/AIDS (Adato and Bassett 2008; UNICEF-ESARO/Transfer Project 2015; Arnold et al. 2011) (particularly HIV prevention and treatment (Mishra and Battistin 2017; Arnold et al. 2011)), mental health (Gaarder et al. 2010; Lund et al. 2011), sexual and reproductive health (Blanchet et al. 2015), chronic disease (Gaarder et al. 2010), maternal morbidity, early initiation of breastfeeding, and WASH (Mishra and Battistin 2017). This list roughly overlaps with our findings.

Context

A selection of consulted research questions ($n = 9$) were about an improved understanding of the environment in which CTP takes place. While a few questions ($n = 2$) specifically addressed a certain type or phase of emergency (i.e. *Are conditional cash transfers feasible in sudden onset disaster (SOD) to improve coverage and utilisation of free services?* and *What phase(s) of the emergency should we focus on for cash in health—is the acute phase a lower priority since services are often free?*), others ($n = 5$) were more general (e.g. *What health outcomes can be appropriately addressed with cash in different contexts?*). Various analyses have concluded that there is no ‘right’ (Boulineaud 2017) or ‘first best’ (Gentilini 2016) humanitarian response (whether purely cash-based, a combination of modalities, and/or direct support) as this depends on the context and needs of its beneficiaries (ODI 2015). Reviews have consistently reported a need for research on CTP and health and nutrition in LMICs beyond Latin America (Bastagli et al. 2016; Lagarde et al. 2009; Yoong et al. 2012) as well as in humanitarian emergencies (Pega et al. 2015; Gentilini 2016; Doocy and Tappis 2016; Mishra and Battistin 2017; Austin 2014; Bailey and Hedlund 2012; Browne 2014; Venton and Bailey 2015; Smith and Mohiddin 2015). Within emergency settings, further investigation is required from a variety of contexts (e.g. nature of emergency, enabling environment, underlying risk factors) (Fenn 2015; Arnold et al. 2011). Evidence to date on humanitarian cash transfers in urban areas, predominantly comes from Somalia, Kenya, Lebanon, Jordan, and Haiti, likely due to the nature and scale of these emergencies (Smith and Mohiddin 2015). Information is particularly necessary for CTP assistance in man-made

disasters and natural disasters other than droughts (Pega et al. 2015).

Limitations

This study has several limitations that should be considered. Participation in the online survey was based on self-selection and the response rate was lower than expected, which is common in online surveys (Evans and Mathur 2005). A limited response rate was also prevalent in the prioritisation stage, likely because the time required for this stage was perceived by members of the AG as too lengthy and complex. Although a gender balance was achieved and there was a good mixture of participants from different geographical areas, types of stakeholders were less equal with academics underrepresented amongst survey participants. Ranking of research categories reflected the number of questions in each category and not the number of participants mentioning the category; questions were not linked to individuals which was a limitation in the analysis. Finally, cash beneficiaries were not consulted due to feasibility considerations.

Conclusions

As the evidence for CTP for health and nutrition in humanitarian contexts is limited, a research agenda-setting exercise was commissioned by the WHO as part of the work plan of the GHC Task Team on Cash. The research agenda presented, which is the product of a four-stage process, defines nine research categories and proposes a framework to understand their interdependence. Literature reviews confirm there currently is little quality evidence on the efficiency or effectiveness of CTP for health and nutrition in humanitarian settings and a need to better understand how CTP compares to, and/or adds value to complement, direct support to service delivery or supply side financing approaches. While there is some evidence from stable contexts on the positive effects of CTP, related to several research categories identified in this agenda-setting exercise, these findings cannot be generalised to humanitarian contexts as conditions are incomparable. Research categories and questions outlined in this paper are not exhaustive and consulted research questions should be seen as illustrative and adaptable to specific contexts. The agenda is intended to serve as guidance for researchers, policy-makers, implementers, and funders.

Endnotes

¹This group provides an inclusive platform for linking global cash initiatives and actors more concretely with the broader humanitarian system, and by extension with the expanding group of field-level cash stakeholders, including governments, NGOs, civil society organisations, private sector, and development partners: <https://www.>

humanitarianresponse.info/en/topics/cash-transfer-programming/geneva-cash-working-group

²Global Health Cluster exists to support health clusters in countries, and Health and Nutrition Clusters are there to improve the effectiveness of humanitarian response programmes and eventually to relieve suffering and save lives: <http://www.who.int/health-cluster/about/en/> and <http://nutritioncluster.net/gnc/>

³This group brings together researchers across LSHTM to focus on improving the health of populations affected by humanitarian crises: <http://crises.lshtm.ac.uk/#>

⁴As a working group of Health Systems Global, the TWG-HS-FCAS draws upon the breadth of experience of key actors in health in fragile and conflict affected states and promotes research, policy, and advocacy actions to contribute to the development and implementation of responsive and context-specific health systems: <http://www.healthsystemsglobal.org/twg-group/8/Health-Systems-in-Fragile-and-Conflict-Affected-States/>

⁵Evidence Aid is a platform that aims to provide reliable, up-to-date evidence on interventions that might be considered in the context of natural disasters and other major healthcare emergencies: <http://www.evidenceaid.org/who-we-are/>

⁶The CaLP Discussion Groups (D-Groups) are a set of forums for global discussion of cash-based responses and related work in emergencies: <http://www.cashlearning.org/join-us/d-group>

⁷The objective of the Market in Crisis D-Group is to provide space for a broad audience of NGO personnel, donors, consultants, students, researchers, or any interested party to discuss topics specific to markets in emergencies and recovery context: <https://dgroups.org/dfid/mic>

Additional files

Additional file 1: 'Online survey'. This file entails the final English survey used as main method of data collection. (DOCX 26 kb)

Additional file 2: 'Research questions'. This document includes all consulted research questions for each of the 22 research categories. (DOCX 70 kb)

Additional file 3: 'Evidence reviews'. This sheet lists details of the evidence reviews used to triangulate the identified research areas. (XLSX 67 kb)

Abbreviations

AG: Advisory group; CaLP: Cash Learning Partnership; CCT: Conditional cash transfer; CHNRI: Child Health and Nutrition Research Initiative; CTP: Cash transfer programming; GHC: Global Health Cluster; LMICs: Low- and middle-income countries; LSHTM: London School of Hygiene & Tropical Medicine; MPG: Multi-purpose grant; NGO: Non-governmental organisation; TT: Task Team; TWG-HS-FCAS: Thematic Working Group on Health Systems in Fragile and Conflict Affected States; WHO: World Health Organization

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Availability of data and materials

Anonymised data may be made available upon reasonable request.

Authors' contributions

AW and AG designed the study with support from the Advisory Group. AW collected the data. AW analysed the data with feedback from AG. AW wrote the first draft of the manuscript. AW conducted the literature review. AG, KS, SD, and PS contributed to the writing of the manuscript. All authors read and approved the final manuscript.

Competing interests

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Author details

¹Independent Researcher, Rotterdam, the Netherlands. ²World Health Organization, Emergency Operations, WHO Health Emergencies Programme, Geneva, Switzerland. ³John Hopkins University, Bloomberg School of Public Health, Baltimore, USA. ⁴World Vision, Research and Learning, Humanitarian and Emergency Affairs, Geneva, Switzerland.

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