European Commission

Operational Note No 6

Health and Education

December 2019

SPaN
Supporting people through crisis

Guidance Package on Social Protection across the Humanitarian-Development Nexus

DEVCO
ECHO
NEAR

Acknowledgement

This operational note has been written by Elisabetta Aurino and Sara Guinti and further benefited from contributions by thematic experts of DG DEVCO and DG ECHO and their advisory services.

The operational note is part of a series of notes the European Commission has invited experts to contribute to. It is part of the EU 'Guidance Package on Social Protection across the Humanitarian-Development Nexus' (SPaN). The Guidance Package initiative is jointly led by the European Commission's Directorate-General for International Cooperation and Development (DEVCO), Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO) and Directorate-General for Neighbourhood and Enlargement Negotiations (NEAR) with the support of DEVCO Unit 04 and the MKS programme. As this is an emergent field of knowledge, the guidance and recommendations of the Operational Notes reflect the independent views of the authors. The contents of this publication do not necessarily reflect the official position of the European Commission.

Introduction

Globally, in 2017 around 201 million people were directly affected by humanitarian crises and in need of humanitarian assistance, compared to 40 million people over a decade ago (Development Initiatives, 2018). Human displacement levels are also unprecedented: almost 70 million people are forcibly displaced, often for decades. Of these, there are nearly 25.4 million refugees, over half of whom are children (UNHCR, 2018).

Traditionally, humanitarian assistance has been focused on short-term response to save lives and address acute needs of crisis-affected populations. With humanitarian crises becoming increasingly complex, recurrent and protracted, and often compounding pre-existing high levels of poverty and vulnerability, a critical need for longer-term solutions has emerged (European Commission, 2019). Health is a key focus of humanitarian assistance and also a metric of humanitarian response. However, humanitarian assistance focusing on health is rapidly changing as the burden shifts towards chronic non-communicable diseases and growing urban refugee populations (European Commission, DG ECHO, 2014). Education is also one of the main pillars of humanitarian response, but the sector suffers from a significant funding mismatch, with only six per cent of the total humanitarian budget going to educational programmes (Justino, 2016).

The 2018 General Guidelines of the European Commission on Operational Priorities for Humanitarian Aid identify the scaling-up of social protection systems through investments in health, education and overall poverty reduction as one of the core avenues to enhance the long-term resilience of vulnerable populations and to enable rapid and efficient assistance in response to shocks (European Commission, 2017,). This global policy shift has also been spurred by the Sustainable Development Goals (SDGs): by explicitly recognising that many of the drivers of humanitarian emergencies can significantly reverse the progress in education, health and other development outcomes of the last decades, the 2030 Agenda sets out a vision for social protection, focusing particularly on vulnerable populations such as those exposed to humanitarian settings, so that 'no one is left behind' in the achievement of SDG 3 (Health) and SDG 4 (Education).

This note builds on the main SPaN Reference Document to illustrate the state of play of health and education in humanitarian settings, by providing: (i) an overview of the role of social protection for addressing educational and health needs (in both humanitarian and development settings); and, (ii) a review of evidence, promising instruments, tools and best practices on the implementation of social protection programmes in emergencies for health and education. The definition of social protection is broad and often subject to debate, particularly in the humanitarian-development nexus. In this note, we focus on the non-contributory social protection transfers that are most commonly employed in humanitarian and fragile settings (e.g. cash and in-kind transfers) (see Box 1).

Box 1: Definition of social protection used in this note

Social protection includes different modalities for delivering direct, regular, and predictable transfers to vulnerable households or individuals on a multi-year basis. Social protection is often embedded in legislation and integrated in sector policies. Its financing mostly relies on domestic budgets, and it represents a foundation in government-citizens' social contracts (Gentilini et al., 2018b). Social protection contributes to human capital (e.g. the stock of health and education) either directly, by providing food, skills and services; or indirectly, through the provision of cash and access, enabling households to invest in health and education (Barrientos et al., 2014). By contributing to human and physical capital through asset accumulation, social protection can break the intergenerational transmission of poverty. Recently, the term **'shock-responsive social protection'** has been introduced, emphasising the role of social protection in supporting populations to meet their immediate needs in times of crisis, thus mitigating the detrimental impacts of shocks. Social protection interventions of this type are also identified as social assistance programmes or 'safety nets' (Gentilini et al., 2018a).

We distinguish between:

- Non-contributory transfers, where the full amount of the transfer is paid by the provider. They include cash (e.g. child grants, social pensions, vouchers) or in-kind (school meals, food-for-work) transfers, as well as targeted subsidies and fee waivers for essential social services[1];
- Contributory social insurance schemes, where participants make regular payments that cover costs related to life-course events. Contributory pensions, health, unemployment or disaster insurance, and funeral assistance are common social insurance schemes;

Labour market interventions and select social services.

As noted, we focus on non-contributory transfers within the broader framework of 'shock-responsive social protection'.

1 *For a useful inventory of all non-contributory social protection in Asia and the Pacific, see: http://www.ipc-undp.org/pub/eng/RR28_Social_Protection_in_Asia_and_the_Pacific_Inventory_of_non_contrib.pdf; for Africa: http://www.ipc-undp.org/pub/eng/Social_Protection_in_Africa.pdf; for Latin America: https://dds.cepal.org/bpsnc/about?bd=cct*

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Understanding Education and Health through a Nexus Lens

We start by providing a glossary of terms commonly used in the health and education sectors in Box 2. Then, in Table 1 below, we present an overview of the global state of play regarding health and education by reporting the main messages emerging from the latest relevant reports.

Box 2: Glossary of Terms

Education

- 'Educational access' or 'schooling': refers to school enrolment, attendance, and progression through the schooling system.
- Educational 'achievements': refer to the learning and cognitive outcomes and to the highest level of education pupils successfully completed. Educational 'sector': all the institutions (ministries of education, local educational authorities, teacher training institutions, schools, universities, etc.) whose primary purpose is to provide education to children and young people in educational settings, through policies, curricula and learning materials (UNESCO, 2016).

Health

- Health care 'access': the ability to command appropriate resources to preserve and improve health. It relates to physical access to services, but also the extent to which a population gains access depends on financial, social and organisational barriers (Gulliford et al., 2002).
- Health care 'coverage': relates to the actual receipt of health care among people who are in need.
- Health outcomes: outcome measures at the individual, group or population levels (e.g. mortality, readmission, patient experience, morbidity etc.).
- Health system: organisation of people, institutions and resources that deliver health care for meeting the health needs of the target population (WHO, 2007).
- Universal Health Coverage (UHC): a situation in which all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.
- Basic package of health services (BPHS): policy documents prepared by the Ministry of Health describing the services that should be available. They usually include: maternal and child health, immunisation, nutrition, control of communicable diseases, mental health (DG ECHO, 2014).
- Communicable disease: an infectious disease that can be transmitted by direct contact or though a vector (e.g. enteric infections, respiratory infections and tuberculosis, malaria).
- Non-communicable disease (NCDs): a disease that is by definition non-infection and non-transmissible. Currently NCDs are the leading cause of death and morbidity globally.

Table 1: Main findings from leading reports on the status of education and health globally

REPORTS	KEY FINDINGS AND MESSAGES
UNESCO 'Global Education Monitoring Report 2019 – Migration, displacement and education: Building Bridges not Walls'[2]	• Emergencies and displacement exert heavy pressure on education systems, both for those who are displaced and those who remain. • More countries are now including refugees within their education systems and avoiding establishing separate, parallel systems. • However, many barriers and challenges in meeting the educational needs of refugees persist, including underfunding, teacher skills and language.
World Bank 'The Human capital project'[3]	• Human capital (people's skills, knowledge, health and resilience) is the central driver of sustainable growth and poverty reduction. • Investments in human capital are becoming more important than investments in physical capital (e.g. infrastructure, assets) as the nature of work is changing. • Development of 'Human Capital Index' to monitor progress in different populations' stock of health and education.
World Bank 'World Development Report: Learning to realize Education's promise'[4]	• Schooling is not the same as learning. Although schooling has increased rapidly at the global level, educational achievements are strikingly low. • Wide learning inequalities within countries (by gender, place of residence, socio-economic status) and across countries. • Learning and quality education should be placed at the centre of educational policies to equip children with the skills required for the 21st century.
WHO 'World Health Statistics. Monitoring Health for the SDGs'[5]	• Less than half the people in the world today get all of the health services they need. • In 2010, almost 100 million people were pushed into extreme poverty because they had to pay for health services out of their own pockets. • 13 million people every year die before the age of 70 from cardiovascular disease, chronic respiratory disease, diabetes and cancer – the majority in low and middle-income countries. • Every day in 2016, 15 000 children died before reaching their fifth birthday.
Global Burden of Disease (2017)[6]	• Between 1990 and 2017, early deaths from communicable diseases and maternal and neonatal disorders dropped, with the largest declines in least developed countries. • The global burden of disease in terms of morbidity is now driven by non-communicable diseases (NCD) including mental and neurological disorders and diabetes. In terms of leading causes for early death, ischemic heart disease, neonatal disorders, and lower respiratory disease are top of the list. • Deaths from armed conflict and terrorism increased by 118 per cent between 2007 and 2018.

2 https://unesdoc.unesco.org/ark:/48223/pf0000266092/PDF/266092eng.pdf.multi
3 https://openknowledge.worldbank.org/bitstream/handle/10986/30498/33252.pdf?sequence=5&isAllowed=y
4 http://www.worldbank.org/en/publication/wdr2018
5 https://apps.who.int/iris/bitstream/handle/10665/272596/9789241565585-eng.pdf?ua=1
6 http://www.healthdata.org/policy-report/findings-global-burden-disease-study-2017

Box 3: Quick insights - The increasing burden of NCDs in humanitarian and displacement settings

Traditionally, the focus of humanitarian health response has been on communicable diseases. However, the epidemiological transition from communicable to non-communicable diseases (NCDs) as the main global drivers of death and morbidity, combined with the displacement of large populations of refugees in urban areas, has important consequences for ensuring access to adequate care for NCDs. Apart from chronic diseases like diabetes and high blood pressure, growing attention is drawn to mental, neurological and substance use disorders (Global Burden of Disease (GBD) 2017 study findings).

Furthermore, many of the refugees have a demographic profile similar to populations in middle-income countries, and may be affected by pre-existing chronic conditions or injuries suffered during the conflict (Blanchet et al., 2016; WHO, OECD, & World Bank, 2018). For this reason, UNHCR and its partners have recently modified their health information systems to include NCDs. For example, among Iraqi refugees in Jordan in 2010, chronic diseases were common, including hypertension (22%), visual disturbances (12%), joint disorders (11%), and type 2 diabetes mellitus (11%) (WHO et al., 2018).

International Standards and Commitments

SUSTAINABLE DEVELOPMENT GOALS

The 2030 Agenda for Sustainable Development identifies 17 Sustainable Development Goals (SDGs) that aim to 'ensure that all human beings can fulfil their potential in dignity and equality in a healthy environment.' The SDG agenda puts equity at its centre by stating the imperative of 'leaving no-one behind'. SDG 4 ambitiously sets out to 'ensure inclusive and equitable quality education and promote life-long learning opportunities for all' by 2030. The goal includes ten targets to guide countries to achieve quality education for all. As compared to Millennium Development Goal 2 ('Achieve universal primary education') and the Dakar 'Education for All' agendas, which were the key references for global educational policy during the period 2000-2015, SDG 4 puts learning and quality education at its core. This shift in global educational focus is motivated by the increasing recognition that massively increased rates of primary enrolment at a global level have not been matched by learning outcomes (see findings of 2018 World Development Report in Table 1). The overall goal is tracked through 11 indicators, which broadly focus on the following categories: (i) proportion of children that achieve minimum proficiency levels in maths and reading are developmentally on track (in the case of early childhood skills); (ii) participation of youth and adults in training; (iii) parity indices (by gender, rural/urban; socioeconomic status); (iv) school quality indicators, including of teachers; (v) volume of development assistance focused on scholarships; (vi) innovation of curricula[7].

Concerning health, all UN Member States agreed to achieve universal health care (UHC) by 2030 as part of the SDG agenda. Although SDG 3, 'ensure healthy lives and promote well-being for all at all ages'[8], focuses explicitly on health, other goals such as SDG 1 on poverty, SDG 4 on education, SDG 5 on gender equality and SDG 2 on food security and nutrition are directly related to the achievement of SDG 3. In fact, it is estimated that at least 10 other goals are related to health. The SDG *foci* on UHC, NCDs, equity and a health-system approach represent a significant advancement from the approach embedded in the Millennium Development Goals. The latter were mostly concerned with maternal and child health and infectious disease (Cometto & Witter, 2013)nurses and midwives and were developed with the objective of attaining relatively high coverage of skilled birth attendance and other essential health services of relevance to the health Millennium Development Goals (MDGs. Accordingly, with SDG 16 (Promote peaceful and inclusive societies for sustainable development), the SDGs explicitly encompass the principles stated in the 1978 Alma Ata declaration, which noted that 'Health for All' would contribute not only to improvements in human development but also to global peace and security. More than 50 indicators have been agreed internationally to measure health outcomes, the proximal determinants of health, and health service provision. The indicators can be grouped in the following areas: (i) reproductive, maternal, newborn and child health; (ii) infectious diseases; (iii)

7 http://uis.unesco.org/sites/default/files/documents/quick-guide-education-indicators-sdg4-2018-en.pdf

8 For a discussion, see: https://www.who.int/gho/publications/world_health_statistics/2016/EN_WHS2016_Chapter6.pdf

NCDs and mental health; (iv) injuries and violence; (v) UHC and health systems; (vi) environmental risks; and (vii) health risks and disease outbreaks. The World Health Organization (WHO) initiated a General Programme of Work aimed at accelerating progress towards the SDGs[9]. The programme focuses on the triple billion targets of: (i) one billion more people benefitting from universal health coverage; (ii) one billion more people better protected from health emergencies; (iii) one billion more people enjoying better health and well-being.

AGENDA FOR HUMANITY

Complementing the SDGs and the 2030 Agenda, the Agenda for Humanity[10] sets out an action plan to decrease humanitarian needs and vulnerability. The agenda focuses on the following areas to reduce humanitarian need, risk and vulnerability: (i) political leadership to prevent and end conflicts; (ii) uphold the norms that safeguard basic humanitarian principles; (iii) equity; (iv) reinforcement of local systems and the anticipation and overcoming of the humanitarian-development divide; (v) investments. Its main outcome was the Grand Bargain, an agreement among 30 of the biggest donors and aid providers to address the humanitarian financing gap. Of relevance to social protection, the Grand Bargain emphasises a shift towards greater cash programming, more un-earmarked finance, and increased multi-year funding to increase predictability and continuity in the humanitarian response.

RESOLUTION 2286 OF THE SECURITY COUNCIL AND 'CALL TO ACTION ON UNIVERSAL HEALTH COVERAGE IN EMERGENCIES'

The resolution 2286 of the Security Council[11] (2015) emphasised the needs of promoting health care during armed conflict. Although the resolution sets an international framework, important challenges remain, particularly with regard to UHC in humanitarian and fragile settings. During the latest World Health Assembly, Switzerland and Afghanistan started a multi-stakeholder 'Call to action on universal health coverage in emergencies'[12] in order to accelerate efforts to improve the coverage of quality essential health services without risk of financial hardship.

SPHERE STANDARDS

Humanitarian Charter

The Humanitarian Charter and Minimum Standards[13] represent a reference tool for all organisations involved in humanitarian assistance based on the principle of humanity and the primacy of the humanitarian imperative.

INEE Minimum Standards

The INEE Minimum Standards for Education: Preparedness, Response, Recovery is the only global tool that articulates the minimum level of educational quality and access in emergencies through to recovery. The INEE Minimum Standards are a companion to the Sphere Handbook.

Relevant EU Policies

Health and education are key priorities for the EU along the humanitarian-development nexus. Table 2 provides a summary of the main policy documents that underpin the EU's investments in education and health, as well as examples of programmes that respond to the development-humanitarian nexus.

9 *http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1*
10 *https://agendaforhumanity.org/initiatives/3861*
11 *http://unscr.com/en/resolutions/2286*
12 *https://www.bag.admin.ch/bag/en/home/strategie-und-politik/internationale-beziehungen/internationale-gesundheitsthemen/UniversalHealthCoverageinEmergencies/UniversalHealthCoverageinEmergencies.html*
13 *https://spherestandards.org/humanitarian-standards/humanitarian-charter/*

Table 2: Relevant EU policies

DEVELOPMENT

Education

The European Commission's Communication On Education and Training in the Context of Poverty Reduction in Developing Countries (2002)[14] affirmed the importance of education in reducing poverty and promoting development. It identifies three priorities for the EU's support: (i) basic education, especially primary education and teacher training, (ii) work-related training, and (iii) higher education

The new European Consensus on Development: Our World, Our Dignity, Our Future[15] recognises access to quality education as a prerequisite for long-lasting development and commits the EU to supporting inclusive life-long learning and equitable quality education through its programmes.

The European Commission Staff Working Document More and Better Education in Developing Countries (2010)[16] identifies the major challenges of access, quality and financing and outlines the EU's approach in overcoming them.

For a complete list of educational projects and funding activities: https://ec.europa.eu/europeaid/sectors/human-development/education_en

Health

The EU pursues a right-based approach to health, based on the 2010 Communication and Council conclusions on the 'EU Role in Global Health'[17]. The EU supports the Global Fund to fight AIDS, Tuberculosis and Malaria[18], as well as GAVI, the Vaccine Alliance[19] and the International Health Partnership for UHC 2030[20]. As the International Cooperation and Development DG is increasingly engaging in fragile contexts, the Commission adheres to the 'New Deal for Engagement in Fragile States'[21] , which emphasises resilience of health systems, including country-owned preparedness: adequate disease surveillance, decision-making processes, regulations, communications and response plans, within the health system and beyond. For a complete overview of development activities in health and related funding streams, please refer to: https://ec.europa.eu/europeaid/sectors/human-development/health_en

HUMANITARIAN

Education

The EU Communication on Education in Emergencies (EiE) and Protracted Crises (2018)[22] sets out the EU's commitment to safe, inclusive and quality education for children and young people caught up crises, setting a target of allocating 10 per cent of humanitarian aid by 2019. The communication acknowledges that an effective response to EiE requires both development and humanitarian instruments and proposes a new framework that strengthens mutual responsibility across instruments through improved coordination, complementarity and political action. This nexus centres on four strategic priorities:

- Strengthening systems and partnerships
- Promoting access, inclusion and equity
- Championing education for peace and protection
- Supporting quality education for better learning outcomes

Health

The EU provides around EUR 200 million every year to support humanitarian health programmes[23]. This includes emergency medical assistance, vaccination, WASH and nutrition interventions. These interventions are guided by the framework laid out in the ECHO General Health Guidelines[24]. The guidelines provide the basic parameters of DG ECHO humanitarian health assistance. In addition to the Guidelines, the Position Paper on User Fees[25] establishes that in humanitarian emergencies, health care should be free at the place of delivery to enhance access for all potential beneficiaries. For additional information, please refer to:

https://ec.europa.eu/echo/what/humanitarian-aid/health_en

14 *https://ec.europa.eu/europeaid/sites/devco/files/communication-education-com2002116-20020306_en.pdf*
15 *https://ec.europa.eu/europeaid/new-european-consensus-development-our-world-our-dignity-our-future_en*
16 *https://ec.europa.eu/europeaid/more-and-better-education-developping-countries-staff-working-document-2010-sec2010-121_en*
17 *https://ec.europa.eu/europeaid/sites/devco/files/communication-eu-role-in-global-health-com2010128-20100331_en.pdf*
18 *https://www.theglobalfund.org/en/*
19 *https://www.gavi.org/*
20 *https://www.uhc2030.org/*
21 *http://www.pbsbdialogue.org/en/new-deal/about-new-deal/*
22 *https://ec.europa.eu/echo/files/news/Communication_on_Education_in_Emergencies_and_Protracted_Crises.pdf*
23 *https://ec.europa.eu/echo/what/humanitarian-aid/health_en*
24 *http://ec.europa.eu/echo/files/policies/sectoral/health2014_general_health_guidelines_en.pdf*
25 *http://ec.europa.eu/echo/files/policies/sectoral/health2014_general_health_guidelines_en.pdf*

HUMANITARIAN

Education

The policy framework for Education in Emergencies and Protracted crises is set out in DG ECHO's Thematic Policy Document No. 10 Education in Emergencies in EU-funded Humanitarian Aid Operations (2019)[26]. This sets out four objectives of the EU's assistance to EiE:

- To increase access to education for young persons affected by humanitarian crises
- To promote quality education to increase personal resilience to the effects of crises
- To protect boys and girls from effects of crises, enabling education to provide life-sustaining and life-saving physical, psychological and cognitive support
- To strengthen the capacity of the humanitarian aid system to enhance EiE delivery[27].
- The EU's EUR 20m Building Resilience in Crises through Education (BRICE)[28] provides a good example of a nexus programme. BRICE supports actions to deliver safe, quality basic education in fragile and protracted crises environments in seven sub-Saharan African states with the aim of building the evidence base around what works best to build sustainable societal and institutional resilience.

The EU also supports global initiatives for EiE; for example, Education Cannot Wait[29] .

For more information, please refer to: https://ec.europa.eu/echo/what/humanitarian-aid/education-emergencies_en

The EU Trust Funds aim at bridging funding gaps for contexts of protracted crisis. As funding may stem from all appropriate EU Financing Instruments (such as the Humanitarian Aid Instrument, the Development Cooperation Instrument (DCI) or the European Neighbourhood Instrument (ENI)) and fiscal year restriction does not apply, EU Trust Funds allow a quick, adequate, flexible and long lasting response to specific crises. Furthermore, Trust Funds can obtain complementary funding from EU Member States or other donors. The first two EU Trust Funds were established in 2014: the first in July 2014 for the Central African Republic, as a mid-term response to the massive political and security crises[30] and named Bêkou (which means 'hope' in the national language, Sango), followed in December 2014 by the EU Regional Trust Fund in Response to the Syrian Crisis[31], (sometimes also referred to as the 'Madad Fund' which in Arabic means 'helping together') to assist Syrian refugees and their host communities. Later, more EU Trust Funds, such as the EU Emergency Trust Fund for Africa[32] and the EU Trust Fund for Colombia followed the first good examples. They aim to support vulnerable population groups affected by specific crises in terms of social protection, education, health, and overall poverty reduction.

26 *https://ec.europa.eu/echo/files/news/eie_in_humanitarian_assistance.pdf*
27 *A full list of EiE projects can be found at the European Emergency Disaster Response Information System (EDRIS)'s website: https://webgate.ec.europa.eu/hac/*
28 *https://ec.europa.eu/europeaid/news-and-events/call-proposals-building-resilience-education-opportunities-fragile-and-crisis-0_en*
29 *http://www.educationcannotwait.org/*
30 *https://ec.europa.eu/europeaid/bekou-trust-fund-introduction_en*
31 *https://ec.europa.eu/trustfund-syria-region/content/home_en*
32 *https://ec.europa.eu/trustfundforafrica/content/homepage_en*

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Education and Health in the Nexus

Social assistance in the humanitarian-development nexus

Humanitarian aid traditionally works on a short-term basis in fragile contexts linked to man-made crises, natural disasters or forced displacement settings, with a strong international leadership driven by humanitarian principles and in substitution (or in parallel) to national governments (Table 3). In contrast, development actors tend to operate with a longer-term perspective, in more stable environments, cooperating preferably with national and sub-national governments and state-led institutions.

Table 3: Traditional humanitarian and development settings

	HUMANITARIAN	DEVELOPMENT
Policy framework	Response aimed at saving lives/ensuring basic needs in different crisis contexts	National development programming (including social protection, health and education policies), international development strategies
Outlook	Mostly 6-24 months	Ideally 5-10 years
Coordination/Leadership	International or national-led, depending on crisis context	Ideally government-led, but in marginalised stable areas, international development actors may take leadership
Legal framework	Humanitarian principles/ international humanitarian law in conflict settings and natural disasters; otherwise sovereign law along with UN resolutions	Sovereign law, UN resolutions (e.g. SDGs)
Types of settings	Mostly fragile Lack of political will and/ or capacity	Stable (ideally willing, but lack of political will may also be present)

Source: Own adaptation of WHO Health Cluster (2018) and Cherrier (2014)

However, as crises become more frequent and protracted, the distinction between short-term emergency response and long-term development has substantially reduced. As widely discussed in the SPaN Reference Document, humanitarian interventions have extended their timeframe and begun pursuing longer-term objectives, including human capital investment by supporting access to education or preventive health care. Humanitarian actors have gained significant experience of working with social protection in crisis contexts.

The modalities for implementing safety-net measures in humanitarian contexts strictly depend on the pre-crisis maturity of the social protection system. Gentilini et al., (2018a) distinguish between: (i) countries with limited national social protection systems and large-scale international humanitarian assistance (e.g. Syria, Yemen); (ii) countries with emerging and highly-owned national social protection systems, although they are funded mostly by external financing (e.g. Ethiopia, Palestine); and (iii) countries with significant national social protection systems (e.g. South Africa, Mexico). Consequently the challenges in implementing social protection instruments vary based on this spectrum in the humanitarian-development nexus (Cherrier, 2014). For instance, in the first type of settings, the major challenge concerns how to help people in need without weakening the legitimacy and capability of the state. By contrast, in settings where social protection systems are emerging, the major challenges relate to improving the predictability of transfers and strengthening institutions. Finally, in settings where social protection systems exist and are well-established, the main challenge is about keeping up the momentum and ensuring wider integration with economic and social systems. Given this diversity of contexts within the nexus, the operational guidelines for programme implementation and the identification of best practices discussed in Sections 5 and 6 will vary significantly depending on the maturity of different countries' social protection systems before the crisis.

Social protection instruments for education and health in the nexus

Box 4: Key facts – Humanitarian settings display the worst health and education indicators globally

- The World Health Organization estimates that 60 per cent of preventable maternal deaths, 53 per cent of under-five deaths, and 45 per cent of neo-natal deaths in 2016 occur in humanitarian settings (World Health Organization, 2019).
- Half of the world's population does not have full coverage of essential health services[33].
- About 100 million people are pushed into extreme poverty (measured as living on USD 1.90 or less a day) because they have to pay for health care.
- Over 800 million people (almost 12 per cent of the world's population) spend at least 10 per cent of their household budgets to pay for health care.
- With regard to education, approximately 37 million primary and lower secondary age children are out of school in crisis-affected countries, accounting for half of all children out of school, although they represent only 20 per cent of all school-age children worldwide.
- Girls are disproportionately affected, especially in conflict, with four of the five countries where education is more unequal for girls being affected by war or insurgency (Nicolai, Hine, & Wales, 2015).

The determinants of health and educational outcomes are complex and multifaceted. To frame the issue, a useful assumption for economists is that households invest in the education and health of household members by maximising a life-course utility function subject to constraints (Glewwe & Kremer, 2006). In development settings, these constraints can relate to both demand-side barriers (e.g. poverty, low perceived returns to health and education investments, discriminatory social norms, etc.), and supply-side constraints (e.g. non-existent or low service quality, including in complementary sectors such as safe water and sanitation, food security and nutrition, etc.).

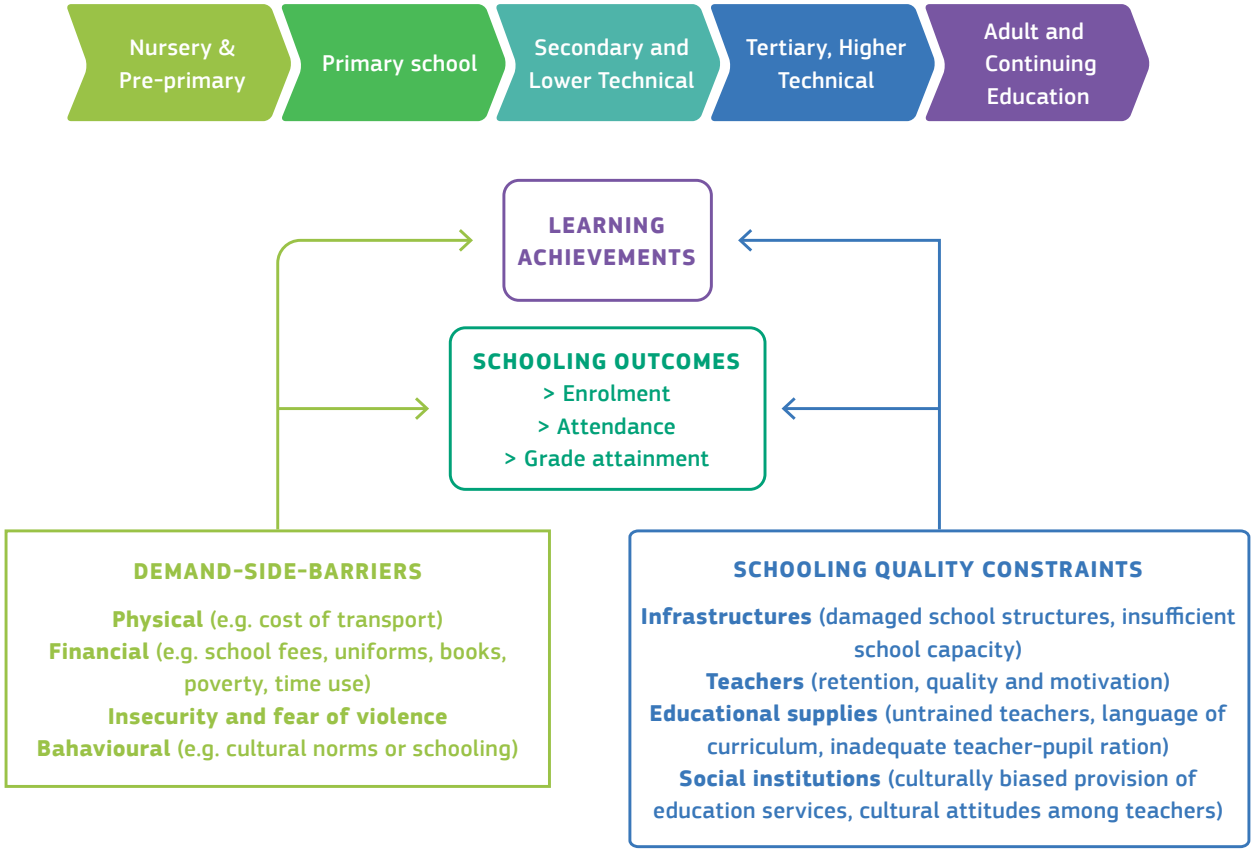
In humanitarian or fragile settings, those demand- and supply-side barriers are often magnified (see Figure 1a and 1b below). On the demand-side, shocks such as conflicts or environmental disasters may push vulnerable households into poverty, or they can exacerbate previous situations of deprivation (e.g. hygiene, water and sanitation with risks for cholera). By increasing the levels of financial hardship, the costs of schooling or health care may become unaffordable. In the case of health, populations affected by humanitarian crises and refugees still face significant direct (e.g. charges for consultation, diagnostic tests and/or medicines, or for preventive commodities as bed nets) and indirect

33 https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

expenditures (e.g. transport or accommodation costs) for health care, which hampers UHC. The large share of out-of-pocket expenditures increases household vulnerability to sudden shocks related to ill health (Blanchet, Fouad, & Pherali, 2016). With a focus on UHC, the link between social protection and health is centred around health financing, with the ideal goal of reaching zero out-of-pocket spending.

Furthermore, during humanitarian crises, the opportunity costs of schooling or to accessing health centres can rise, as coping with the shock often increases the demand for all family members to work. Humanitarian crises can also intensify physical and social barriers impeding access to education and health services. For instance, the destruction of nearby schools or health centres increases the costs of transportation to the next closest facilities. Similarly, discrimination against refugees in hosting populations may impede their access to health and education services. Increased insecurity, fear of violence or unsafe environmental conditions may also hamper school attendance or willingness to travel to schools, health centres or to food markets.

Figure 1a. Supply- and demand-side barriers to education during humanitarian crises



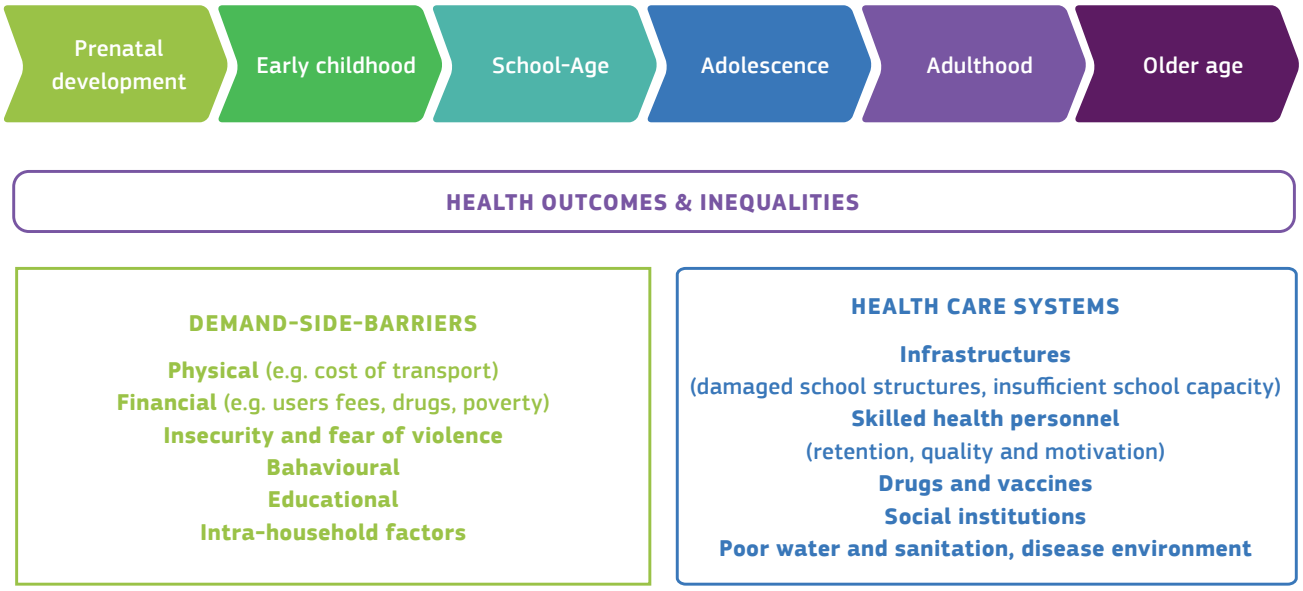
Examples of Social Protection

- Multi-purpose cash transfers
- Education-specific cash and voucher assistance
- In-kind incentives, e.g. transport, uniforms, books, food (school feeding)
- Child safety and protection assurances, guidance, counselling
- Psychosocial support, counselling
- Educational fee waivers

Examples of Social Protection

- Free basic education
- Child-friendly spaces – classrooms and recreational
- Proximity of schools
- Teachers – skilled, language of instruction, gender, ethnicity
- Adapted curriculum and materials
- Education assistance for vulnerable children (children with learning disorders, children with disabilities).

Figure 1b. Supply- and demand-side barriers to health during humanitarian crises and examples of social protection



Importantly, humanitarian crises do not affect all population sub-groups equally, thus potentially increasing pre-existing disparities on the basis of gender, age, socio-economic status and disability. For instance, worldwide, women and children are up to 14 times more likely than men to die in a natural disaster (Zeid et al., 2015). Children and adolescents are especially vulnerable to humanitarian disasters, given that many human capital investments occur in childhood (see Box 4). Elderly and disabled people are also at higher risk of poorer health outcomes during emergencies, as compared to other population sub-groups. As health care in fragile and humanitarian settings is mostly provided by an unregulated private sector, wide heterogeneity across population groups regarding their ability to afford health expenses leads to increasing inequalities of access to health care (WHO Health Cluster, 2018). Inequality in access should be therefore taken into account in the design of interventions that can effectively protect the most vulnerable population groups as per SDG 3 and SDG 4 (For a detailed discussion see Note 10).

Box 5: Quick Insights – The long-term and intergenerational effects of exposure to humanitarian crises during childhood

At least 476 million children aged 3-15 years live in countries affected by crises, and around 65 million of them are directly affected by emergencies (Nicolai et al., 2015). Protecting children's health and education from the negative effects of humanitarian crises is imperative, as a body of evidence has documented the detrimental long-term effects on life-course health, education, incomes and overall well-being of being exposed to humanitarian crises during childhood (Akbulut-Yuksel, 2017; Akresh & De Walque, 2008; Buvinić, Das Gupta, & Shemyakina, 2014; Caruso & Miller, 2015). Recent literature has shown that the negative implications of exposure to humanitarian crises or disasters on health and education are also transmitted to the next generations: for instance, Caruso and Miller (2015) show that children of mothers affected at birth by a large earthquake in Peru have 0.4 of a year's less education.

AN OVERVIEW OF SOCIAL PROTECTION INSTRUMENTS SUPPORTING EDUCATION

Providing cash or in-kind resources (e.g. uniform, stationery, books,) to children and their parents through cash or food transfers is a common intervention to address financial and physical barriers to education in stable settings and has been widely extended to humanitarian contexts (Roelen et al., 2018). The Global Education Cluster (GEC) recently published a synthesis report and guidelines for Cash and Voucher Assistance for Education Emergencies[34]. In addition, other recent research (CaLP, 2018), (UNICEF, 2019) provides useful evidence of the effect and risks of cash transfers.

Cash transfers to families with school-age children can relax demand-side constraints to schooling by: i) promoting physical access to education through reduction of transport costs; ii) reducing the financial costs of education by covering school fees, iii) lowering the opportunity costs of child labour; and iv) increasing the acceptability of education by encouraging vulnerable groups to attend schools (Roelen et al., 2018; UNHCR, 2017). The use of cash has also been shown to prevent dropouts and lead to re-enrolment of children who have been out of school. The use of cash transfers is growing in scale in humanitarian crises, since they are considered an efficient and effective modality to deliver quick and dignified responses to crises (Doocy & Tappis, 2016; UNHCR, 2018). Transfers can be disbursed unconditionally (UCT) or with some level of conditionality (CCT), which means that beneficiaries must fulfil some prerequisites (e.g. enrolment or a minimum level of school attendance) to receive the transfer. Conditionality must be regularly monitored, with related requirements in terms of resources and time. However, conditionality can work as a self-selection mechanism, thus supporting governments to target social benefits towards population groups that are below this threshold[35]

Cash plus programmes combine cash transfers with additional programme components that stimulate behavioural changes and/or address supply-side constraints. With regard to education, the provision of information on the returns to education, psychosocial support to the household at pay points, community-level training by volunteers or NGOs, and home visits are examples of those additional programme components (Roelen et al., 2017).

School vouchers provide funding to households to buy food or enrol children in a given school of their choice. The impact of vouchers on education has been demonstrated in various contexts: increased private school enrolment among the poorest income groups; increased academic performance, lower drop-out rates (Morgan et al., 2015; Duflo et al., 2015; Angrist et al., 2002)[36]. UNHCR suggests limiting the use of vouchers in favour of cash transfers, as vouchers restrict the use of financial assistance and render a programme less cost-efficient (UNCHR, 2017). However, the use of vouchers is recommended when cash might put staff or recipients at risk, or be used to fund armed groups.

School feeding is among the most common forms of social protection, reaching 375 million children daily for a global investment of over USD 70 billion per year (Drake et al., 2017). School feeding is a multi-sectoral intervention addressing education, health, and agriculture. Most school feeding programmes focus on primary schooling, although some programmes may also include early childhood education (ECD). School feeding decreases the opportunity costs of schooling through the provision of an in-kind transfer, in the form of a hot cooked meal, a snack or a take-home ration, or a combination of those modalities. School feeding reduces short-term hunger, which improves children's concentration and cognitive abilities. In addition to the general goals of promoting schooling and nutrition, school feeding in humanitarian settings may encourage child safety, protection, dignity, integrity and feelings of normalcy, by protecting against child labour, recruitment into armed forces, and early marriage (Tull & Plunkett, 2018; WFP, 2007). At the same time, no rigorous research exists on the effects of school feeding programmes on education access in crisis-affected countries (Burde et al., 2015) and the existing evidence base is largely representative of developed or developing countries.

In post-conflict and transitional contexts, school feeding is also used to assist in the restoration of education systems, to encourage the return of internally displaced persons and refugees, and to promote social cohesion among children (Harvey, et al., 2010).

34 https://reliefweb.int/sites/reliefweb.int/files/resources/1551285775.GEC%20synthesis%20report%20FINAL%20rgb.pdf
35 For an in-depth discussion on conditionality as a targeting tool, see Content Note 1.
36 All cited in King et al., 2019.

General food distribution (GFD) or other types of food assistance (e.g. food for work or food for training) can also support education in humanitarian contexts, although the link with education is less explicit than in school feeding programmes, and might negative impact on schooling (Aurino, Tranchant, Sekou Diallo, & Gelli, 2019). For instance, as a social protection tool, GFD protects households from adopting detrimental coping strategies (e.g. larger absenteeism because of the increasing resort to child labour or school dropout) in the face of shocks. Also, by providing food directly, GFD may free up income resources within the household budget to be invested in education and human capital investment. Interventions that integrate cash and food can also improve education outcomes by supporting households in their immediate food needs and freeing up resources to invest in child human capital.

Child safety and protection is a critical enabler to promote school attendance. Often, already vulnerable children may be exposed to harassment, bullying and violence on their way to and at school unless proactive measures are taken to promote their safety. Zero-tolerance policies to harassment need to be rigorously enforced in schools, with effective mechanisms for children to report incidents. The creation, both within schools as well as within communities, of **child-friendly spaces** where children can feel safe and supported are important in restoring a sense of security and normality in conflict- or crisis-affected settings. **Proximity to schools**, especially for younger children, can present a major barrier to participation and further expose children to risk of abuse and exploitation. Provision of safe transport and chaperoning schemes, especially for girls, can help mitigate this constraint.

Psychosocial support and counselling services are required within schools and communities to support children experiencing trauma. This requires effective reporting and referral processes, and teachers as well as other professionals to be trained and supported in delivering effective services.

Additional support for more vulnerable children, especially those with disability, is even more critical for those caught up in conflict or crises where both their vulnerability and the challenge of accessing suitable schooling may be increased, requiring support both within communities as well as schools.

Both internally and internationally displaced children face challenges when entering different education systems. For instance, they may have minimal, if any, understanding of the **language of instruction**. This will inevitably be affected by the language of the available teachers, so identifying and contracting teachers sharing a common language is a mitigating measure, though this is often politically controversial and hard to enact. Similarly, the **curriculum and teaching and learning materials** may be in a language that children do not understand.

AN OVERVIEW OF SOCIAL PROTECTION INSTRUMENTS SUPPORTING HEALTH

From a legislative perspective, the 1948 Universal Declaration of Human Rights sets out the fundamental right to health care, without discrimination, during times of war and in peace. In addition, the 1951 Convention on the Status of Refugees states that refugees are entitled to health services equivalent to those of the host population. In countries where health services may be inadequate for the host population, fulfilling the right to health for refugees is less straightforward, and it is also politically challenging. Therefore, there is a wide consensus that UHC should be guaranteed by the state during any humanitarian crisis, and all humanitarian and development actors should support this overarching goal (Thompson & Kapila, 2018). UNHCR (2015) identifies universal access to health services as the starting point for any effective demand-side intervention to support health.

Social protection instruments can address demand-side constraints[37] by promoting security against health risks, ensuring access to good quality health care and guaranteeing basic income levels for the promotion of UHC. In contexts where health services have adequate capacity and quality, but where patients are charged for these services, humanitarian and social protection actors can support access at different levels of the health system by funding the purchase of these services for the target population. Different modalities to cover financial costs for health care are offered by the following instruments.

37 *Social protection can address also supply-side factors by supporting existing health services and systems, providing direct external assistance to guarantee essential health services or purchasing services by existing providers. However, this second aspect of health humanitarian intervention is not the content of this note as discussed in Box 1.*

Cash transfers can address financial barriers covering out-of-pocket expenditures for both direct and indirect costs of health services. According to the WHO guidelines (WHO Health Cluster, 2018), in order to maximise their impact, cash transfers should target patients who need to use health services, and the amount of the transfer should cover diagnosis and treatment costs, and indirect costs. Cash transfers may also promote the use of free preventive services, such as immunisation or antenatal care, by establishing conditionality conditions to transfers' disbursement. Conditional cash transfers has been proved to significantly increase the number of preventative health services visits, and thus stimulate demand for health services in development contexts (Fernald et al., 2008; Lagarde et al., 2007)nutrition, and education. Families enrolled in CCT programmes receive cash in exchange for complying with certain conditions: preventive health requirements and nutrition supplementation, education, and monitoring designed to improve health outcomes and promote positive behaviour change. Our aim was to disaggregate the effects of cash transfer from those of other programme components. \n\nMETHODS\nIn an intervention that began in 1998 in Mexico, low-income communities (n=506. Social norms and attitudes to health care, possible sanctions for non-compliance, as well as delivering modalities plays a role in determining the effect of introducing conditionality on behavioural changing (Gaarder et al., 2010). As for education, conditionality increases monitoring costs. Often programme beneficiaries in humanitarian contexts cannot comply to the conditions for reasons beyond their control, such as unattended shocks, or violence escalation in conflict settings (WHO Health Cluster, 2018).

Cash plus interventions include awareness raising on health, dietary and sanitation practices and infant and young child feeding practices (such as the promotion of breast feeding). Cash plus programmes can be adapted to humanitarian crisis settings. For instance, the delivery of mental health services in addition to the cash disbursement can enhance psychological well-being to beneficiaries exposed to man-made or natural shocks.

Commodity or value **vouchers** are another commonly-used instruments in developing countries to subsidise access to health services for targeted populations. Brody et al. (2013) show that vouchers have a positive effect on health service delivery, although their impact on health outcomes is not clear and varies across contexts. To guarantee access to quality services and avoiding patients using money to buy substandard or ineffective (traditional) services, or poor-quality medicines, the use of vouchers can be restricted to providers from which minimum quality standards can be ensured.

Targeted health user-fee exemption. Targeted user-fee exemptions removing payment at the point of care by patients aim at removing one of the biggest barrier to access to care, in a view to facilitate the achievement of universal health coverage (UHC) and the Sustainable Development Goals 1 and 3. Such measures can target certain population groups, such as poorest households and/ or most vulnerable groups, such as under-fives. In spite of the existence of extensive literature on user fees, little is known about the long-term effects of user fee exemption policies on healthcare use in developing countries. Existing evidence is mixed (see Box 6 – The effects of user-fees and their abolition in Uganda). In Zambia, although the removal of user fees had positive immediate effects (free care at the point of use), there was considerable inequality in the incidence of catastrophic health expenditures. Free health care poses a sustainability challenge if expenditures are not paired with revenues (Masiye et al., 2016). Therefore, political commitment towards universal health coverage (UHC) is fundamental.

It is noted that for user-fee removal policies to be effective in increasing service use in the long term, they need be accompanied by additional measures, which notably target governance in the medical supply chain management, geographical barriers and knowledge gaps. Burkina Faso has recently introduced targeted exemptions.

Box 6: The effects of user-fees and their abolition in Uganda (Xu et al., 2006)

In Uganda, the first formal attempt to introduce user fees failed in 1990, which led to fees being charged illegally. User fees were universally introduced in 1993 and were expected to generate public resources, promote efficient use of these resources, and improve the quality and equity of health services. Unfortunately, the funds generated were typically less than 5 per cent of total expenditure for most hospitals and health districts, and had little or no effect on the quality or efficiency of services. Furthermore, their introduction was associated with a dramatic drop in take-up of health services. User fees were subsequently abolished in 2001. Although the abolition of user fees was a measure intended to improve equitable access, while it did improve access rates, it also increased household expenditures because medicines had to be purchased from private pharmacies and it also led to a system of informal payments to health workers.

Box 7: Social health protection across the nexus in Burkina Faso

In Burkina Faso, chronically high acute malnutrition and under-five child mortality rates threatened the lives and mental and physical development of children, especially during recurrent drought episodes such as the one experienced in 2005. In this context of a 'forgotten crisis', humanitarian organisations started to offer free access to health and malnutrition treatment in northern areas of the country where global acute malnutrition rates were far beyond the internationally accepted emergency threshold. This approach was part of the DG ECHO Global Plan Sahel designed as response to the regional Sahel Food and Nutrition Crisis, in line with the EU commitment to linking relief, rehabilitation and development (LRRD) in 2001.

From 2008 onwards these geographically targeted projects were coupled with extensive research and advocacy work through a network of NGOs and research institutes, and continued for several years, becoming a pilot for a new policy instrument.

It was in 2016 that free access to health finally became a reality for children under five and pregnant and breastfeeding women on national level in Burkina Faso, when the newly elected government decided on a major change in health financing policy: direct payments for health care for vulnerable groups were abolished as part of the national social protection system. Unlike in other countries in Africa, this decision took quite a long time. A crucial factor was the continued funding of pilot projects to test the new policy instrument and to generate evidence. Moreover, it took the continued mobilisation of advocacy coalitions , as well as action to counter preconceived notions about the instrument, and the emergence of an essential political window of opportunity – the 2014 popular uprising – for the decision to be possible.

Food assistance programmes (GFD, food for work and school feeding interventions) also have the potential to yield positive effects on the health outcomes of beneficiaries, especially by improving their food security and nutrition outcomes. For instance, Tranchant et al. found that humanitarian GFD and school feeding improved food security and child height in Mali (Tranchant et al., 2018). For in-depth discussion, see Operational Note 7 (Food and Nutrition Security). In a similar fashion to education, mixed cash and food interventions can have positive effects on health outcomes, by freeing up income resources that can be redirected to enhance preventive and curative health care.

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Evidence of Impact – What does it tell us?

Although there is extensive empirical evidence analysis of the effects of social protection on health and education in non-humanitarian settings (see Box 9), the available evidence base for humanitarian contexts is remarkably limited. Furthermore, the existing knowledge is of mixed quality (see Box 8 for the definition of rigorous evidence): peer-reviewed experimental or quasi-experimental studies are scant, and most evidence relies on programmatic reviews and case studies (Murphy et al., 2018; Slater et al., 2012). Reporting of inequalities in access and impact of social protection on education and health by gender, poverty and other factors, as well as by type and degree of crisis, is very limited (Slater et al., 2012). In this section we discuss the available evidence, which we obtained by conducting a literature review to identify relevant research articles on the topic[38].We categorised the articles emerging from this search into peer-reviewed and non-reviewed papers. We included all peer-reviewed papers and non-reviewed studies that employed rigorous methodology. Other contributions coming from grey literature, i.e. project evaluations, lessons-learned guides and policy papers published by international organisations and NGOs have been included in the discussions in the subsequent sections about 'operational insights' and 'promising practices'. The list of rigorous studies included in this review is presented in Annex 1. Below we present a brief summary of what emerged from them about the impact of social protection programmes on education and health outcomes.

Box 8: Key insights – Defining rigorous evidence

An impact evaluation is an assessment of how an intervention or a policy being evaluated affects some outcome. Impact evaluation methods need to rule out the possibility that any factors other than the programme explain the observed impact. Statistical and econometric techniques can be used to identify a comparison group of beneficiaries who remain unaffected by the programme, and to estimate the counterfactual outcome. Experimental designs (e.g. randomised control trials) and quasi-experimental designs (e.g. quasi-natural experiments, difference-in-differences, regression discontinuity, propensity score matching) are considered the most rigorous types of impact evaluations from a quantitative methods perspective.

Box 9: Rigorous reviews of social protection for health and education in development contexts

There is extensive empirical evidence about the effects of social protection on health and education in non-humanitarian settings. Such evidence is well documented by the following reviews:

- Baird, S., Ferreira, F. H., Özler, B., & Woolcock, M. (2014). Conditional, unconditional and everything in between: a systematic review of the effects of cash transfer programmes on schooling outcomes. Journal of Development Effectiveness, 6(1), 1-43.
- Drake, L., Fernandes, M., Aurino, E., Kiamba, J., Giyose, B. , et. al. (2017). School Feeding Programs in Middle Childhood and Adolescence. In: Disease Control Priorities (third edition): Volume 8, Child and Adolescent Health and Development, edited by D. Bundy, N. de Silva, S. Horton, D. T. Jamison, G. Patton. Washington, DC: World Bank.
- Lagarde, M., Haines, A., & Palmer, N. (2007). Conditional cash transfers for improving uptake of health interventions in low-and middle-income countries: a systematic review. Jama, 298(16), 1900-1910.

38 *The following search criteria were applied. Main bibliographical databases: Google Scholar, the International Initiative for Impact Evaluation (3ie), the World Bank Development Impact Evaluation Initiative (DIME), the Poverty Action Lab, and the Social Science Research Network. Keywords terms: 'cash transfers', 'social protection', 'school feeding' and 'child development' or 'education', or 'nutrition', or 'health' and 'humanitarian' or 'conflict' or 'crisis' or 'emergency' or 'climate shock'. Other contributions: grey literature issued by the European Commission, World Bank, UNICEF, Save the Children, UNHCR, Cash Learning Partnership (CaLP), WFP, FAO, OPM, and ODI, etc.).*

- Ranganathan, M., & Lagarde, M. (2012). Promoting healthy behaviours and improving health outcomes in low and middle income countries: a review of the impact of conditional cash transfer programmes. Preventive medicine, 55, S95-S105.
- Owusu-Addo, E., & Cross, R. (2014). The impact of conditional cash transfers on child health in low-and middle-income countries: a systematic review. International Journal of Public Health, 59(4), 609-618.
- Brody, C. M., Bellows, N., Campbell, M., & Potts, M. (2013). The impact of vouchers on the use and quality of health care in developing countries: a systematic review. Global Public Health, 8(4), 363-388.

Education

- **Mixed evidence on the impact of cash transfers among Syrian refuges in Lebanon**: the UNHCR winter cash assistance programme had a positive effect on school enrolment and attendance (Lehmann & Masterson, 2014). Transfers provided by the UNICEF and WFP No Lost Generation Programme had limited effects on enrolment but substantive impacts on school attendance (due to capacity constraints) among children enrolled in afternoon shifts (De Hoop et al., 2018). In contrast, no significant impact on school enrolment has been found for the Multipurpose Cash Assistance Programme of the Lebanon Cash Consortium (LCC) (Battistin, 2016).
- **Conditional cash transfers have been found to have a positive impact on school enrolment in high-intensity conflict areas** (Wald & Bozzoli, 2011) **Conditional Cash Transfer Programs** (CCT), **and on child development indicators** in protracted fragility linked to exposure to natural shocks in Nicaragua (Macours, et al., 2012).
- **School feeding programmes are generally associated with a positive impact on school enrolment and attainment** among conflict-afflicted children in Mali and in refugee camps in Northern Uganda (Alderman, Gilligan, & Lehrer, 2012; Aurino et al., 2019) there is limited causal evidence to support it. Moreover, little is known about how the design of FFE programs affects schooling outcomes. This article presents evidence of the impacts of alternative methods of FFE delivery on schooling in Northern Uganda using a randomized controlled evaluation conducted from 2005 to 2007. We compare the impacts of the World Food Program's in-school feeding program (SFP. In conflict areas, the effects depend on conflict intensity: programmes lead to rises in enrolment mostly in high-intensity conflict areas, while school feeding mostly raises attainment among children residing in areas not in the immediate vicinity of the conflict (Aurino et al., 2019). However, there are also negative effects that can include diversion of resources as well as partial and inequitable distribution, which can exacerbate tensions.
- **GFD had a negative effect (around 20 per cent) on school attendance for boys residing in households receiving GFD in high-intensity conflict areas in Mali.** Most of the existing rigorous evidence focuses on **school-aged children**: only two studies looked at social protection impact on pre-schoolers (Gilligan et al., 2012) and adolescents (Rosas Raffo & Sabarwal, 2016). Assessments by gender and levels of exposure to conflict are also limited. Most studies focus on schooling, rather than on learning, which is the focus of SDG 4.
- **The provision of safe or child-friendly spaces (CFS)** can help protect children and provide physical and psychological support to children caught up in crises (UNICEF 2011). Schools, where functional, are important safe spaces when afforded protection, and can also help build social cohesion in fractured communities. Conversely, safe spaces can temporarily assume some of the functions of a school where none exists.

Health

- **There is a remarkable evidence gap on the effects of social protection on health outcomes in humanitarian settings**. Pega et al. (2015) reviewed the effects of unconditional cash transfers on health services and health outcomes in humanitarian countries and identified only five rigorous studies. Just two of these assess the impact on health indicators (Lin & Salehi, 2013; Macours et al., 2012)utilisation of maternal and child health services remain low, especially in rural areas. First introduced in Latin America and now expanding to Africa and Asia, conditional cash transfer (CCT. The others focus on nutritional outcomes (Aker, 2013; Langendorf et al., 2014). In addition, Rosas & Sabarwal, (2016) looked at the impact on health facility visits of cash transfers conditional on participation in public works.
- **Within this limited evidence base, one study shows positive effects of cash transfers on early childhood health outcomes.** Macours et al., (2012) find a positive and significant effect of the Atención a Crisis programme in Nicaragua on child mobility indicators at the first follow-up, and on fine motor two years later.
- **There is a positive impact of conditional cash transfers on health inputs:** Lin & Salehi (2013)utilisation of maternal and child health services remain low, especially in rural areas. First introduced in Latin America and now expanding to Africa and Asia, conditional cash transfer (CCT shows that CCT may be an effective tool to stimulate demand for maternal health through increases in institutional delivery and use of preventive child health services such as immunisation in Afghanistan; Rosas & Sabarwal, (2016) shows that CCT in Sierra Leone significantly increases health facility visits by 8 per cent for boys aged 0-5 years, but not for girls.
- **In May 2018, the European Commission published an evidence-based planning resource** '*Strengthening Integration of Nutrition within Health Sector Programmes*'. The document comprises eight evidence briefs, of which the one on 'management of moderate and severe acute malnutrition in children, and pregnant and lactating women' is of particular relevance in humanitarian settings. The authors also highlight that '*further improving integration of nutrition and health programmes in both humanitarian settings and in routine service provision will ultimately result in improved nutrition and health outcomes and contribute to achieving the EU commitments and the SDGs*'.[39]

39 https://europa.eu/capacity4dev/file/75785/download?token=cfb27Koq

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Key Lessons and Insights Arising from Operational Experiences

To complement the studies mentioned in the previous section, we draw on operational experiences (e.g. project evaluations, lessons-learned guides and policy papers) in order to improve understanding of the effectiveness of social protection for health and education in the nexus as well as to sketch key lessons and insights.

Adapting the modality, size, duration and delivery of transfers to the context

A key message arising from the operational experiences reviewed is that successful approaches to social protection in the nexus need to be tailored to the context-specific and multi-dimensional barriers to health and education that households face. Interventions need to be adapted in terms of modality, transfer size, duration and delivery.

With regard to education, the available evidence highlights that transfers are effective in increasing schooling outcomes insofar as they can offset recourse to child labour (both within or outside the household) as a key coping strategy in the face of shocks or by alleviating other challenges associated with poverty (Aurino et al., 2019; J. de Hoop & Rosati, 2014; Jacobus De Hoop et al., 2018). The evaluation of the Girls' Education Fund (see Box 12) highlighted that programmes which reduced the cost of schooling by supporting households to pay school fees or by providing school kits or sanitary pads increased school attendance among girls. Further, transfers should be aligned as far as possible to the academic year (e.g. monthly or termly transfers), in order to ensure consistency with schooling needs. Also, the amounts of the cash transfers should be tailored to the educational level. For instance, in Chad, pupils receive an annual unrestricted cash transfer of USD 43 and USD 60 for primary and secondary school respectively (UNCHR, 2017). Similarly, school feeding should be also adapted to context in terms of the intervention objectives and the groups targeted. For instance, in-school meals can be more effective in avoiding school dropout and enhancing attendance, while take-home rations can also have positive externalities on the health of younger and older siblings (Kazianga, Walque, & Alderman, 2009). Evidence from rural and food-insecure areas of sub-Saharan Africa has highlighted that combining school meals with take-home rations is particularly effective at keeping adolescent girls in school (Gelli, Meir, & Espejo, 2007).

On the health dimension, the Health Cluster has elaborated a hierarchical selection procedure for decision makers to identify preferred financing options, including cash transfer modalities, to support access to health services when essential health services of moderate quality are available[40] (WHO Health Cluster, 2018). The choice of the optimal (mix of) options depends on the social protection programmes present in the state before the crisis; by the accessibility of health services before the intervention; and the feasibility of implementing a particular option in a given context.

Finally, in relation to the transfer delivery mechanisms, the UNHCR has developed a helpful tool for designing cash-based interventions in humanitarian settings. This tool can be used at the response design stage to assess the range of cash delivery mechanisms available and determine what is most suitable for the given context[41]. The tool highlights the importance of context for tailoring different modalities to the specific settings in order to

40 https://www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf
41 https://www.unhcr.org/5899ebec4.pdf

maximise the chances of relevance and effectiveness (e.g. urban areas versus refugee camps). Also, the use of technology can leverage innovative and relatively low-cost platforms for cash delivery in humanitarian settings (Asi & Williams, 2018). For instance, the introduction of mobile phone–based money transfer systems (m-transfers, or mobile money) offers an alternative infrastructure for delivering cash in remote and fragile areas, reducing leakage associated with manual cash delivery, especially in non-stable areas (Aker et al., 2016). However, e-transfers pose significant challenges related to data protection.

Training opportunity!

The socialprotection.org community of practice has posted a free course to assist humanitarian practitioners in taking the necessary steps to operationalise the protection of beneficiary data in programmes using electronic transfers: **kayaconnect.org/course/info.php?id=516**

Designing tools to improve the efficacy of conditionality and targeting

Evidence available from humanitarian and non-humanitarian contexts indicates that transfers do not have to be conditional to be effective in enhancing schooling, if the only barrier to education is financial. Also, in fragile contexts, strict conditions may add additional strain for beneficiaries already dealing with post-traumatic stress and extremely challenging conditions. 'Soft conditions', such as labelling an UCT as an 'education grant' can be equally effective as conditions in fostering school enrolment and attendance, as documented by de Hoop et al., 2018 in the case of Syrian refugees in Lebanon. On the other hand, if conditions are linked to some specific groups or behaviours, CCTs can trigger behavioural change. For instance, the evaluation of the Girls' Education Fund has highlighted that even raising awareness among parents about distributing household chores more equitably between boys and girls can improve girls' schooling outcomes. Analysis of contextual barriers to education is therefore needed before setting the conditionality.

In relation to targeting, information from social protection programmes that existed before the crisis can help identify beneficiaries and improve targeting outcomes. For instance, the OECD Social Protection System reviews suggests that a way to bridge the governance and administrative gaps between UHC and other social protection policies is to use the existing social protection targeting mechanisms when setting up health insurance schemes, or, as in the case of Cambodia, to embed UHC within the national social protection policy (OECD, 2017). Similarly, health or schooling systems can support the identification of beneficiaries for social protection programmes. Information about wider population groups – including potential future recipients or households who have been assessed but classified as ineligible – is often collected by social protection systems, but not always stored and maintained (International Conference on Social Protection in context of fragility and forced displacement, 2017). Recent years have seen a rapid acceleration in integrated approaches to data and information management for social protection, in order to provide a coordinated and harmonised response to the multi-dimensional vulnerabilities faced by individuals across a life-cycle (Gentilini et al., 2018). Box 10 presents the introduction of a management information system (the Single Registry) in Kenya. A key issue, however, is the operationalisation of sound data protection across the full programme cycle, as discussed in Section 6 of this note.

Box 10: The Single Registry in Kenya

A harmonised management information system, the Single Registry, was launched in Kenya in 2016 to improve the delivery of social protection programmes (http://socialprotection.or.ke/single-registry). While each programme, including cash transfers for health and education, is responsible for collecting and maintaining data on its own beneficiaries and activities, essential data from each programme are transmitted to the Single Registry. The registry is also linked to the national identity system. Using the Single Registry, the number of beneficiaries of different programmes can be analysed by area, for example, or households receiving multiple benefits can be identified. The database facilitates the provision of support to households at times of crisis in two ways: first, other implementers – including those providing emergency response – can set up their own database such that it links to the Single Registry; second, it enables the coverage of existing programmes to be analysed, to determine whether they can be used for crisis response. Further reading: Aurino et al. (2018) 'Administrative Data: Missed opportunity for learning and research in humanitarian emergencies?': https://blogs.unicef.org/evidence-for-action/administrative-data-missed-opportunity-for-learning-and-research-in-humanitarian-emergencies/

Contributing to enhanced integration across sectors

There may be trade-offs across outcomes in programming transfers. For instance, a recent evaluation of emergency general food assistance in Mali highlighted that while GFD increased household food security and child nutrition (Tranchant et al., 2018), it also had a negative effect on schooling, particularly for boys (Aurino et al., 2019). These trade-offs depend on the costs and feasibility of providing assistance in conflict-affected areas, and on the multiple risks faced by vulnerable households and their individual members during a crisis. A coordinated and multi-sectorial approach should therefore be encouraged in order to assess multiple benefits and potential trade-offs, particularly between health and education, and the WASH, nutrition, food security and shelter sectors. Joint assessment and programming of social protection activities among multiple dimensions of intervention may help with: (i) assessing the multiple risks and needs households face; (ii) accounting for and taking advantage of trade-offs and complementarities within and across programmes; and (iii) designing a more coherent approach for delivering assistance. However, joint programming may also have implications in terms of lowering overall coverage, which is another important trade-off (Aurino et al., 2019).

Multi-purpose cash grants (MPGs), described in Box 11, provide a valuable operational tool for addressing the multi-dimensional needs and vulnerabilities of households in crises. MPGs require a joint multi-sector need assessment in the earliest days of a crisis and subsequent in-depth sector assessments. The IASC Needs Assessment Task Force[42] and the Multi-Cluster/Sector Initial Rapid Assessment (MIRA) Manual[43] provide guidelines for harmonising and promoting cross-sector needs assessment initiatives.

Box 11: Multi-purpose Cash Grants

Multi-purpose Cash Grants (MPGs) are unrestricted cash transfers that allows beneficiaries a wider and more dignified choice of assistance, based on their preferences. MPGs correspond to the amount of money a household needs to cover, fully or partially, a set of basic and/or recovery needs. This modality recognises that people affected by crisis are not passive recipients of aid who categorise their needs by sector. MPGs can be used in multiple contexts – urban and rural, rapid and slow-onset, chronic and acute crises, and even natural and complex disasters. A core element for the implementation of MPGs is a context-specific **Situation and Response Analysis** so that response options and modalities can be designed based on needs assessment and other contextual information. The operational guidance and toolkit for MPGs promoted by the Cash Learning Partnership (CaLP) recommends including health and education outcomes in the vulnerability assessment (CaLP, 2015). As multi-purpose cash assistance can meet multi-dimensional needs of beneficiaries, it requires a multi-sector and often inter-agency approach to assessments, analysis, programme design and implementation. Existing platforms like the Inter-Agency Standing Committee (IASC) and other coordinating mechanisms at local level should provide the operational basis for the coordination effort to deliver services across sectors (The World Bank, 2016).

42 *https://www.humanitarianresponse.info/en/programme-cycle/space/page/assessments-background*
43 *https://interagencystandingcommittee.org/iasc-transformative-agenda/documents-public/multi-clustersector-initial-rapid-assessment-mira-manual*

Training opportunity!

The Practical Scenario: Coordinating Multi-Sector Cash Transfer Programmes course allows learners to practise applying their Cash Transfer Programming (CTP) knowledge and skills in a programmatic setting. Available for free at: **socialprotection.org/practical-scenario-coordinating-multi-sector-cash-transfer-programmes**

Enhancing platforms for improved coordination of humanitarian and development actors

Overall responsibility for education and health rests with national governments, including in refugee contexts for the signatories of the 1951 Refugee Convention. In reality, the willingness, preparedness and capacity to fulfil these functions is highly varied in humanitarian crisis, and a myriad of actors operate at various levels providing resources, expertise and capacity to augment state-led efforts (Nicolai et al., 2015). In order to overcome this fragmentation and increase effectiveness, improved project management and inter-sector/cross-agency coordination in terms of programmes and information is needed (Karamperidou et al., 2019). Some examples of the available forums for country-level coordination of humanitarian response are the:

- IASC Education Cluster (educationcluster.net);
- UNHCR Refugee Coordination Model (emergency.unhcr.org/entry/256733/refugee-coordination-model-rcm);
- National Disaster Management Agency (NDMA) in South Asia (gsdrc.org/publications/national-disaster-management-authorities);
- Inter-Cluster Coordination Group (ICCG) IASC, 2016 (humanitarianresponse.info/en/operations/somalia/inter-cluster-coordination-group-iccg);
- WHO, through its Health Emergencies Programme (WHE), proposing '*The new way of working – Strengthening the Humanitarian, Development, Peace Nexus*' [44];
- Humanitarian-Development-Peace Initiative (HDPI) by the United Nations and the World Bank Group[45] in countries affected by fragility, conflict and violence (Cameroon, Somalia, Yemen, Sudan).

Progress in each country will be tracked closely so that results and lessons learned can inform efforts to adjust, replicate, scale up, and mainstream this 'New Way of Working' (2017). To incentivise coordination among multiple and heterogeneous actors it is essential to bridge the humanitarian-development divide presented in Table 3. Gentilini et al. (2018) suggest some key strategies to improve coordination among actors:

- Humanitarian organisations should guarantee greater flexibility in grant agreements and funding, in order to allow for flexible, longer-term programming in collaboration with national governments. Upon activation of clusters or any other type of coordination organisms, education and health sector leaders should establish a donor committee focusing on removing barriers between sectors and planning beyond narrow mandates.
- To ensure that emergency health and education responses are well planned, culturally-relevant and tailored to contextual specificities, organisations leading inter-agency coordination should actively seek out partnerships with national and community actors and, when necessary, invest in scaling up their capacities. Representatives of local implementing partners need to be fully involved in strategic planning and regularly participate in coordination meetings, to encourage the quick uptake of strategic decisions and recommendations.

44 *https://www.who.int/health-cluster/about/structure/new-way-working.pdf*
45 *https://www.worldbank.org/en/topic/fragilityconflictviolence/brief/the-humanitarian-development-peace-initiative*

Foster interaction with supply-side service delivery: the contribution of cash plus

Although supply-side interventions or health/education system financing are not the focus of this note (see Box 1), the efficacy of social protection in determining access to quality education and health care also critically depends on the quality and availability of services. Crises considerably stress educational and health systems, which are often weak to start with. Coverage and quality of educational and health services can be very compromised during acute phases of humanitarian crisis. School and hospitals may be closed or unable to fully operate for several reasons, i.e. shortage of personnel or drugs/learning materials, damaged infrastructure and impeded access due to insecurity or physical obstructions. The same crisis-specific factors also affect the operability of social protection interventions (WFP, 2007). The quality of health service provision may be affected by the presence of informal local health providers, e.g. community health workers, healers or witchdoctors, and actors from key related sectors (e.g. water, sanitation and hygiene), who may have no interaction with the formal public or private health care sectors, as well as the role of non-state armed groups in health service provision in conflicts. In conflict settings, services may be withheld from certain groups in violation of humanitarian principles and medical ethics.

Given these constraints, there may be little scope to implement an intervention focusing exclusively on demand-side barriers if educational and health supplies are not available or are of insufficient quality. In other words, cash transfers do not substitute for services, and their use should be consistent with the obligation of ensuring service quality (WHO Health Cluster, 2018). On the other hand, evidence from non-humanitarian settings suggests that supply-side interventions alone may not be sufficient to increase schooling and learning outcomes in post-crisis contexts (Glewwe & Kremer, 2006; Snilstveit et al., 2015), which suggests that combining social protection to households with supply-side interventions constitutes a promising approach, particularly to increase learning outcomes, which are the ultimate focus of SDG 4. An example of a cash plus programme that combines cash transfers with service delivery within the Girls' Education Challenge Fund is described in Box 12.

Box 12: Girls' Education Challenge Fund

The Girls' Education Challenge Fund was launched by the Department for International Development (DFID) in 2012, with the ambitious aim of targeting one million marginalised girls by March 2017. The 'InnovationWindow' projects operated in 12 countries, most of them in the midst of humanitarian crises or transitioning from conflict: Afghanistan, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nepal, Rwanda, South Sudan, Tanzania, Uganda and Zambia. The interventions mixed economic interventions to offset the cost of education (e.g. cash transfers, in-kind support or loans) with other components, i.e. improving school infrastructure and resources, teacher training and support, provided extra-curricular or non-formal education within the communities, strengthened school governance and management structures, empowerment and violence-related activities with young girls. Overall, there was a small increase in attendance rates and a substantial increase in learning outcomes. However, we cannot disentangle the effect of social protection-based interventions (e.g. cash transfers, in-kind support) from the other programme components (Girls' Education Challenge Fund, UK Aid, 2017).

Training opportunity!

This webinar explores the different types of cash plus interventions, different entry points to promote cash plus at country level based on the existence and maturity of national social protection schemes, and institutional coordination with state actors. Although the seminar focuses on agriculture-related 'plus' activities, the webinar provides background information that can be adapted to health or education programming. **socialprotection.org/fao-and-cash-how-maximize-impacts-cash-transfers**

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Promising and Innovative Practices

Flexibility and scalability of existing systems for responding rapidly to shocks

Prior to an emergency, introducing greater flexibility and scalability in programme design increases the capability of social protection to respond to shocks. In order to be 'shock-responsive', social protection systems should be capable of 'scaling out' to non-regular social protection beneficiaries that have been affected by a shock and/or of 'scaling up' to increase transfer amounts to existing beneficiaries in times of acute need (Oxford Policy Management, 2016).

Horizontal expansion or **scale-out** consists in the expansion of an existing programme, whose design (e.g. rules, conditionality, targeting process and grant size) remains essentially the same as before the crisis, but using the operations and funds of humanitarian actors (Oxford Policy Management, 2017). An example of scaling-out for education is the conditional cash transfer project for education ('CCT-Ed') in Turkey. The programme was horizontally expanded to support refugee children's education and their families, through support from European Civil Protection and Humanitarian Aid Operations (ECHO). The intervention's objective is to get refugee children into regular school attendance, and it sets different values in assistance to reduce girls' discrimination in school enrolment. Refugees registered within the government of Turkey's registry of refugees were allowed to apply to CCT-Ed by presenting their refugee ID.

Turning to an example of scaling-out for health, refugees in Iran are integrated into national schemes to gain access to preventative, free-of-charge primary health care. Since 2015, refugees also access the national Universal Public Health Insurance scheme, on a par with Iranian nationals. The UNHCR and ECHO provided budgetary support to finance the enrolment of refugees with the requisite documentation. So far, the inclusion of refugees is being carried out in phases: coverage was extended to refugees for hospitalisation services in 2015, and for secondary and tertiary health care services in two 12-month cycles (2016-2017 and 2017-2018). Refugees are responsible for paying part of their health insurance premiums, which are subsidised by the Government of Iran (International Conference on Social Protection in Contexts of Fragility and Forced Displacement, 2017). User fee exemptions can improve the provision and use of health services and promote UHC. In Burkina Faso, a user-fee exemption was introduced in 2016[46] when the government integrated it into the national health policy as a social protection component[47]. Results of this pro-poor initiative show how subsidising health care can reinforce the resilience of populations[48].

Vertical expansion or **scale-up** is the increase in benefit amounts at an acute time of need to existing social protection beneficiaries. An example of vertical scale-up for education and health after a shock is Pantawid in the Philippines, where a nationwide CCT is the flagship anti-poverty programme. Conditions for receiving the transfer include regular school attendance, health checks for children and pregnant women, and attendance of parents at monthly family development sessions. Cash transfers were identified as the preferred approach to support recovery from Typhoon Haiyan (November 2013), as the Pantawid programme was well established in the affected regions. WFP piloted an Emergency Cash Transfer (ECT) project that specifically targeted Pantawid beneficiaries in typhoon-affected areas. ECT provided an unconditional 'top-up' cash transfer on top of the regular Pantawid transfer. UNICEF decided to provide its cash assistance to Pantawid beneficiaries through the same mechanism in order to increase

46 *This followed the positive results obtained by an experiment for children under five and pregnant and breastfeeding women, run with the support of ECHO in two districts of the Sahel region starting in 2008.*

47 *http://www.vesa-tc.umontreal.ca/pdf/Brief_HealthUserFeesExemptionBurkina&Resilience_2013_web.pdf*

48 *https://journals.openedition.org/factsreports/1758#tocto1n7*

households' income stability in the immediate term, thus supporting livelihood recovery and reducing recourse to negative coping strategies such as withdrawing children from schooling.

Targeting and delivery of international assistance through national systems if they exist

During a crisis, if national delivery systems for social protection exist and function, they offer a unique starting point for the targeting and the delivery of international humanitarian assistance, which humanitarian actors could use to define their response strategy (Gentilini et al., 2018). Channelling the resources for accessing health and education services through the national system can potentially contribute to recovery by instilling a sense of security. The capacity of humanitarian intervention to build upon national delivery systems will strictly depend on the maturity of social protection systems before the crisis (Gentilini et al., 2018a).

Development agencies should support national systems to maintain their capacity during crises, or promptly rebuild such capacity when scaled down by acute crisis (Bastagli, 2014). As an example, UHC2030 has developed the 'Seven Behaviours' as the most effective way to ensure coordination around health systems strengthening[49]. This support may yield benefits for re-launching or building national social protection systems after the crisis (see next point). Post-crisis it is therefore important to share lessons and systems generated by international actors during an emergency (vulnerability data, beneficiary lists, distribution systems, etc.) with governments in order to speed up the recovery process. However, especially in conflict and fragile situations, the transfer of sensitive information from international organisations to national authorities and vice versa or publication of data should be done with particular caution and appropriate security safeguards to ensure confidentiality. Best practice and requirements for personal data protection should be followed, such as dissociating personal details from the rest of the information (European Commission, DG ECHO, 2016).

Transition to post-conflict recovery

Humanitarian assistance can be an important window of opportunity for reforms and the introduction of long-term social protection measures such as social insurance coverage. Post-crisis periods can constitute important opportunities to learn from the past, capitalise on interest, and innovate (Kruk, Freedman, Anglin, & Waldman, 2010; Martineau et al., 2017). Initiatives implemented during the immediate post-crisis period can be determinant for long-term trajectories of social protection, health and education system development (Martineau et al., 2017). For instance, the emergency nutrition programme implemented in Sierra Leone during the Ebola crisis was later integrated into the government's Basic Package of Essential Services (Blanchard et al., 2017).

Stewardship is particularly important in recovery settings. Stewardship refers to the functions carried out by governments to achieve national health and education policy goals, including equity, coverage, access, quality, and patients' rights. In fragile and conflicted-affected settings, questions of stewardship in health care delivery can be problematic, as the government may have weak political will and/or capacity, and health policy is shaped by the interplay of different actors. For instance, in South Sudan NGOs managed 86 per cent of the health facilities immediately after the signature of the Comprehensive Peace Agreement in 2005, with consequent fragmentation, low coverage of health services, dismal health outcomes and limited government capacity (Cometto et al., 2010). One example in the health-related sector of 'WatSan' or WASH (water, sanitation, hygiene) has been developed and assessed in Zaatari refugee camp in Jordan – the REACH WASH Infrastructure and Services Assessment . The REACH assessment (2017) shows 'that the WASH programming of UNICEF and partners in Zaatari has increased the number of households with private WASH infrastructure. This implies that the shift towards longer-term, sustainable WASH programming has been successful through the construction of a wastewater network and private infrastructure that has covered the camp comprehensively and been positively perceived by beneficiaries'.

49 https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/Seven_behaviours/UHC2030_seven_behaviours_products/UHC2030_postcard_7_behaviours_V2.pdf

Humanitarian actors should prioritise the aims of building government capacity early in the recovery process and supporting the development of good governance structures and efficient procedures adapted to the local context. This mitigates fragmentation and verticalisation of the interventions during acute crises and builds the foundations for the development of long-term social protection systems (Cometto et al., 2010).

Monitoring and evaluation (M&E) of social protection to fill critical evidence gaps

As per our findings in the literature review (Section 4), rigorous available evidence on both efficacy and cost-effectiveness of social protection programmes for health and education is scarce, especially for the health domain. Existing evidence from development contexts may not be transferable to humanitarian contexts, and there is a critical need to improve understanding of the complex interplay driving household decision-making on education investments and use of health services in emergencies, when households may choose to prioritise other expenditures. Additional research needs to be conducted by comparing the effectiveness and efficiencies of different social assistance interventions in the same setting (e.g. cash versus food in the case of education, or voucher/fee waivers versus cash for UHC). Moreover, practitioners need clear guidelines on how to develop an optimal mix of supply-side and demand-side intervention based on an accurate analysis of comparative advantages and efficiencies (WHO Health Cluster, 2018). M&E methodologies need to be standardised to maximise comparability. More attention should also be devoted to assessing heterogeneity of impacts across gender, age and other drivers of vulnerability, in order to tailor responses to differential needs of different groups. There is an encouraging growing trend to allocate specific resources to evidence generation and knowledge management even in challenging settings (Gentilini et al., 2018). Programmatic data could feed into monitoring and evaluation activities to tackle key data gaps, although there should be a system in place to ensure privacy and security. Operational research (OR) can contribute to fill the knowledge gap[50]. In health, OR can do research into strategies, interventions, instruments, tools or knowledge that can enhance the quality, coverage, effectiveness or performance of the health system or the disease programme in which the research is being conducted: this may consist of reviews of data already collected in patient registers, treatment cards or patient files, evaluations of operational practices or the implementation of new strategies and technologies. MSF has adapted it to the humanitarian action and set up the Operational Research Unit LuxOR to undertake research projects supporting humanitarian action all over the world[51]. Implementing organisations should have a clear data policy which incorporates the principles of the European data protection regulations (e.g. informed consent, right to be forgotten, right of access, right of portability, etc.), and discussions with stakeholders to maximise transparency. Involvement of data protection experts in the planning of M&E activities is critical.

50 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539036/
51 https://msf.lu/en/operational-research/luxor

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Annex 1

List of rigorous empirical studies included in the review of evidence

IMPACT OF SOCIAL PROTECTION INTERVENTION ON EDUCATION OUTCOMES								
HUMANITARIAN TYPE	**COUNTRY**	**PROGRAMME**	**MODALITIES**	**STUDIES**	**PUBLISHED**	**METHODOLOGY**	**TARGET GROUP**	**OUTCOMES**
Internally displaced population	Northern Uganda	World Food Programme's in-school feeding programme (SFP)	School feeding versus THR conditional on school attendance	Alderman, Gilligan, & Lehrer (2012)	Yes (EDCC)	Randomised Control Trial (RCT) (Difference-in-Differences, DiD)	Primary school-age children	School enrolment, school attendance, age at school entry, grade promotion, and progression to secondary school.
Conflict exposed area	Mali	World Food Programme's in-school feeding programme (SFP)	School feeding and general food distribution (GFD)	Aurino et al. (2019)	Working Paper	Quasi-experimental (DiD and Propensity Score Matching (PSM))	School-aged children	School enrolment, absenteeism and attainment
Conflict exposed area	Rural Colombia	Familias en Acción	CCT conditional on medical check-ups for children less than 7, and 80 per cent school attendance for children 7-17.	Wald and Bozzoli (2011)	Conference Paper	Natural experiment (degree of conflict exposure)	Children aged 0-17	School enrolment, grade progression
Refugees	Lebanon	No Lost Generation	UCT to households for children enrolled in an afternoon shift (Labelled but not conditional).	De Hoop et al. (2018)	Working Paper	Quasi-experimental – Regression Discontinuity Design (RDD)	Primary school children	School enrolment and attendance, household education expenditure

HUMANITARIAN TYPE	COUNTRY	PROGRAMME	MODALITIES	STUDIES	PUBLISHED	METHODOLOGY	TARGET GROUP	OUTCOMES
Natural disasters	Nicaragua	Atención a Crisis	CCT conditional on medical check-ups for children under 5, and school enrolment and regular attendance for children 7-15; CCT + scholarship for vocational training courses; CCT + lump-sum payment to start a small non-agricultural activity	Macours et al. (2012)	Yes (Applied Econ.)	RCT	Children aged 0-15	Cognitive development of children less than 6 (TVIP, Language, Short memory, Assoc. Memory, Social Personal, BPI)
Drought and food crisis	Niger	Concern Worldwide humanitarian programme	UCTs delivered via the mobile phone: One-third of targeted villages received a monthly cash transfer via a mobile money transfer system (called zap), one-third received manual cash transfers and the remaining one-third received manual cash transfers plus a mobile phone.	Aker et al. (2011)	Working Paper	RCT	Households in selected villages having produced less than 50 per cent of their consumption needs	Household education expenditure
Civil war (internally displaced population)	DRC	Concern Worldwide humanitarian programme	UCT vs. VOUCHERS of the value of the transfer about 2/3 of the total annual GDP per capita for DRC	Aker (2013)	Working Paper	RCT (no control group – voucher is the reference group)	Internally displaced households in an informal camp in the Masisi territory	Household education expenditure, school dropout (coping strategy)

HUMANITARIAN TYPE	COUNTRY	PROGRAMME	MODALITIES	STUDIES	PUBLISHED	METHODOLOGY	TARGET GROUP	OUTCOMES
Conflict-exposed area	Uganda	World Food Programme (WFP)	UCT versus take-home rations, (and control group)	Gilligan et al. (2012)	IFPRI Working Paper	RCT (early childhood development centres randomly assigned in one of three intervention arms: food, cash, or control)	Children aged 3-5	ECD participation measures (Days ECD centre was open in the past 7 days, days child attended). Cognitive and non-cognitive development indicators
Famine	Niger	World Food Programme (WFP)	First phase: Cash for work (treat 1) versus food for work (treat 2). Second phase: cash transfer (treat 1) versus food transfers (treat 2)	Hoddinott et al. (2013)	IFPRI Working Paper	RCT – only one round survey with retrospective data collection	All households in selected clusters	Household education expenditure
Syrian refugees	Lebanon	UNHCR Winter Cash Assistance Programme (International Rescue Committee)	UCT	Lehmann & Masterson (2014)	Project report	Quasi-experimental (RDD)	Syrian refugees HHDs living at high altitudes	School enrolment and attendance
Post-conflict area	Sierra Leone	Youth Employment Support Project	CCT (Cash for work)	Rosas and Sabarwal (2016)	WB Policy Research Working Paper	RCT	Youths aged 15-35 years (mean age is 27 years)	School enrolment and attendance (adolescents)
Refugees	Lebanon	Multipurpose Cash Assistance Programme	UCT	Battistin (2016)	Project report	Quasi-experimental (RDD)	Economically vulnerable Syrian households	School enrolment
Post-conflict area	Southern Sudan	Food for training and income generation (FFTIG) in Juba – WFP and BRAC	Food for training	Sulaiman (2010)	STICERD Working Paper	RCT (some evidence of contamination and non-compliance, then DiD)	Most vulnerable households (80 per cent female headed)	School enrolment (6-14)

IMPACT OF SOCIAL PROTECTION INTERVENTION ON HEALTH								
HUMANITARIAN TYPE	**COUNTRY**	**PROGRAMME**	**MODALITIES**	**STUDIES**	**PUBLISHED**	**METHODOLOGY**	**TARGET GROUP**	**OUTCOMES**
Natural disasters	Nicaragua	Atención a Crisis	CCT conditional on medical check-ups for children less than 5, and school enrolment and regular attendance for children 7-15; CCT + scholarship for vocational training courses; CCT + lump-sum payment to start a small non-agricultural activity	Macours et al. (2012)	World Bank Policy Research Working Paper	RCT	Children aged 0-15	Gross motor, fine motor, leg motor
Post-conflict	Afghanistan		CCT	Lin and Salehi (2013)	Yes (Lancet)	Quasi-experimental	Mothers and community	Maternal and child health-services: institutional delivery and DPT3 vaccination
Post-conflict	Sierra Leone	Youth Employment Support Project	CCT (Cash for work)	Rosas and Sabarwal (2016)	World Bank Policy Research Working Paper	RCT	Youth aged 15-35 years (mean age is 27 years)	Health facility visits of children 0-5

Contact information

European Commission

Directorate-General for International Cooperation and Development
Rue de la Loi 41 - B-1049 Brussels
Fax: +32 (0)2 299 64 07
E-mail: europeaid-info@ec.europa.eu

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