Multi-purpose cash assistance and health
Evaluating the effect of the Emergency Social Safety Net (ESSN) programme on access to health care for refugees in Turkey
Key messages

- Multipurpose cash transfers play a vital role in helping vulnerable (mainly Syrian) refugees to meet their basic needs in Turkey. However, they do not appear to significantly affect access to, or expenditures associated with, health service utilization.

- Care-seeking rates for both adult and child illness are high and around half of refugee households in Turkey report that they had no recent health expenditures. This finding is not unexpected since refugees in Turkey have good access to health services largely thanks to the Government of Turkey’s establishment of a social system that allows all refugees to benefit from free health services in public hospitals throughout the country.

- Health expenditures among refugees are very low relative to those reported in the two other major refugee-hosting countries in the region – Jordan and Lebanon. In Turkey average monthly household spending on health among refugee households is approximately 40–80 Lira (US$7–15) by comparison with an average of US$ 138 in Jordan and US$ 157 in Lebanon.

Background

With 3.9 million refugees and asylum seekers, Turkey is host to the largest refugee population in the world, most of whom are Syrian and are integrated into Turkish communities, primarily in Istanbul and the border provinces of Gaziantep, Hatay and Sanliurfa. The Government of Turkey (GoT) leads the refugee response, and since 2014, Syrian refugees have been recognized as having Temporary Protection which grants them legal stay, access to rights and public services including free medical care and education, and the ability to apply for work permits and social assistance. From the onset of the Syrian conflict in 2011 until the end of 2017, the GoT spent an estimated €31 billion to support the GoT with hosting refugees, including funding the Emergency Social Safety Net (ESSN) programme. Despite significant investments in humanitarian response, economic vulnerability of refugees and asylum seekers is a principal concern as approximately 15 percent live below the World Bank poverty line for upper middle income countries, as of December 2018.

ESSN is funded by the European Civil Protection and Humanitarian Aid Operations (ECHO) and implemented through a partnership of the Turkish Ministry of Family Labour and Social Services (MoFLSS), the World Food Programme (WFP) and the Turkish Red Crescent (TRC). By January 2019 the programme had provided almost €1 billion in multipurpose cash (MPC). The ESSN programme complements existing national social assistance systems and local offices and aims to assist vulnerable households in meeting basic needs including rent, food and utilities. Registered refugee households residing outside of camps with international protection...
or temporary protection status are eligible to apply. Households determined to be most in need are selected; this typically includes larger families or those with higher dependency, single-headed households, people with disabilities and other vulnerabilities. Refugees with work permits or registered assets, such as property or cars in Turkey, are not eligible to receive assistance.

From the launch of ESSN in late 2016 through to the end of August 2018, 462,117 households, with approximately 2.26 million individuals, applied and 52.5 percent of families were eligible to receive assistance. In late 2018, nearly 1.4 million people were receiving assistance, of whom 88.3 percent were Syrian, 8.3 percent Iraqi, 2.6 percent Afghan and 0.8 percent other nationalities.

ESSN provides monthly unrestricted multi-purpose cash transfers via a debit card as well as periodic “top-ups” for smaller families who do not benefit from economies of scale. Those with severely disabled household members also receive monthly top-ups. Debit cards called Kizilaykart, distributed by the majority State-owned Halkbank, can be used to obtain cash from ATMs (with no fees at State-owned banks) or to make in-shop purchases. Multipurpose Cash Transfers (MPCs) allow recipients to have choice in how they manage household priorities and spend assistance; choice in where they shop allows refugees to stretch limited budgets. Provision of assistance through MPC programmes in Turkey is part of a broader global agenda to provide more direct benefits for affected populations – The Grand Bargain. One of The Grand Bargain commitments is to increase the proportion of humanitarian assistance delivered as cash, as opposed to in-kind, to a target of 25 percent of all humanitarian assistance by 2020.

**Study rationale**

MPC assistance is widespread in the Syria regional response and ongoing discussions in the humanitarian community are centred around how to better understand and document the impacts of it, particularly sector-specific benefits that may result from MPCs. In the health sector, there is evidence of the positive impact of cash-based approaches on use of health services in non-crisis contexts, but the link has not been adequately researched in emergency settings. Systematic reviews of cash transfers in humanitarian crises reveal little evidence as to how cash-based approaches affect health outcomes, though there is conclusive evidence of their benefits with respect to alleviating food insecurity during crises.

Efforts to address this gap are underway in Jordan and Lebanon where Johns Hopkins School of Public Health (JHSPH) is working in collaboration with the UN Refugee Agency and other partners to assess the health-related outcomes of multipurpose cash transfers. This study leverages available data from Turkey and provides analysis to build the evidence base on the outcomes of MPC programming in the Syria regional response. The study aims to contribute to the development of a better understanding of how cash transfers can affect health outcomes (expenditures, care-seeking behaviour, health service utilization, etc.) among refugees by comparing recipients of multipurpose cash with non-recipients, and analyzing changes in health expenditures over time.

**Methodology**

The analysis included data collected by WFP between 2017 and 2019 on refugees in Turkey. Two independent data sources were used. The first, the Comprehensive Vulnerability Monitoring Exercise (CVME), is a cross-sectional survey of refugees that was implemented four times over the two-year period. The CVME collects data from ESSN applicant households (both eligible and ineligible households) as well as non-applicant households.

The second data source was longitudinal data from ESSN applicant households collected during the Pre-Assistance Baseline (PAB) and six subsequent rounds of Post-Distribution Monitoring (PDM). The PAB and PDM include data from a random sample of ESSN applicant households only.

The CVME is intended to provide an in-depth understanding of vulnerability and unmet needs among refugees in Turkey; it is used
to assess the effects of the ESSN programme by comparing the vulnerability of ESSN beneficiaries to ineligible refugee households and non-applicants. The PAB and PDM are used to characterize the effects of ESSN assistance on beneficiary households over time.\textsuperscript{15}

CVME surveys include between 600 to 1,300 households in each round.\textsuperscript{16} The PAB includes 8,690 households of which 91 percent completed at least one subsequent survey (PDM). The PAB/PDM analysis includes both 1) longitudinal analysis of PAB and PDM rounds 1, 2, 4 and 6 which are panel data, where households that participated in the PAB were followed over time; and 2) a combined analysis of PDM rounds 5 and 6 to enable focus on the most recent data (late 2018) and inclusion of newer beneficiaries.

CVME and PDM data were analysed separately with CVME using indicators related to care-seeking behaviour and PDM to health expenditure. In both cases, descriptive statistics were generated for all rounds, and an analysis plan was developed after examining completeness, quality and descriptive statistics that were best suited to the available data and health outcomes being assessed.

In cases where the sample was not representative of the population, weighting was used to make results from the different datasets more comparable. Expenditure data was log transformed in regression models due to the skewed distribution. Multivariate linear and logistic regression were used to assess factors that influenced health outcomes in both datasets to characterize the effects of MPCs on health outcomes.

**Findings**

After adjusting for household demographic and socioeconomic characteristics, there were no statistically significant differences in health expenditures between non-applicants, ineligible applicants and beneficiaries based on CVME regression analysis. Certain demographic groups of households spent less on healthcare than others. For instance Syrian households had lower expenditure than non Syrian. Households with no pregnant or lactating women and those without disabled members also had lower expenditure, as did smaller households (< four members) and those with with lower non healthcare spending.

The effect of employing livelihood coping strategies on health expenditure varied by round. However, while these factors were found to be significantly associated with health expenditure, given the low (and often non-existent) health expenditures reported

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**Key findings related to health expenditure**

- Fewer than half of households reported no health expenditures in the preceding six months, and mean expenditures across beneficiary groups and CVME survey rounds were low. In the preceding month’s PAB/PDM rounds they ranged from 50-69 TL (US$ 9-12).

- For both studies a minority of households had high health expenditures.

- After adjustment, increased health expenditures were not associated with receipt of MPCs; some household sociodemographic characteristics were significantly associated with higher or lower health expenditure, but differences were generally of small magnitude and therefore of limited public health importance.

- Beneficiaries were often less likely to reduce essential expenditures or borrow compared to non-beneficiaries; differences were not always significant.

- Household health expenditures and the need to reduce essential expenditures to meet basic needs both decreased over time among beneficiaries and non-beneficiaries, which is suggestive of an improving situation.
overall, the differences were generally of small magnitude and therefore may be of limited public health importance.

In addition to total health expenditure, both health expenditure as a proportion of total household expenditure as well as borrowing to pay for health care costs were evaluated. Health expenses comprised less than 1.5 percent of total household expenses across all groups and CVME survey rounds. Findings in the PDM rounds confirmed those of the CVME rounds – that spending on health represented a low proportion of total household expenditure. Beneficiary households spent a significantly lower proportion of total expenditures on health compared to non-beneficiary households (6.5 percent vs. 8 percent) and non-beneficiaries were significantly more likely to borrow to pay for basic needs, including health care costs, than beneficiaries (17 percent vs 13 percent). In PDMs, 23-41 percent of households reported reducing essential expenditures, including health, with a gradual decline over time; beneficiaries were generally less likely to reduce essential expenditures than non-beneficiaries, however, differences between groups were not always statistically significant.

Longitudinal analysis of the PAB/PDM data allowed for evaluation of the average effect

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### Household and health expenditure data

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Mean household expenditure over preceding six months (CVME)</td>
<td>245 TL – 604 TL (US$42–US$105)</td>
</tr>
<tr>
<td>Median household expenditure over preceding six months (CVME)</td>
<td>20 TL -200 TL (US$3.5–USD35)</td>
</tr>
<tr>
<td>Percentage of households with no health expenses in preceding six months (CVME)</td>
<td>24%–46%</td>
</tr>
<tr>
<td>Mean health expenditure for beneficiaries and non beneficiaries in previous month (PAB/PDM)</td>
<td>50 TL–85 TL (US$9–US$15)</td>
</tr>
<tr>
<td>Median health expenditure for beneficiaries and non beneficiaries in previous month (PAB/PDM)</td>
<td>0 TL</td>
</tr>
<tr>
<td>Monthly mean household health expenditures for non beneficiaries and beneficiaries (PDM 5&amp;6) (difference not significant)</td>
<td>73 TL (US$12.7) vs. 54 TL (US$9.4)</td>
</tr>
<tr>
<td>Percentage of beneficiaries reporting no health expenditures in the preceding six months (PDM)</td>
<td>61%</td>
</tr>
<tr>
<td>Percentage of non-beneficiaries reporting no health expenditures in the preceding six months (PDM)</td>
<td>63%</td>
</tr>
<tr>
<td>Proportion of total spend on health (beneficiary households)</td>
<td>6.5%</td>
</tr>
<tr>
<td>Proportion of total spend on health (non beneficiary households)</td>
<td>8%</td>
</tr>
<tr>
<td>Proportion of households that borrowed money to pay for basic needs including health (beneficiary)</td>
<td>13%</td>
</tr>
<tr>
<td>Proportion of households that borrowed money to pay for basic needs including health (non beneficiary)</td>
<td>17%</td>
</tr>
<tr>
<td>Proportion of households that reported reducing essential expenditures (including health) over time (PDM)</td>
<td>23-41%</td>
</tr>
</tbody>
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### Key findings related to care-seeking

- After adjustment, odds of care-seeking were not associated with receipt of MPCs; as with health expenditure, some household sociodemographic characteristics were significantly associated with care-seeking, but differences were generally of small magnitude.

- Care-seeking rates were high for both adult and child illness with 76-92% of households reporting that care was received for all ill adults and 70-95% reporting it was received for sick children. In many cases, beneficiaries had higher care-seeking rates than non-beneficiaries, but differences were not always statistically significant.

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of assistance over time for a given household receiving assistance over the course of approximately two years. Together the models provide evidence of significant reductions in both health expenditure and odds of reducing
expenditure on other basic needs to cover health among both beneficiaries and non-eligible households.

With respect to health expenditure, analysis suggests that at baseline (PAB), health expenditures were lower but not significantly different between beneficiaries (147 TL) and non-eligible households (202 TL). Over the course of the follow-up period, the average reduction in expenditure was greater (80 percent decline) among non-beneficiaries than beneficiaries (72 percent decline), a significant difference (p<0.001). By contrast, at baseline, the odds of reporting reduced expenditure to cover health expenses was significantly higher among beneficiaries (0.71) than non-eligible households (0.59). Odds were reduced in both groups such that by PDM 6, both groups had lower and not significantly different odds of reduced expenditure (0.30 and 0.33 for beneficiaries and non-applicants, respectively).

CVME surveys also collected data on illness in the preceding month for adult and child household members. Overall, care-seeking rates were high for both adult and child illness with 76-92 percent of households reporting that care was received for all ill adults and 70-95 percent reporting that care was received for children. Government health facilities were the most common sources of care, and were used by 70-95 percent of households. Non-applicant households typically had the lowest care-seeking rates for both children and adults. This is consistent with the observation that government registration, a prerequisite for access to the national health system, was lower among non-applicants than applicants. However, after adjusting for demographic and socioeconomic factors, differences in care-seeking by beneficiary status were found to be non-significant in most rounds.

Increased odds of care-seeking were associated with smaller household size, presence of one or more elderly person, and absence of a child under five. The relationship between education and care-seeking was inconsistent across rounds. However, given high health-seeking behaviours, differences were significant but small in magnitude. The combined findings from analysis of CVME and ESSN PAB and PDM data are well aligned with the favourable

health access conditions for refugees in Turkey resulting from free access to care and good coverage of health services via the national health system. Care-seeking rates for both adult and child illness were high and there were no statistically significant differences in odds of care-seeking between ESSN beneficiaries and non-beneficiaries. There were few statistically significant differences in health expenditures between ESSN beneficiaries and non-beneficiaries and no consistent patterns of higher or lower expenditures by beneficiary status. However, longitudinal analysis of PDM data showed decreasing health expenditures over time.
Conclusions and recommendations

This study leveraged available data from Turkey with the aim of providing analysis to expand the evidence base on outcomes of MPC programming in the Syria regional response. Findings from analysis of CVME and ESSN PAB and PDM data are well aligned with the favourable health access conditions described in other sources. Only the CVME has data on health service utilization and care-seeking; rates for both adult and child illness were high. In regression models, odds of care-seeking were lower for non-applicants and ineligible households than for beneficiaries. However these differences were primarily explained by differences in government registration, demographics and socioeconomic status such that after adjusting for other covariates differences were generally not statistically significant. Nearly all households reported care-seeking at government health facilities, which helps explain the low health expenditures observed.

In the most recent assessments, large proportions of households reported no health expenditures. Mean health expenditures reported in all rounds of CVME and PDM surveys were relatively low. There were few statistically significant differences in health expenditures between ESSN beneficiaries and non-beneficiaries and no consistent pattern of higher or lower expenditures by beneficiary status. In regression models for health expenditures using CVME data, there were no significant differences in health expenditures between ESSN beneficiaries, those who were ineligible and non-applicants. In longitudinal models using PDM data, health expenditures and the need to reduce essential expenditures (including health) to meet basic needs decreased over time but it is difficult to assess if this is a trend or the result of changes in the sampling methodology. Assessment of high expenditure households, including household composition, health needs, and care-seeking practices (i.e. use of public or private sector facilities) could give more insights on how to better support health needs among this segment of the population.

Of note, households with member(s) that had a disabled or chronically ill member were significantly less likely to report having no health expenditures and more likely to report borrowing to meet basic needs. ESSN beneficiary households with a disabled or chronically ill member also had significantly higher mean health expenditures than non-beneficiary households (80 TL vs 54TL).

The Government of Turkey should be commended for its progressive policies, which grant refugees legal stay and access to public services, including free medical care and education, along with the ability to apply for work permits and social assistance. The establishment of Migrant and Refugee Health Centres, which are concentrated in areas with large refugee populations, have helped to reduce the potential strain of additional people on the health system and also provide refugees with access to translators and other professionals (such as Syrian doctors and nurses) to meet their specific needs.

In this environment, where the refugee population does not face financial barriers to health care, it is not surprising that receipt of MPCs had little impact on health service utilization or household health expenditures. This is in notable contrast to other contexts, such as Jordan and Lebanon, where Syrian refugees have sizeable out of pocket payments to access health care. Refugee household expenditures on health in the month before the survey average US$138 a month in Jordan and US$157 in Lebanon.

In settings where financial constraints limit access to care, MPCs may have a greater impact on care-seeking and health spending, while in the Turkish context they do not appear to significantly affect access to or expenditures associated with health service utilization –
although they are critical for helping to meet the basic needs of refugee populations.

Research on the impact of MPCs on health service utilization and expenditures for Syrian refugees in Jordan and Lebanon is ongoing, with results anticipated to be available in late 2019. Results for this research, along with findings from Jordan and Lebanon, will be further synthesized into a regional analysis that examines both associations with national health policies for refugees and MPCs on health service utilization and expenditures.

Acknowledgements

This brief was prepared by Shannon Doocy and Eva Leidman, of the Johns Hopkins University Center for Humanitarian Health and summarizes findings presented in the July 2019 report, Multi-Purpose Cash Assistance and Health: An Analysis of the Emergency Social Safety Net (ESSN) Program for Refugees in Turkey. Inquiries can be directed to Shannon Doocy (docoy1@jhu.edu) or Aysha Twose (aysha.twose@wfp.org).

References


