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World Health Organization

Guidance note on the role of Cash and Voucher Assistance to reduce financial barriers in the response to the COVID-19 pandemic, in countries targeted by the Global Humanitarian Response Plan COVID-19

WHO and Global Health Cluster
Cash Task Team
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Key messages and response options:

The response to COVID-19, including treatment of patients, is a Common Good for Health. When COVID-19 is declared a national emergency, governments should consider suspending user fees for essential health services by all providers for the duration of the crisis.

- *To compensate the loss of revenues, governments should establish a system through front-loading budgets and pre-funding public and private providers, or through contracting and reimbursements mechanisms, including health emergency equity funds or voucher systems.*

In practice, it is likely that patients will still have formal or informal expenditures related to COVID-19 treatment or for essential health services, be it in a health facility or at home, or related to indirect costs. The increased health needs coupled with the general trend of income loss due to lockdown measures can lead to increased financial barriers.

- *The measure above can be complemented through targeted cash or voucher assistance to such households for specific health care costs.*
- *Multi-purpose cash transfers to meet basic needs for vulnerable households that have lost income due to lockdown measures, or because they are quarantined and/or otherwise caring for a sick household member, will improve their ability to access health services.*

To prevent transmission by suppliers and among staff that continue to work in vital sectors, including the delivery of humanitarian goods and CVA, or from staff to clients and beneficiaries, they are all expected to implement the basic preventive measures to reduce the risk of transmission.

- *Ensure that clients or beneficiaries can access items safely, and are not put at risk, for example, by ensuring that markets respect basic risk mitigation protocols.*
- *Where feasible use mobile or electronic contact less payments.*
- *The contact surfaces of ATM machines should be regularly disinfected and ensure that users keep 1.5 meter distance between them.*

Introduction

As the COVID-19 pandemic is still unfolding, most countries have started introducing measures to cope with the increased case load of severe COVID-19 patients while maintaining core health services and implementing measures to control the transmission of the virus. Partners involved in Cash and Voucher Assistance (CVA) in humanitarian contexts have also started exploring what role CVA could play to address the economic impact and income loss. The health partners need to consider that the impact of the increased health needs coupled with the general trend of income loss can lead to increased financial barriers.

Given the differences between countries affected and their pre-existing systems in place to provide financial protection for health services, this paper provides general guidance on identifying financial barriers, and considering supply side financing options and complementary CVA within the broader response interventions to the pandemic, based on the, 'Working paper for considering Cash Transfer Programming for Health in Humanitarian Contexts'. For other guidance on the COVID-19 pandemic, see the WHO webpages.

The target audience for this paper include those involved in national planning for the epidemic response and maintaining essential health services during the COVID-19 epidemic, particularly in the countries targeted by the Global Humanitarian Response Plan for COVID-19, health cluster coordinators, national Inter Cluster Coordination Groups, Cash Working Groups, health practitioners, program managers, and cash focal points.

Most countries affected by this epidemic have declared this epidemic to be a national crisis. The response, including treatment of COVID-19 patients, is considered a Common Good for Health and should thus be of no cost to patients or populations at risk. The combination of the increased health needs related to the epidemic, combined with the public health measures to mitigate or contain the epidemic will lead to significant disruption in production, and reduced access to goods and services. Moreover, the economic impact and subsequent loss of income will push households into further vulnerability and reduce their ability to meet their basic needs, including health care related costs.

Acknowledging the financial barriers imposed by user fees in any emergency context, there is consensus that essential health services during a humanitarian crisis should be provided free of charge at the point of delivery. Governments should consider suspending user fees for essential health services from all health service providers during the COVID-19 emergency and anticipate compensating providers for the loss of revenue.

The reality is that often people still have direct and indirect healthcare expenditures. This paper will explore different options to address these, and where to consider CVA options. The paper will also give general guidance to other sectors on how to apply epidemic mitigation measures while maintaining critical functions, to ensure access to essential goods and services, and the potential role that role multi-purpose cash assistance (MPC) can have.

The humanitarian community implemented CVA during the Ebola response, but lessons learned require adaptation to the characteristics of this COVID-19 epidemic and the public health measures taken to mitigate or contain it. See the CaLP link for additional resources.

1. **Response to COVID-19, including treatment of patients is a Common Good for Health, and should therefore be financed with public funding.**

Preventive interventions and treatment for any epidemic disease should be free of charge for those targeted and at the point of delivery, financed from public funds. Health prevention and promotion interventions, and other public health functions such as preparedness and response to epidemics, cannot be assured through demand side financing. When treatment centres are established for the severely ill COVID-19 patients, this treatment should be paid by government and/or subsidized with external donor funding.

When the severe COVID-19 caseload starts exceeding the capacity of the public health facilities, governments will consider expanding this through non-governmental, private for profit, faith-based, military or other health service providers. Those that relied on user fees will need to be compensated when these are to be suspended. *The preferable option is that the government establishes a system through front-loading budgets and pre-funding/paying public and private providers or through contracting and reimbursements*. At the same time, they need to ensure that health facilities are adequately prepared, trained and equipped to address COVID-19 and essential health services in ways that are safe for staff and patients. This often involves additional direct support to strengthen existing capacities: supply of quality medicines and equipment, incentives to health workers and in-service training, supervision of quality and managerial support, and extra capacity such as laboratories.

In practice, it is likely that patients will still have formal or informal expenditures related to COVID-19 treatment, be it in a health facility or at home. For instance, in countries that had smaller scale epidemics requiring hospitalization, isolation and specialized treatment, patients received the medication for free but were charged for other admission costs, still leading to catastrophic expenditures.

Health expenditures can also be related to indirect costs, such as non-medical hospitalization costs, transport or costs for a caretaker who accompanies the patient. Asking families to care for COVID-19 patients at home will lead to income loss. *These can be compensated through targeted cash assistance to such households, either to allow them to pay for specific health care costs, and/or income support to meet their basic needs.*

When the health workforce capacity is scaled up for the response, or when incentives need to be paid for staff to work in COVID-19 treatment centres, digital or mobile payment platforms that are often put in place for multi-purpose and/or social cash transfers *can also be used for such payment*, as done during the Ebola epidemic in West Africa.

2. **Maintaining core health services during a COVID-19 epidemic; suspending user fee practices for the duration of the crisis.**

When the COVID-19 is declared a national emergency, governments should consider suspending user fees by all providers. Any form of co-payment is associated with barriers for seeking access to essential health services and put households at risk for catastrophic health expenditures. In a crisis such as the current COVID-19 epidemic, whereby the measures to control the epidemic have a high economic impact and many households lose income, these financial barriers are exacerbated by the subsequent inability to pay.

Financing options to anticipate and/or compensate the loss of revenue and cope with increased expenditures include front-loading budgets and pre-fund/pay public and private providers. This can also be done through contracting and reimbursement mechanisms, including health emergency equity funds or voucher systems. These can be complemented by targeted cash assistance to patients and caretakers for indirect health care related costs.

While a policy for suspending user fees is often put in force by governments in large scale crises, with assistance from the international humanitarian donor community and partners that support service delivery during the emergency, measures to compensate loss of revenue are often inadequate or not implemented. The willingness of service providers not to charge the patient will depend on their trust in the government to compensate them for the loss of revenue. If this is not done prior to or soon enough after the introduction of the fee suspension policy, providers will start charging patients again when they rely on these for their income.

Furthermore, as seen in many other humanitarian contexts and countries that have a policy for free access to a minimum package of health services but with a high proportion of the total health expenditures through private out of pocket payments, MoH health facilities often face shortages of medicines and/or medical supplies, which results in patients having to buy medicines elsewhere. Addressing such underlying health system development challenges with supply side financing solutions during a crisis is often not realistic.

While this should not be promoted as a longer-term solution to finance access to health services, multi-purpose cash transfers (MPC) to meet basic needs for vulnerable households that have lost income due to the lockdown measures, or because they are quarantined and/or otherwise caring for a sick household member, will improve their ability to access health services. These could be one-off or multiple for the duration of the epidemic and the lockdown measures. However, additional measures will have to be put in place to reduce catastrophic health expenditures, often related to admission.

MPC should not inadvertently contribute to a fee-charging culture for priority services, which would undermine progress towards universal health coverage to improve patient financial protection by minimizing reliance on out-of-pocket cash payments at the point of service use. Furthermore, in countries with fragile settings and humanitarian contexts, patients may obtain poor quality services or medicines from unregulated providers.

3. Public health measures to mitigate or contain the COVID-19 epidemic in a country

People can catch COVID-19 from others who have the virus. The disease can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID-19 coughs or exhales. These droplets land on objects and surfaces around the person. Other people then catch COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth. People can also catch COVID-19 if they breathe in droplets from a person with COVID-19 who coughs out or exhales droplets.

All countries affected by COVID-19 have promoted public health messages to slow or stop the spread of the virus include regular handwashing, physical distancing (1.5 metre), avoid touching eyes, nose and mouth, following good respiratory hygiene and staying home if you

feel unwell. (but seek medical attention with more severe symptoms and for other illnesses). While additional measures to mitigate or contain the epidemic differ between countries, they generally include restricting flights and the movement of people, closing of businesses in the non-vital sectors, working from home when possible, closing schools, disinfecting commonly used surfaces, and no gatherings (including restriction on who can attend funerals and weddings).

Experience so far has shown that these measures can be effective in flattening the epidemic curve, or even containing the epidemic. What is less clear is when such measures can be lifted or how, depending the strategy that was chosen.

For the measures that require households to purchase products such as for disinfecting surfaces and hand hygiene, governments should consider either providing these in-kind to the most vulnerable households or subsidizing these through pre-selected suppliers with vouchers. Targeting criteria will have to be put in place, particularly to those who are quarantined and do not have the means of accessing these items.

4. Effects of the epidemic and implication of the public health measures on other sectors

While we are still learning about how COVID-2019 affects people, older persons and persons with pre-existing medical conditions (such as high blood pressure, heart disease, lung disease, cancer or diabetes) appear to develop serious illness more often than others. It is not yet clear how it will affect people with HIV and children with acute malnutrition.

As people within the economic productive age groups (the working age population) are likely to have an asymptomatic or milder form of the disease, it is not the disease itself but the public health measures to control the epidemic that have significant impact on other sectors

5.1 Effects on sectors and business closures for the duration of the epidemic

The different forms of lockdown lead to closure of all non-essential businesses, shops and services, including for instance schools, and service industries. People working in such businesses are likely to lose either partial or total income. Additionally, when people with respiratory tract infections and their families are asked to go in quarantine, they also become at risk of losing income. Many countries do not have much fiscal capacity to implement measures that will prevent small or larger businesses to go bankrupt, or adequate social safety nets to provide temporary income support to affected households. In such cases, there will be a strong incentive for people to continue working despite the restrictions. When jobs are lost in the cities, people may also move to relatives in the rural areas, thus contributing to the spread of the disease.

These new needs can be predicted and anticipated, including analysis of which households would be most vulnerable. *In countries where humanitarian multi-purpose cash assistance programming exists, extending the MPC programs to these households should be considered. For example, one-off MPC to families with COVID-19 patients or those in self-quarantine, and/or monthly MPC transfers to vulnerable households that lost income due to the lockdown.*

5.2 Effect of the public health measures on vulnerable households

The effect of these measures will be felt greatly by households that are already vulnerable, including the refugee and IDP communities, where many families rely on cash income from various informal sources including labour employment outside camps. These communities will not have the means to prepare or stock up before the lockdowns. This is particularly important to consider in areas where market access is already a challenge. The loss of livelihoods will exacerbate these households' economic vulnerability.

5.3 Effects on vital sectors and businesses that remain open during the epidemic

Most countries defined their vital services that need to remain open, including, pharmacies and medical health facilities, banking, power and water supply. Support services that are needed for these businesses or services to remain functional are included, such as transportation. The provision of food, grocery stores and other basic needs are always included in this category, as well as the entire supply chain. See the link for further information on the COVID-19 impact on food and agriculture.

To prevent transmission among staff that continues to work, or from staff to clients and customers, they are all expected to implement the basic preventive measure (see link): physical distance, hand hygiene, and staying home if symptoms are present. In shops, this translates to only allowing a limited number of clients in at the same time and ensuring that people queuing outside maintain at least 1.5 meter distance from each other. Furthermore, other measures can include disinfecting handles of shopping carts, and other surfaces regularly touched by staff and clients. Staff that need to be in contact with clients need personal protection equipment (PPE), and if possible a transparent physical barrier between them and the clients.

While in open markets the stalls that sell non-essential items can be closed, there will be challenges enforcing the basic preventive measures. Larger ones would require support for enforcement of crowd control to maintain physical distance. Public transport in many countries usually remains functional so workers can go to work, but initial experiences indicate that keeping a distance is often not feasible.

5.4 Public health measures applied in the delivery of humanitarian goods and cash.

As for the businesses and essential societal services that remain functional, the same preventive measures that reduce risk for COVID-19 transmission should be applied when delivering humanitarian assistance, such as at distributions of goods, services and/or CVA; physical distancing, limiting contact, hand washing before and after receiving the transfer.

During the design of a CVA response, distributions will have to be organized and implemented in new ways, to reduce crowding and enforce distancing. For staff in more close contact with beneficiaries, consider a transparent barrier between the persons behind the registration desk, and regularly disinfect contact surfaces and pens. Communication with communities is also essential before distribution to reduce crowds and inform the community of the targets and the criteria – as well as distribution times and regulations. Informational sessions on

adherence to the distancing for crowd control may also be required, before and during the distribution, particularly in some situations when people may fear shortages. See for more details the WFP guidance for cash-based transfers in the context of the COVID-19 outbreak.

Furthermore, as people with symptoms pose the highest risk for transmission, beneficiaries coming to the distribution can be screened for increased temperatures (using contactless thermometers) and Respiratory Tract Infection symptoms and guided to a separate delivery point with more strict measures. In addition, *measures can be implemented for people with symptoms to have an alternate collect the assistance on their behalf*, so they can stay home.

5.5 Safe use of cash and ATMs, and the role mobile/electronic contact-less payments to reduce risk of transmission

As mentioned above, the main transmission for COVID-19 is through close exposure to respiratory droplets. It is not certain how long the virus that causes COVID-19 survives on surfaces, but it seems to behave like other coronaviruses. Studies suggest that coronaviruses (including preliminary information on the COVID-19 virus) may persist on surfaces for a few hours or up to several days. This may vary under different conditions (e.g. type of surface, temperature or humidity of the environment). Surfaces regularly touched by beneficiaries or clients should be regularly cleaned with a simple disinfectant.

Where this is possible, contact-less electronic or mobile payments should be the preferred option to reduce the risk of transmission. Where this is not possible, those handling cash should adhere to the basic preventive measures as stated above; regular handwashing and avoid touching of the mouth, nose, or eyes when having been in contact with any surface that can potentially be contaminated.

Additionally, these measures should also extend to *ATM machines or other forms of cash exchange/withdrawal, including maintaining 1.5 meter between users, and the surface of the machines/counters should be regularly disinfected.*