

Co-hosts:



Speakers:



Welcome to the Webinar!

Cash and Voucher assistance (CVA) for Health outcomes

2 April 2020

CVA for Health outcomes

Agenda:

1. Introduction
2. Key messages on CVA for the health sector in humanitarian crises and epidemics, *by the Global Health Cluster Cash Task Team*
3. Sexual and Reproductive Health in Humanitarian emergencies, *by KIT*
4. Cash for Health in Humanitarian Settings: Household Health Needs, Spending, and the Burden of Health Care Costs, *by IRC*
5. Deciding to use CVA for health outcomes: process from Ecuador, *by CARE*
6. Questions & Answers

CVA for Health outcomes

Speakers



Speaker/Host

**Andre
Griekspoor**

*Global Health
Cluster, Senior
Health Policy
Advisor*



Speaker

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Speaker

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Speaker

**Holly Welcome
Radice**

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Moderator

Alice Golay

*CaLP Senior
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CVA for Health outcomes

Ground rules



- Webinar to last 90 minutes.



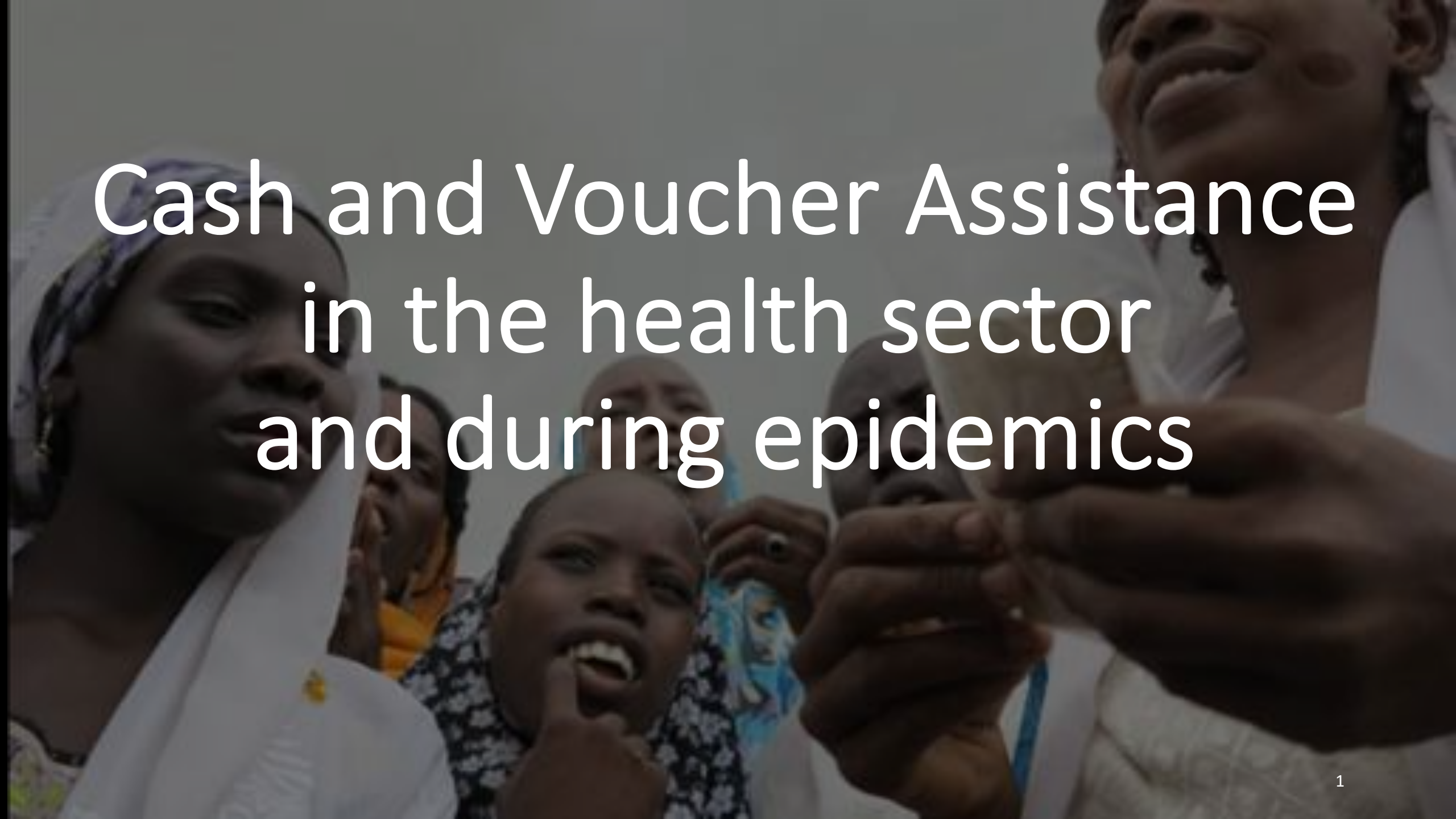
- Mute your microphone please.



- Use chat throughout the webinar for questions.



- Webinar will be recorded & recording shared.

A group of people, including a woman in a white headscarf and a man in a white shirt, looking upwards with expressions of hope or anticipation. The background is a soft, out-of-focus light blue.

Cash and Voucher Assistance in the health sector and during epidemics

*Essential health services
during humanitarian crises
should be free of charge
at the point of delivery*

*GHC position paper on user fees, 2010
Health financing in fragile settings, 2019*

- Reduce reliance on user fees, as these always lead to barriers for accessing health services
- Protection against catastrophic health expenditures
- But often people still have direct and indirect healthcare expenditures

Adapt CVA to characteristics of the health sector



TARGETING:
RISKS VS AVERAGE
NEED



TRANSFER VALUE
AND FREQUENCY



QUALITY OF HEALTH
SERVICES AND
MEDICINES
PURCHASED



ENSURE SUPPLY OF
DRUGS AT HEALTH
FACILITIES



OFTEN LOW
DEMAND FOR
PREVENTIVE CARE



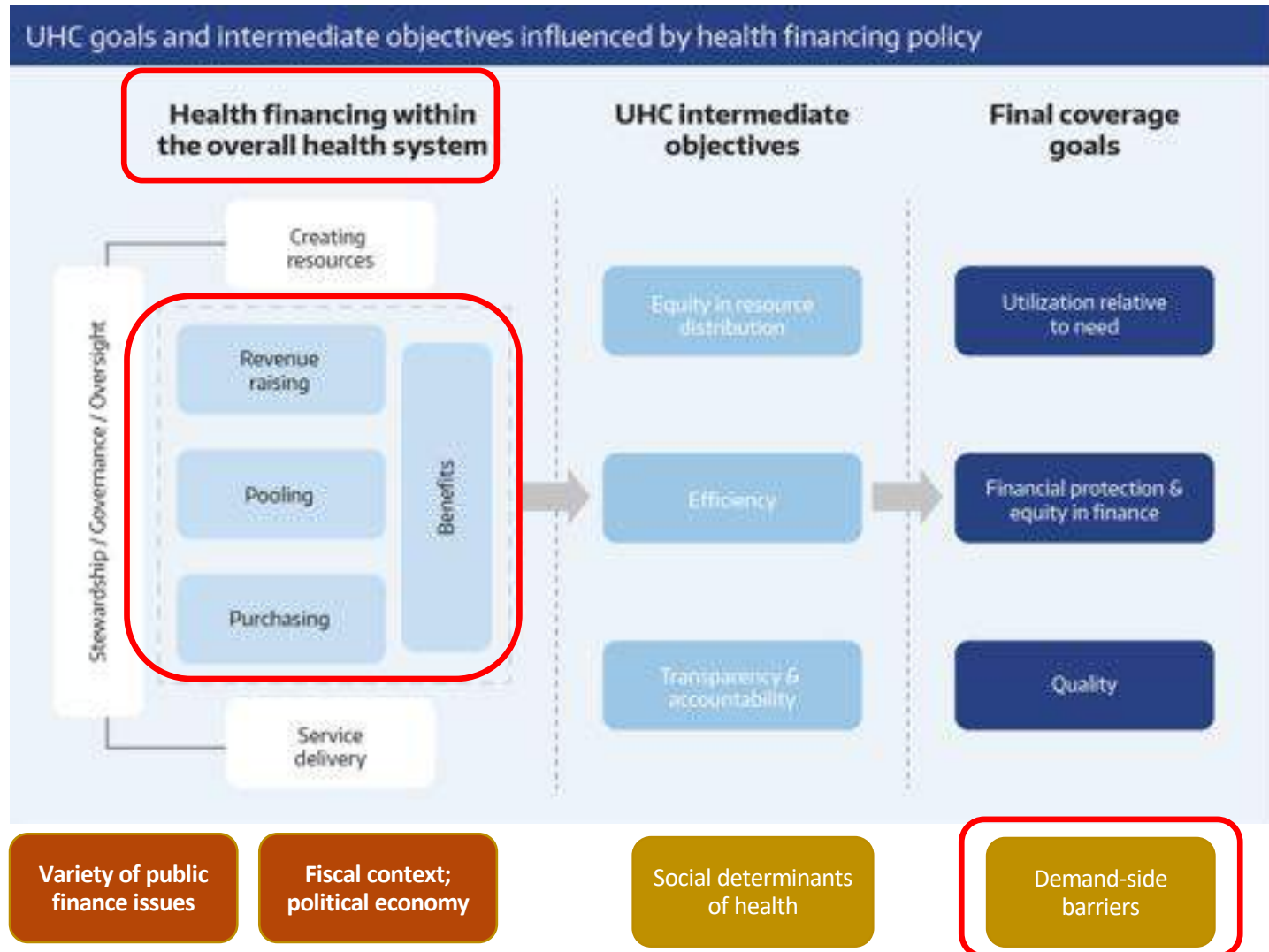
COMMON
GOODS FOR
HEALTH

CVA within Health financing for UHC

**HEAVILY
DRIVEN BY
SUPPLY SIDE
THINKING**

ASSUMPTION THAT
BY IMPROVING
QUANTITY AND
QUALITY OF SUPPLY,
AND REDUCING
“PRICE” AT THE
POINT OF SERVICE
USE, UNMET HEALTH
NEEDS WILL BE
REDUCED.

BROADLY THIS
APPROACH HOLDS
TRUE; BUT NOT
ALWAYS AND ALONE
IS NOT ENOUGH.

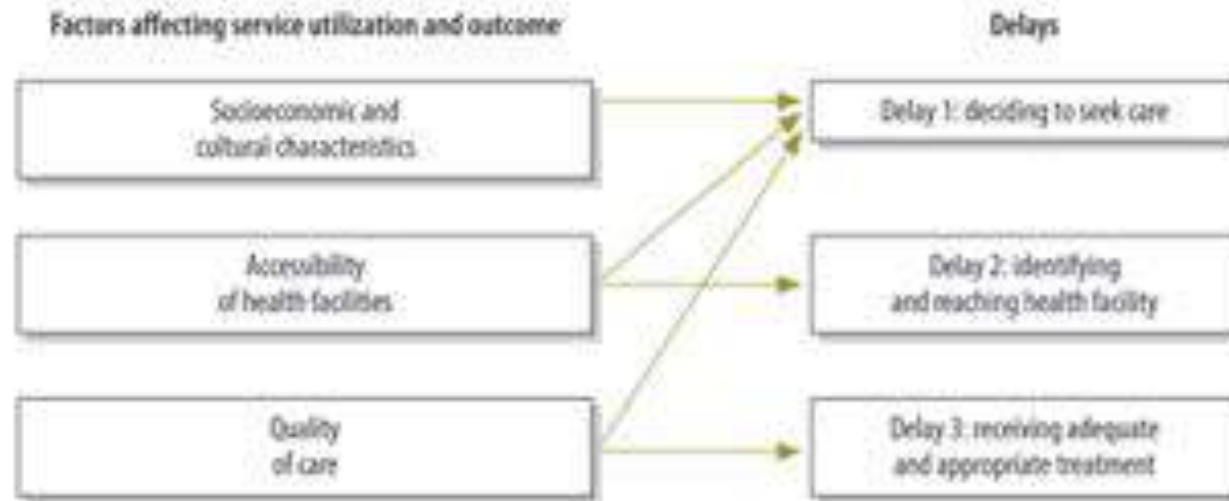


Various demand-side barriers exist

3-Delays model

developed in the context of maternal mortality and emergency care; has broader relevance.

Coverage is **ineffective** when beneficiaries do not receive needed services/products even when legally entitled.



SOCIO CULTURAL

(attitudes to health/treatment seeking behaviour)

COST

(time & money, direct and indirect, opportunity cost)

KNOWLEDGE

(poor understanding of entitlements; education, unclear/complex benefits)

Need to understand the main demand-side barriers and underlying causes

<https://www.who.int/bulletin/volumes/93/6/14-146571/en/>

GHC Cash Task Team Working Paper on CVA for health in emergencies (March 2018)

- CVA can be useful **to improve access to and utilisation of health services**, by reducing direct and indirect financial barriers, and/or incentivise utilisation
- When **health services are available with adequate capacity and quality but user fees are applied**, the **preferred response option is through provider payment mechanisms**, with **CVA to be considered complementary** to such supply side health financing strategies, **and not aim to replace these**.
- **CVA to purchase health services** should in principle be targeted to patients when they need to use a priority service, **the amount of the transfer** should cover to the **direct and indirect costs of seeking treatment**, and **only be obtained from pre-selected providers that meet minimum standards for effectiveness and quality**.

Multi-purpose cash transfers to meet basic needs for vulnerable households does improve their ability to access health services

But MPC should not inadvertently contribute to a fee-charging culture for priority services

- Reasons to engage with MPC assistance and CWGs:
 - Household surveys always indicate that they use a proportion of the MPC for health
 - Though no effect on catastrophic expenditures
 - Household surveys for Basic Needs Assessment (that also look at health needs, health seeking behaviour, barriers and health expenditures)
 - Reflect health expenditures in MEB
 - Use results from Post Distribution Monitoring (proportion of MPG used for health, changes in negative coping mechanisms for health, etc)

CVA and the COVID-19 pandemic

Response to COVID-19, including treatment of patients, is a Common Good for Health, and should be free of charge

When the 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

- Financing options to compensate the loss of revenue and cope with increased expenditures include front-loading budgets and pre-funding public and private providers.
- Or through contracting and reimbursement mechanisms, including health emergency equity funds or voucher systems.
- Complemented by targeted cash assistance to patients and caretakers for indirect health care related costs
- 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. 8

To prevent transmission in programs and among staff that continue to work in vital sectors, or from staff to clients and beneficiaries, they are all expected to implement the basic preventive measures:

*Physical distancing
Hand hygiene
PPE and IPC for staff
Disinfecting surfaces
Stay at home with mild COVID-19 symptoms*

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

- If assistance is provided through cash or vouchers, organisations should ensure that beneficiaries can access basic items safely, and not putting them or their staff at further risk.
- Where feasible use mobile, or electronic contact less payments, to reduce the risk of transmission.
- Surface of ATM machines should be regularly disinfected, 1.5 meter distance between users.
- Sensitization of both clients (beneficiaries) and financial service providers on safe transaction measures
- Vouchers for disinfectants, soap?

Evidence on CVA for health from development contexts cannot always be extrapolated to humanitarian contexts.

As there is very little evidence for the use of CVA in humanitarian settings, we need to promote research and start documenting current practice for learning.

- Evidence from development settings on CVA and health indicates that it does add value
- Initial evidence on CVA and health in humanitarian settings indicates it can be done
- Have CVA consistently considered in health strategies in HRPs
- Develop more practical guidance
- Collect case studies
- Managing risks

Thank you for your
attention!

Any questions?

Annex 1 to consider selecting preferred financing options, including cash transfer modalities for health, based on the comparative advantages

1. Subsidised coverage under national health insurance
2. Purchasing prioritised services through contracting, possible health emergency pooled fund

If not (yet) possible:

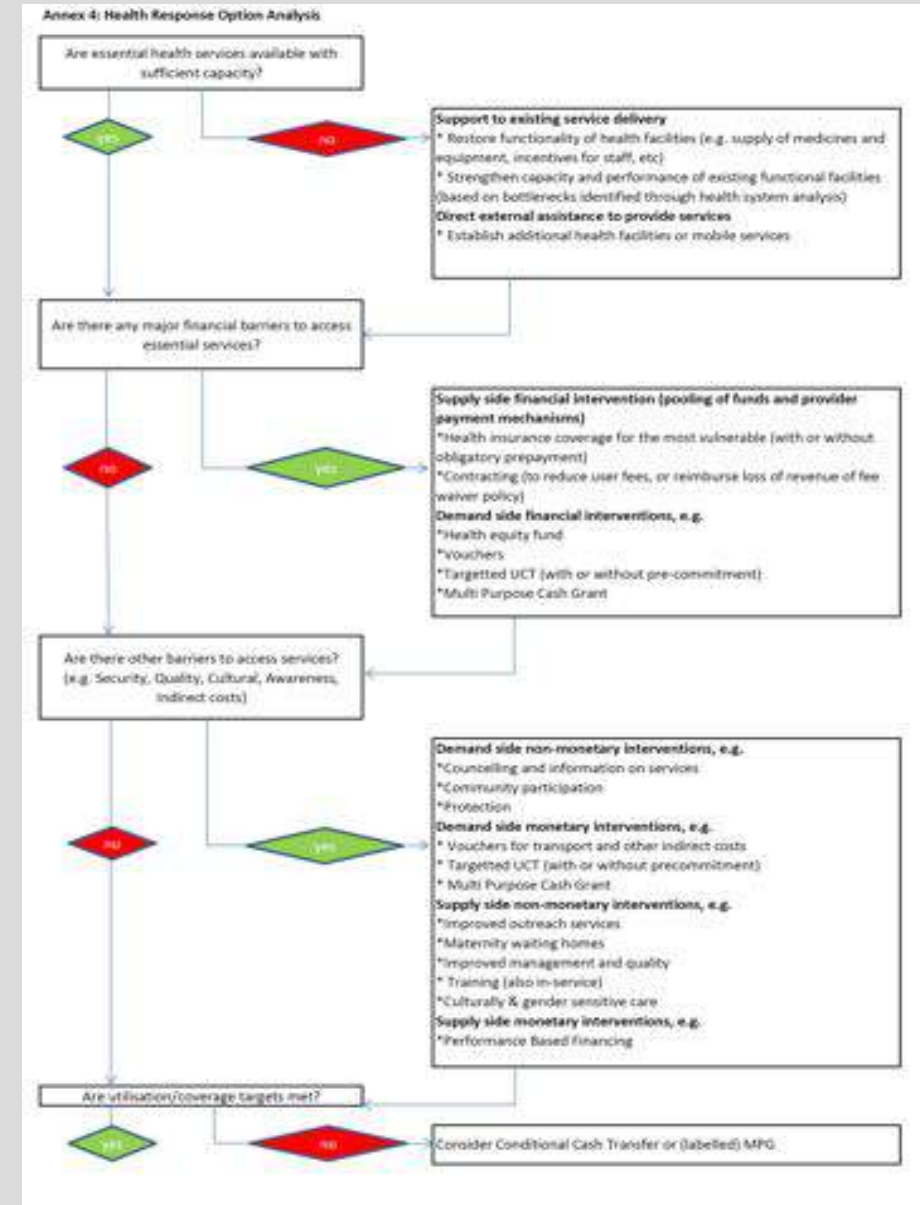
3. Service or commodity vouchers
4. Value vouchers for people with predictable health needs
5. Unconditional cash for a defined health need with pre-commitment to seek the service from a qualified provider
6. Add amount for health expenditures to MPC

Giving unrestricted and unconditional cash for health is easiest and most efficient, but has worst characteristics for equity and financial protection, and people may access poor quality services

Annex 4: Simplified decision tree

Key questions to see if CTP can be appropriate:

- Are essential health services to address the main causes of morbidity and mortality available with sufficient capacity?
- Are there any major financial barriers to access essential services?
- Are there other barriers to access services?
- Are utilisation/coverage targets met?



Suggested resources

- **General resources**

Cash Learning Partnership: <http://www.cashlearning.org/>

ODI (2016), Cash transfers what does the evidence say?

ODI (2018), The Grand Bargain Annual Independent report

- **Specific to Cash and Health:**

Global Health Cluster: <http://www.who.int/health-cluster/about/work/task-teams/cash/en/>

UNHCR (2015), CBI for health in refugee settings: a review

ODI (2011), Rethinking cash transfers to promote maternal health

UNDP (2014), Cash transfers and HIV prevention

- **Online trainings:** <https://kayaconnect.org/local/search/>

- Cash Transfer Programming-the fundamentals (Level 1&2)

- Coordinating multisector CTP

- CTP and social protection



Sexual and Reproductive Health - Opportunities for using cash and voucher assistance (CVA) in emergencies

02 April 2020

Outline

1. Sexual and Reproductive Health and Rights (SRHR) during emergencies
2. Potential role of cash and voucher assistance (CVA) to reduce financial barriers to SRHR services
3. Existing evidence on the use of CVA for SRHR from development and humanitarian settings
4. Considerations on the use of CVA for SRHR during emergencies



KIT
Karlsruhe Institute of Technology



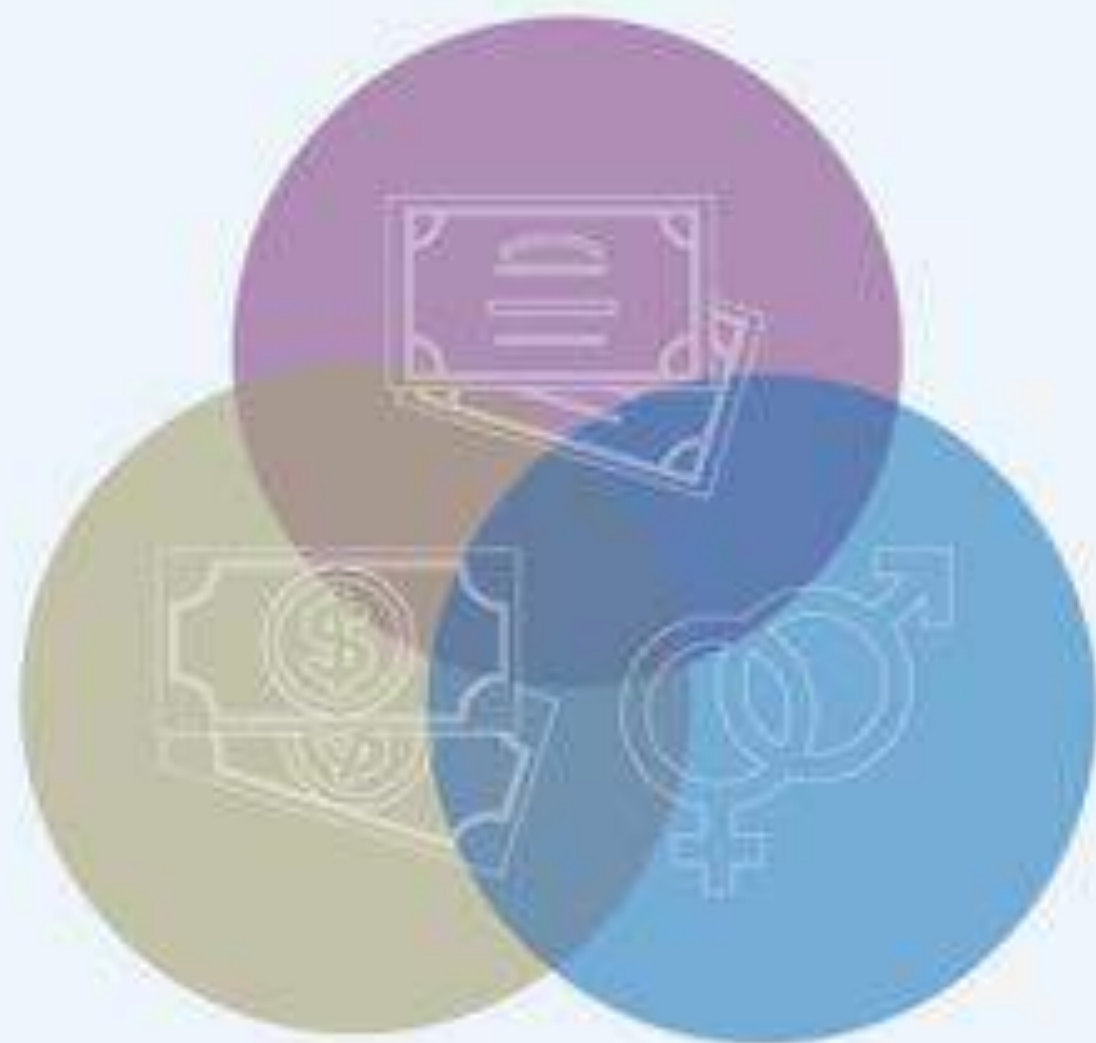
HEALTH
CLUSTER



Ministry of Foreign Affairs of the
Netherlands



World Health
Organization



Consultation Meeting

Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian emergencies

5 - 6 March 2020, Amsterdam

Sexual and Reproductive Health and Rights during emergencies



Sexual and Reproductive Health and Rights (SRHR)

“Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity.”

Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing.

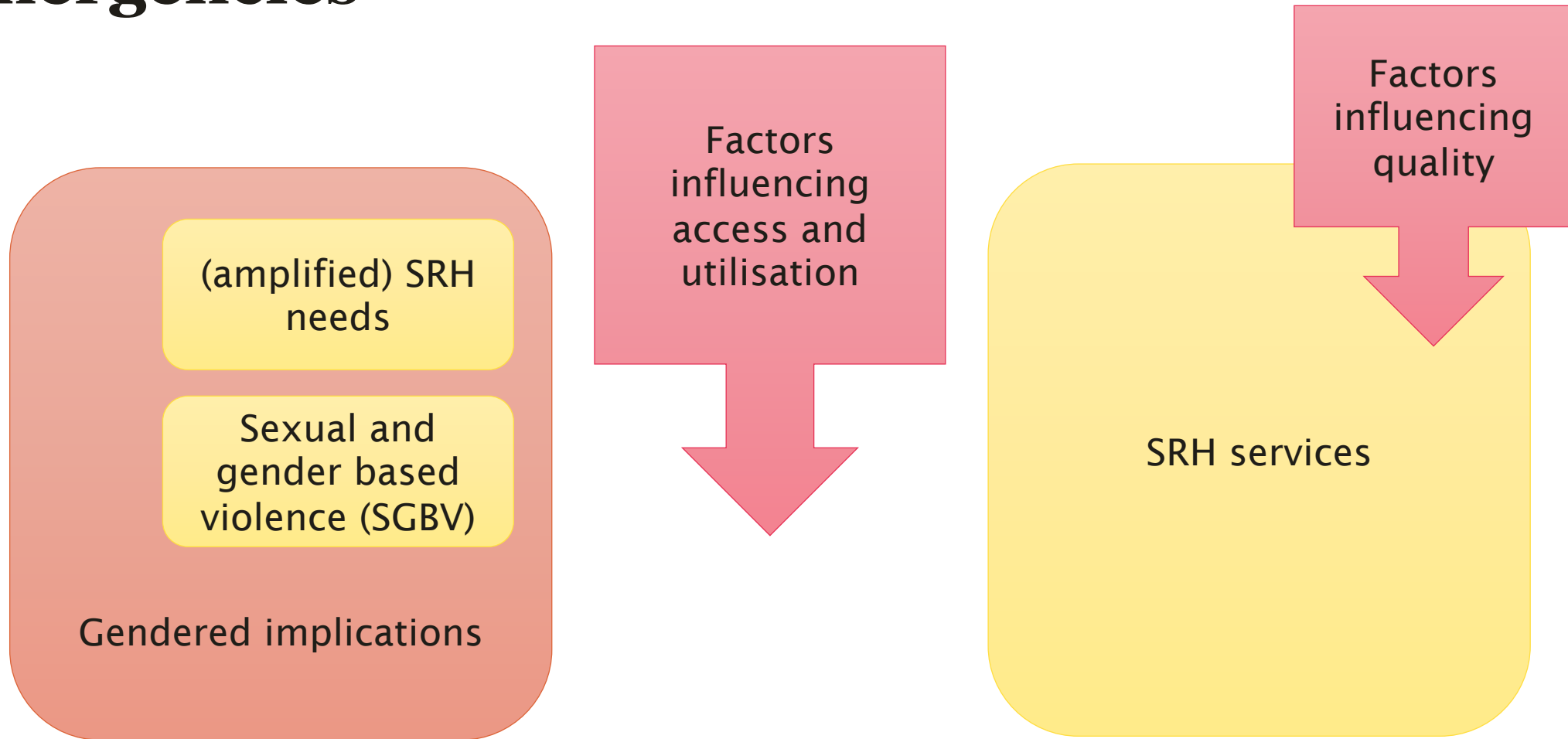
All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals...”

- Detailed description of the SRH rights of people -

“...Essential sexual and reproductive health services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health.”

- Detailed description of the range of SRH services -

Sexual and Reproductive Health during emergencies



Potential effects of COVID-19 on provision of SRHR services

Examples of potential effects on the supply side:

- Diversion of –already scarce– resources (human and material)
- Diversion of financial resources (at international and national level).
- Disruption of supply chains leading to shortage of drugs and medical products

Examples of potential effects on the demand side:

- Increased barriers to seek for care resulting from prioritization of other household activities
- Increased barriers to reach health services
- Increased financial barriers due to reduced income

Role of cash and voucher assistance (CVA) to reduce financial barriers to SRHR services

Cash and Voucher Assistance (CVA)

Voucher schemes and cash transfers have a place under the family of Results Based Financing (RBF) interventions. Both are modalities of assistance aimed at “enabling households and individuals to meet their basic needs for food, non-food items, and/or services, or to buy assets essential to resume economic activity”

(OECD, 2017).

The effect of voucher schemes and cash transfers mostly affects “users” of the health system. Therefore, they are called demand-side interventions.

Potential effects of COVID-19 on provision of SRHR services

Examples of potential effects on the supply side:

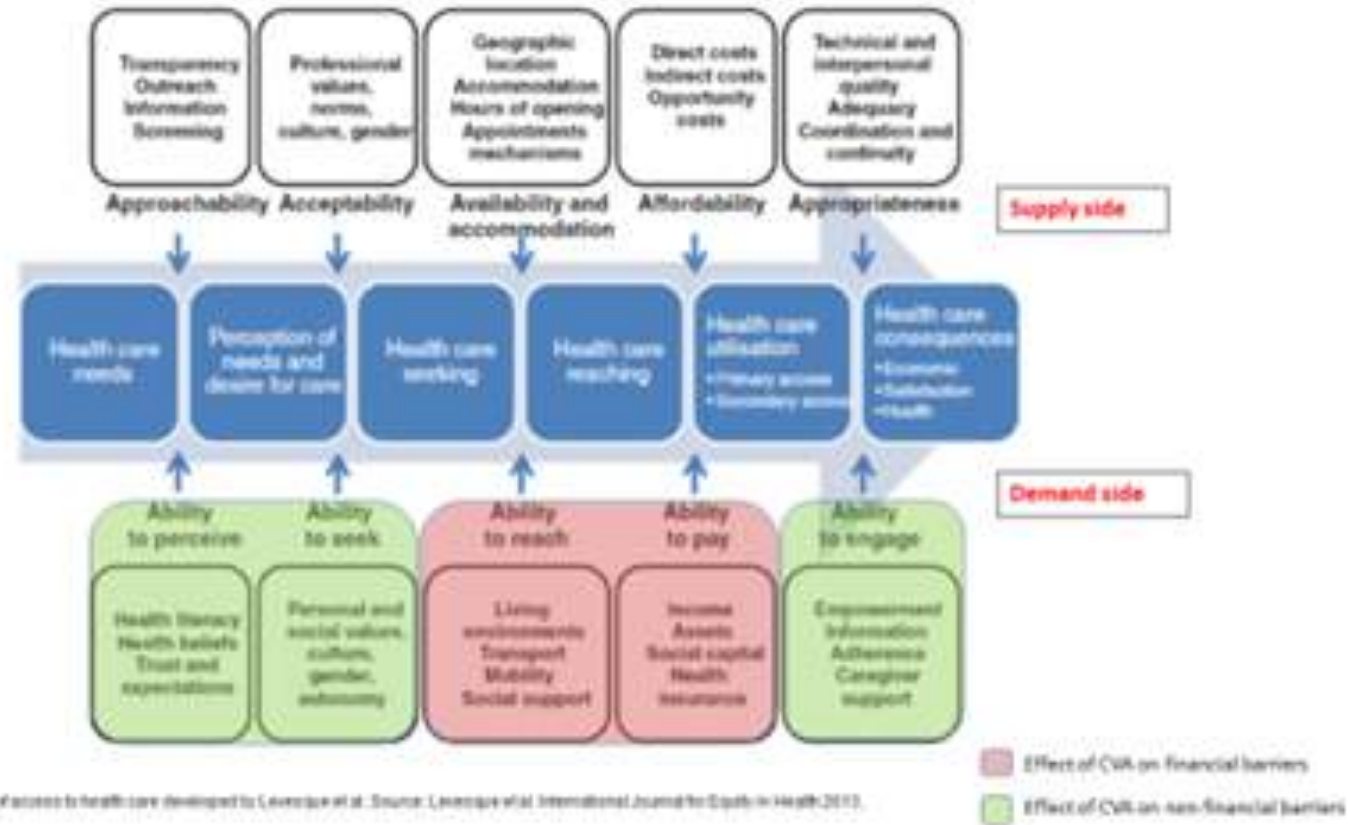
- Diversion of –already scarce– resources (human and material)
- Diversion of financial resources (at international and national level).
- Disruption of supply chains leading to shortage of drugs and medical products

Examples of potential effects on the demand side:

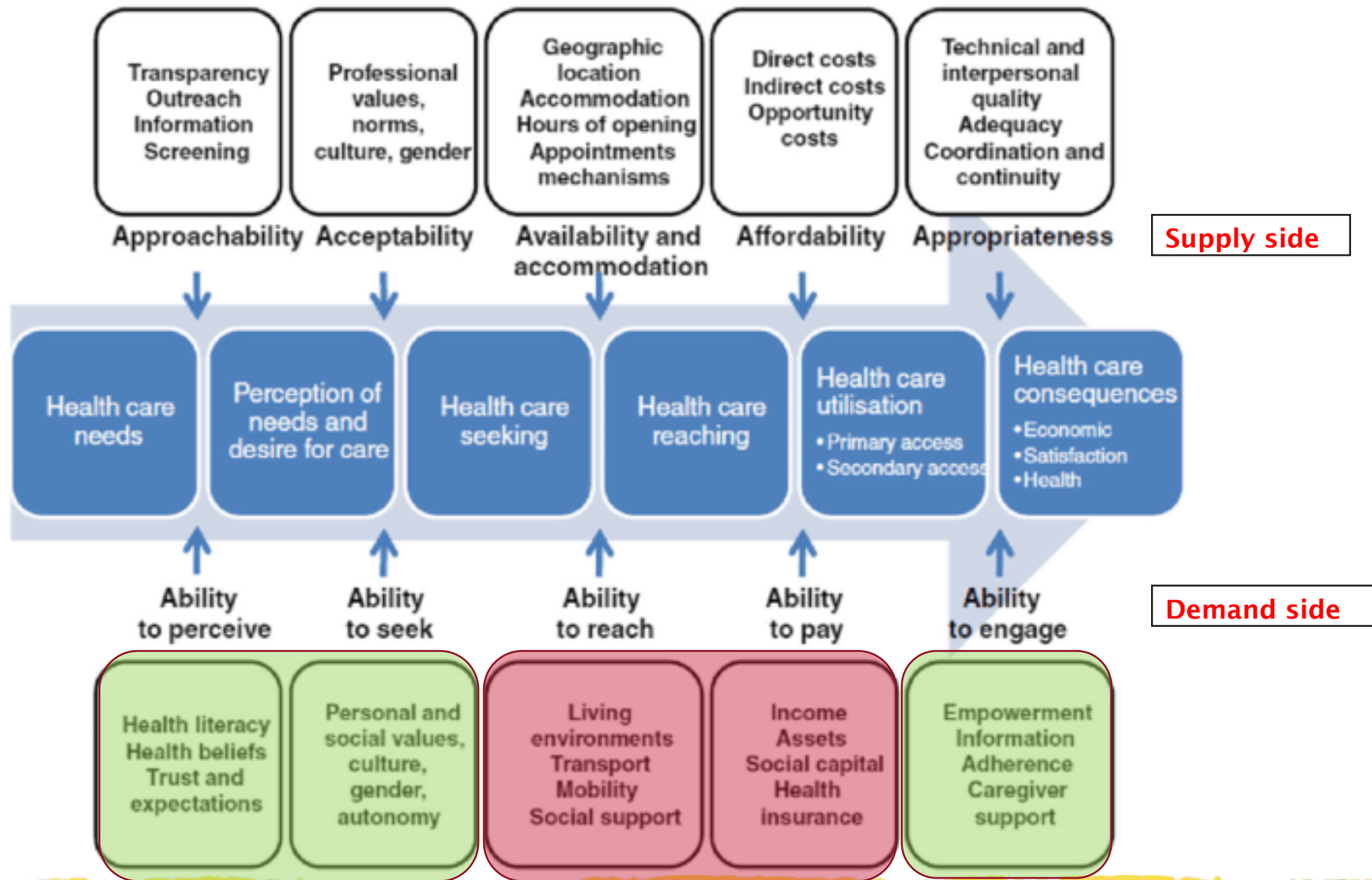
- Increased barriers to seek for care resulting from prioritization of other household activities
- Increased barriers to reach health services
- Increased financial barriers due to reduced income



Framework of access to health care



Source: A conceptual framework of access to health care developed by Leveque et al. Source: Leveque et al. International Journal of Equity in Health 2013, 12:1



Evidence on the use of CVA for SRHR from development and humanitarian settings

Summary of evidence on CVA for SRHR in development settings

| Effects reported on the demand side | Effects reported on the supply side |
|---|---|
| <p>A large number of systematic, landscape and literature reviews as well as individual studies of CCT and voucher programmes show that:</p> <ul style="list-style-type: none">- <u>Robust evidence that vouchers increase service utilisation</u>: ANC (including earlier and more frequent ANC), skilled attendance at birth, institutional delivery and PNC- A complex picture of experiences with CCTs which reflect the <u>importance of financial and other cultural, social, geographical and health systems factors as barriers to accessing care</u>- <u>CCTs have shown little effect on MNH outcomes</u> (mortality, low-birthweight, post-delivery behaviours, fertility)- <u>Emerging evidence that vouchers are cost-effective and can change health seeking behaviour in a sustainable manner</u>. Some evidence that CCTs can affect behaviours and learning in the longer-run (i.e. once CCT stopped) | <ul style="list-style-type: none">• The majority of studies underline the <u>need for concurrent (or staggered) supply-side investments</u> to overcome important barriers to access• <u>Increased demand and utilisation of services puts pressure on already constrained service delivery capacities</u>• <u>Modest evidence that vouchers can increase quality of services</u>. <u>CCTs have no effect on improvements in quality of maternity care unless accompanied by supply-side investments</u>• Strong evidence that <u>vouchers can reach underserved populations</u> (effective targeting) |

Adapted from presentation from Anna Gorter (2020) RBF for health applied in the development sector. Amsterdam

Key findings of literature review on CVA for SRHR in humanitarian settings

| Effects reported on the demand side | Effects reported on the supply side |
|--|--|
| <p>Quantitative (SM and FP):</p> <ul style="list-style-type: none">• Increase in use of services (LARC/IUD/ANC), on institutional deliveries, and higher odds of institutional delivery• 1 project smaller effect on poorer group (Edmond et al. 2019)• Cost effective against status quo (Alfonso, N et al. 2013) <p>Qualitative (SGBV):</p> <ul style="list-style-type: none">• Cash perceived by women (Jordan) to reduce household tensions/positive effect on psychosocial benefits and social cohesion• Cash did not appear to influence underlying factors making individuals vulnerable to SGBV (Lebanon)• Effect on prevention and mitigation of GBV (Ecuador) (But in Kenya low uptake because of stigma, fear, shame of reporting GBV)• Cash + Psychosocial support combined perceived as helpful• Increased awareness of FP services | <p>Vouchers (SM and FP):</p> <ul style="list-style-type: none">• Providers (including private) motivated to offer services• Services running in spite of conflict• Opens doors for PPP (potential to increase scope and coverage)• Expands client base• Improved quality (also for clients not part of CVA)• Upgrade health facilities• Standardized quality assurance• Access to improved provider training• Increase in workload when not supported with intervention on supply side (clinical and admin staff)• Cumbersome administrative work <p>CCT (SM):</p> <ul style="list-style-type: none">• Active CHWs (Afghanistan) in spite of conflict / incentives made them feel appreciated and compensated |

Considerations on the use of CVA for SRHR during emergencies

Considerations while using CVA for SRHR in emergencies

- Evidence shows that CVA can lead to increased utilization of SRH services
- Barriers to access SRH services not only financial ones
- Evidence suggests that in emergencies CVA is mostly used in projects focusing on safe motherhood, family planning, and GBV
- Evidence on effects of CVA focus almost exclusively on indicators of service utilization

Considerations while using CVA for SRHR in emergencies

In relation to COVID-19

- Given the burden of the COVID-19 epidemic on health systems, efforts need to be done to secure additional resources to ensure continuity of provision of essential health services, including SRH services
- Being a demand-side intervention, CVA does not have any effect on supply-side issues or problems. Specific actions need to be put in place aiming to strengthen the health system
- CVA can have a role in reducing the financial burden at home and in reducing financial barriers to access health services.

Thank you

Cash for Health in Humanitarian Settings:

Household Health Needs, Spending, and the Burden of Health Care Costs

April 2020



USAID
FROM THE AMERICAN PEOPLE

Objectives

This was a descriptive study that aimed to...



(1)

Understand how households prioritize health needs **and what types of health needs**



(2)

Document how these needs are currently met and related expenditure



(3)

Map how household spending on health needs changes **with the introduction of a humanitarian cash assistance program** and explore the role that cash is playing **in any change that we observe**

Cash Assistance Programs

Pakistan

Program: Cash-for-Work

of households: 500 (200 Peshawar, 300 Bannu)

of transfers: 3

Amount per transfer: Rs. 8000/tranche (~\$72)

Identification criteria include:

- # of disabled or chronically ill household members
- Income and asset ownership
- Recent history of assistance received through other sources

Cameroon

Program: Unconditional cash

of households: 250

of transfers: 6

Amount per transfer: CFA 39,900/tranche (~\$70)

Identification criteria include:

- IRC's vulnerability criteria finalized in collaboration with community representatives
- Door-to-door and community-based approach

Research Design

- **Mixed-methods study**
 - **Supply side:** rapid health facility assessments
 - Two of each kind of facility within a 25km radius of intervention area
 - **Quantitative household surveys**
 - High frequency bi-weekly (every 2 weeks) surveys
 - **Qualitative semi-structured interviews at specific points in time**
- **Recall period: 2 weeks**
- **Study not intended to measure impact, instead it aimed to understand whether there is health expenditure, what type of health expenditure and how cash is used**

Context and Sample



- 11 rounds of data collection (March-August)
- **Two districts:** Peshawar (urban), Bannu (peri-urban)
- **Peshawar:** 97 households (723 individuals)
- **Bannu:** 100 households (649 individuals)



- 9 rounds of data collection (January-June)
- **One district:** Logone-et-Chari in Makaraya (rural)
- **Logone-et-Chari:** 128 households (927 individuals)

Economic Profile and Spending in the Household

Income

| | Median income range | |
|------------------------|---------------------|-----------------|
| Peshawar | \$26.32-49.03 | Rs 3,113-5,800 |
| Bannu | \$20.29-33.82 | Rs 2,400-4,000 |
| Logone-et-Chari | \$1.70-11.60 | XAF 1,001-6,825 |

- **Households earn** below the minimum wage, and often below the poverty line
- **Cash transfer was between** 138% to 3,896% of median monthly income



Minimum Wage (Per Adult)

Khyber Pakhtunkhwa Province:

Rs 15,000/month in 2018*

Cameroon:

XAF 36,270/month*



Poverty Line (Per Adult)

Pakistan national standard:

Rs 3,030/month per adult*

Cameroon:

XAF 339,715/year per adult* \approx 28,309/month per adult



Poverty Line (Per Household)

Pakistan:

Rs 18,180/month (\$115/month)

Cameroon:

XAF 56,618 to 84,927/month (\$96 - \$144/month)

*based on nationally representative household consumption data



Quick Facts

During cash assistance, we find....

- ↑ Increase in all types of spending, particularly food spending
- ↑ Increase in loan repayment by households
- ↓ Decrease in borrowing by households

Supply Side: Health Facility Assessments

Supply Side: Health Facilities Assessment

The rapid health facility assessment captured information on the following:



Number of basic drugs and supplies available:

includes insulin, antibiotics, dressing kits, analgesics, iron supplements



Number of basic services available: includes various HIV tests, blood glucose test, hemoglobin tests, X-rays



Number of basic equipment functioning:

includes thermometer, stethoscope, blood pressure apparatus, IV, examination table, delivery table



Access to facility: registration free, consultation fee, time to referral hospital

| Facility Type | Bannu | Peshawar | Logone-et-Chari |
|-------------------|-----------|----------|-----------------|
| Public/government | 9 | 4 | 9 |
| Private | 5 | 2 | 4 |
| Other* | 0 | 2 | 7 |
| Total | 14 | 8 | 20 |

*In Logone-et-Chari, Cameroon, this includes 3 chokous and 2 other traditional healers

In Bannu, this includes 5 pharmacies/medical stores



Quick Facts

- **Adequate supply for basic drugs and supplies, but weak for basic services**
- **Peshawar had strongest supply: all facilities had at least 50% of basic equipment, most had 50% of drugs/supplies**
- **Bannu had poorer supply: most facilities had less than 50% of basic services, but at least 50% of basic equipment and drugs/supplies**
- **Logone-et-Chari had poorest supply: most facilities had less than 50% of basic services, slim majority had at least 50% of basic equipment and drug/supplies**

Secondary Sources

Pakistan:

- At least 10 organizations providing free services in Peshawar and 5 in Bannu (mostly vaccinations, primary care, children under 5, pregnancy-related care)
- Government has uniform fee structure for IDPs and host community populations (between \$0.25 and \$3 for basic services)

Cameroon:

- Two organizations providing free services in our project area (pregnant women, children under 5)
- Aside from vaccination campaigns, government doesn't provide free services

Aggregate Health Expenditure and Cash Usage

Health Needs and Expenditure

We captured information on:

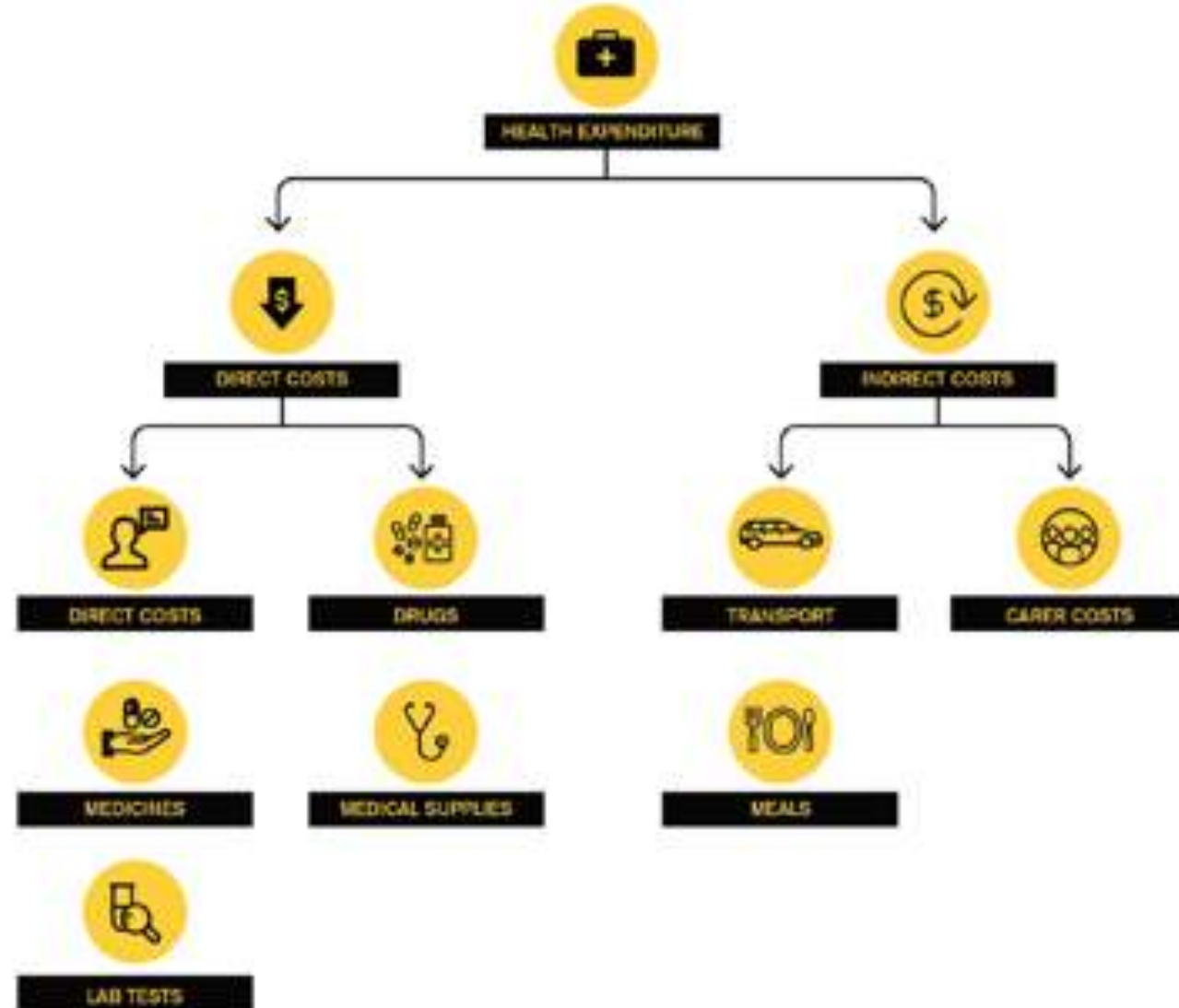
- Preventive health needs (including pregnancy)
- Unpredictable health needs, i.e. illness and injury
- Predictable health needs, i.e. chronic illness

Sample size small for certain categories

- Preventive health care utilization and expenditure in Pakistan
- Pregnancy in both countries
- Chronic illness in Cameroon

so we encourage cautious interpretation of these findings!

For each health need, we collect the following information:



Aggregate Health Expenditure

Across all types of health needs, we see varying levels of need per round of data collection

- **Peshawar:**
 - 32-85% of households required health services across all rounds
 - People tend to seek care and also report incurring a cost
- **Bannu:**
 - 63-89% of households required health services across all rounds
 - People don't always seek care, but when they do, they usually incur a cost
- **Logone-et-Chari:**
 - 45-82% of households required health services across all rounds
 - People tend to seek care, but don't always incur a cost

Aggregate Health Expenditure

Total aggregate spending was...

- **Peshawar:**
 - 35.4% of aggregate reported income for the relevant 3 month period
 - 20.8% of aggregate cash transfer amount
- **Bannu:**
 - 66.4% of aggregate reported income for the relevant 3 month period
 - 30% of aggregate cash transfer amount
- **Logone-et-Chari:**
 - 107.2% of aggregate reported income for the relevant 3.5 month period
 - 10% of aggregate cash transfer amount

Catastrophic Spending

In any given round, between

3.41% – 45% of households in Peshawar

4% – 32.32% of households in Bannu

10.94% – 18.75% of households in Logone-et-Chari

reported incurring health expenses that were 40% or more of their non-food expenditure.

On aggregate,

15.8% of households in Peshawar

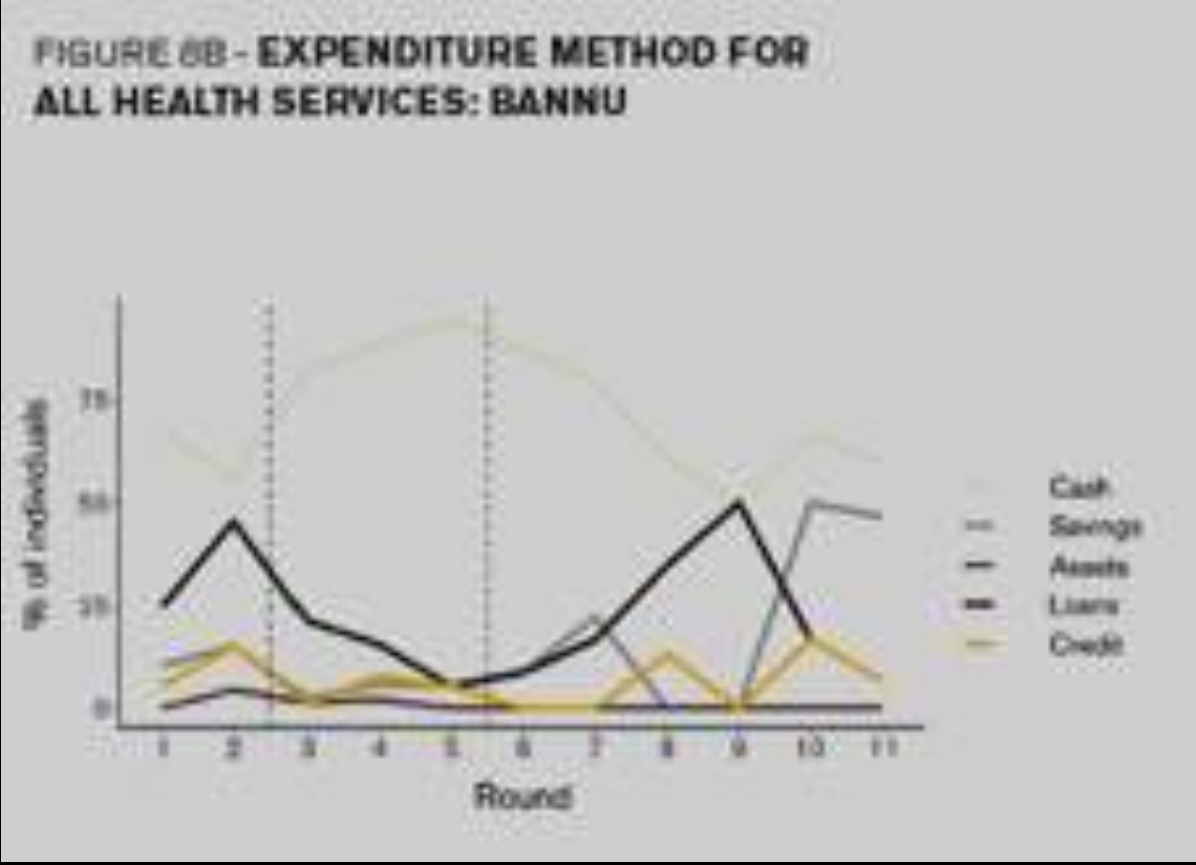
12.4% of households in Bannu

11.7% of households in Logone-et-Chari

experienced catastrophic spending on health expenses

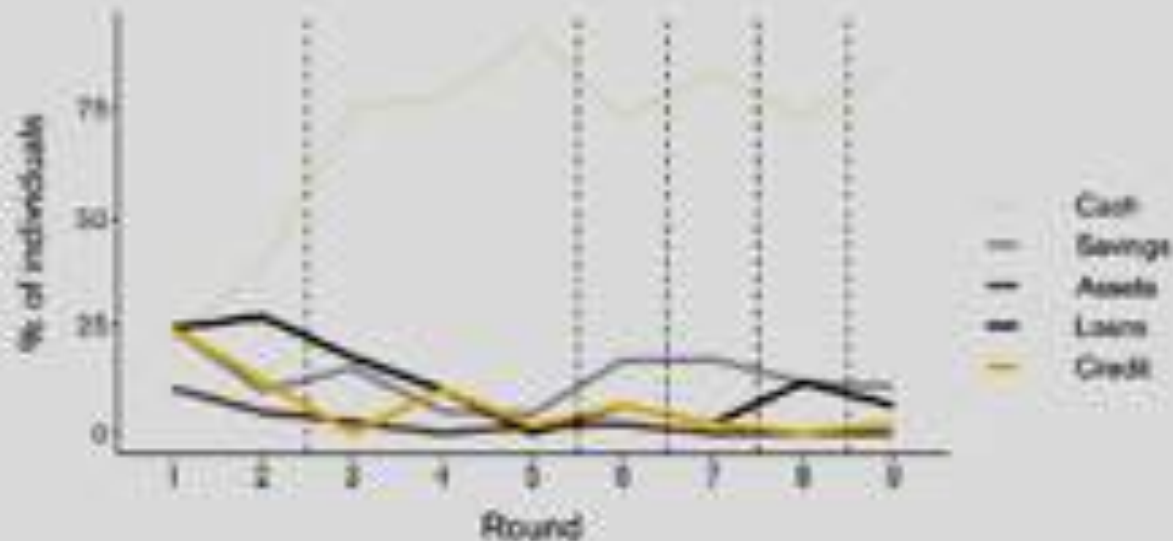
Cash Usage: Peshawar + Bannu

Across all three sites, we observed that once the cash assistance starts, there is an increase in the use of cash to make health related payments and a decrease in loan usage for health payments



Cash Usage: Logone-et-Chari

FIGURE BC - EXPENDITURE METHOD FOR ALL HEALTH SERVICES: LOGONE-ET-CHARI



People use cash to meet health needs

“Spent this cash on my daughter’s treatment and bought medicine for myself and the remaining cash was used in household”

– Cash assistance beneficiary, Peshawar

“Spend [first transfer] on daily home expenses. Also repaid loan which was used on son’s health as he had fallen from roof and need thorough treatment”

– Cash assistance beneficiary, Bannu

“I used half of the money to seek health care due to low blood pressure. I used the other half to buy 2 bags of millet for household consumption. I also shared with around 10 of my neighbors”

– Female IDP, Logone-et-Chari

Conclusion + Recommendations

Conclusion

1 The assumption of free services doesn't hold up in our study settings

2 Cash is used to pay for health expenditure

3 Cash may be facilitating timely access or influencing care-seeking behavior

Recommendations



Donors, health practitioners, and the health cluster should ensure coordination among humanitarian actors to make sure that there are in fact still free high quality services available and accessible to displaced populations.



Donors, practitioners, and the relevant clusters and coordinating bodies should include health in the ingredient list for the Minimum Expenditure Basket that is typically used to determine the cash transfer value in many humanitarian settings where health is identified as a priority need during needs assessments.

Recommendations



We should explore additional support options, cash or otherwise, to ensure services for pregnant women are free.

For more information, please refer to the following:

[Full report](#)

[Research brief](#)

[Research Annex A](#)

[Research Annex B](#)

[Website](#)

Deciding to use cash and voucher assistance for health outcomes: process from Ecuador

Holly Welcome Radice

Cash and Markets Technical Advisor

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care®



**Bureau of Population, Refugees and Migration
US Department of State**

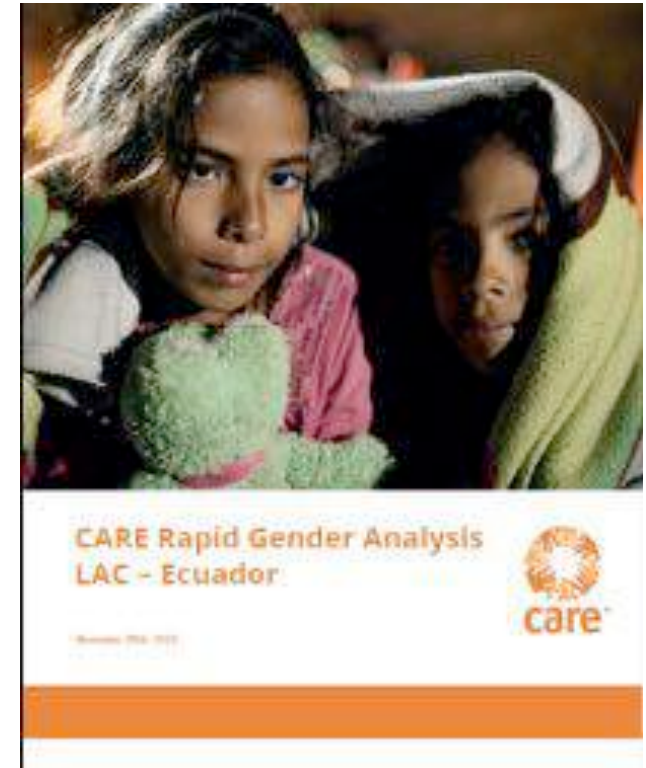
Context

- Humanitarian crisis in Venezuela is affecting 16 countries in Latin America and the Caribbean, including Ecuador.
- Cash and voucher assistance (CVA) being used in Ecuador by a variety of actors
- Universal, free health care; Government has made efforts to increase in response to crisis, but system is saturated
- Migrants arriving in poor conditions—chronic lack of attention, acute health needs arising from journey
- CARE Ecuador integrated response



HEALTH SITUATION FOR VENEZUELAN MIGRANTS IN ECUADOR

- 57% migrants need health attention; 84% had not received attention
- More women and members of LGBTQI+ community needed services
- High knowledge of contraception across groups; significantly lower in adolescents
- 56% men and women claimed to have no access to contraception; for LGBTQI+ population 69% made the claim
- Lack of information, xenophobic behavior of some service providers, traditional stereotypes
- Health centers congested, increase in risky pregnancies and births (e.g. mothers with STIs, teenagers)



PROJECT CONCEPT



- Protection lens especially focus on women and LGBTIQ+ populations and sexual reproductive health
- Venezuelan migrants and vulnerable Ecuadorians
- Meet the health needs based on Ministry of Public Health directives and the National Health System; and MISP
- Analysis of local markets based on needs, cost efficiency, needs and Ministry standards
- Use public and sector private providers

TYPES OF VOUCHERS



Medicines & specialized examinations



Treatments & prescriptions



Testing HIV & STDs



Pregnancy tests & antenatal tests



Contraceptives & lubricants

VOUCHERS

Proyecto PRM: "Respuesta de Protección Multisectorial para Poblaciones Vulnerables del Ecuador Afectadas por la Crisis Humanitaria"

Número de solicitud: 00001

SOLICITUD DE EXÁMENES DE LABORATORIO

Fecha: 12/12/19

Número de personas: 05

Considerar a los niños: Sí No

Localidad: QUITO

| NEURÓLOGA | QUÍMICA CLÍNICA | URINA | HEPAS |
|---|--|---|---|
| <input checked="" type="checkbox"/> Neurociencias | <input type="checkbox"/> Cloruro | <input checked="" type="checkbox"/> Hem | <input type="checkbox"/> Hemocultivos |
| <input type="checkbox"/> Parasitología | <input checked="" type="checkbox"/> Creatinina | | |
| | <input type="checkbox"/> Urea | | |
| | <input type="checkbox"/> Fosfatasa | | |
| | <input type="checkbox"/> Fosfatos | | |
| | | HEMOCUENTA | OSIOS |
| | | <input checked="" type="checkbox"/> Hematocrito | <input checked="" type="checkbox"/> Hemoglobina |
| | | <input type="checkbox"/> Hemoglobinas | <input type="checkbox"/> Hemoglobinas |
| | | <input type="checkbox"/> Hemoglobinas | <input type="checkbox"/> Hemoglobinas |

Situación de la familia: Inicial

Médica General Consultar Consultar

Situación de salud: Inicial

En: Total Parcial Consultar

Nombre y apellido:

Nombre y apellido:

VOUCHER PARA ENTREGA DE MEDICAMENTOS

Nro. PRM: 2019-2020 00001

Fecha emisión: 12/12/19

Lugar/Quitar: QUITO

Organización que emite el voucher:

Nombre de la persona jefe/a de hogar:

No. de Identificación:

| Nombre del medicamento/produto | Presentación | Cantidad máxima | Cantidad actual | Descripción adicional |
|--------------------------------|--------------|-----------------|-----------------|-----------------------|
| Paracetamol | Ta 500 mg | 10 | 0 | |

Nombre de la Farmacia:

Nombre agente:

Nombre y apellido:

Nombre y apellido:

Nombre y apellido:

VOLUNTARIO POR:

AUTORIZADO POR:

RECIBI CONFIRMADO:



RESULTS AND NEXT STEPS

- Nearly 600 people benefited from vouchers; overall health component benefited over 3000 people
- Coordination with Ministry of Health at local levels to promote access of participants to the National Health System
- CARE Ecuador plans to extend, improve and integrate with CVA used in GBV case management
- CARE dedicated to learning and sharing with local organizations and other country offices and partners



Thank you

CVA for Health outcomes

QUESTIONS & ANSWERS

Session

CVA for Health outcomes

Some key resources:

- **Global health cluster website:** [GHC and cash](#)
- **CaLP website:** [COVID page and guidance](#) and Health specific page
- **CARE:** CVA and GBV Compendium, in [English](#), [Arabic](#), [French](#) and [Spanish](#)
- **IRC:** Case study report and brief [here](#) and blog post [here](#)

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Thank you for joining!!