INTRODUCTION

The current outbreak of the COVID-19 virus has severe implications for health systems all over the world. This is even more true for lower and middle income countries (LMICs), which generally have weaker health surveillance and health systems, and may therefore carry the heaviest burden. In recent decades, many of these countries have adopted Results Based Financing (RBF) mechanisms as part of their broader health system strengthening and health governance efforts. Such RBF programs, too, are currently under strain as a result of the pandemic. At the same time, the RBF approach, thanks to its adaptability and its systemic nature, may provide an effective framework to embed a specific COVID-19 response into broader and more sustainable system strengthening.

This document aims to make an inventory of RBF adaptations that can be considered as part of a COVID-19 response, with the dual objective of containing the spread of the virus and preserving availability and quality of vital public health services. As an international NGO with long standing experience in the application of RBF, especially in fragile and/or conflict affected settings, Cordaid has seen many such adaptations work in the past. This ‘Quick Reference Guide’ was compiled by the core members of Cordaid’s Community of Experts on Results Based Financing (CoE RBF) and brings together their past experiences as well as new ideas that emerged at the onset of the current crisis. The core contributors represent a large array of countries: Jos Dusseljee, Maarten Oranje and Carmen Schakel (all Cordaid Global Office, The Netherlands), Polite Dube (Cordaid Ethiopia), Inoussa Malam Issa (Cordaid DRC), Juvenal Ndayishimiye (Cordaid Burundi), Athanase Nduhira (Cordaid CAR), Endris Seid (Cordaid Zimbabwe), Eubert Vushoma (Cordaid Liberia), Eric Bigirimana (Bregmans Consulting, formerly Cordaid CAR) and Samar Al-Qadi (Yamaan, Yemen). While acknowledging all valuable contributions, an inventory like this is of course never exhaustive, and suggestions for additions and adjustments, as the COVID-19 epidemic unfolds in Sub-Saharan Africa, are highly welcomed. For contact details please be referred to the final page of this document.

Under the current circumstances, new RBF interventions may also be considered in countries, especially if the objective is to have a COVID-19 response which also addresses long term deficiencies in the health system. This Quick Reference Guide does not focus on such new interventions, but on existing RBF programs which under the current circumstances require adaptation. Many of the suggestions listed will, however, be equally applicable for such a newly initiated program. Similarly, many of the proposed adaptations could be equally relevant during other outbreaks of infectious diseases of epidemic proportions, or in crisis situations of a different nature. The reader is reminded, however, that this set of suggestions was developed specifically with the current COVID-19 crisis in mind. Finally, given the geographical scope of Cordaid’s current RBF portfolio, the focus here has been on countries in Sub-Saharan Africa. Most of the suggestions, if not all, should also be applicable in similar settings elsewhere in the world though.
THE COVID-19 OUTBREAK IN AFRICA

In recent weeks, the outbreak of the COVID-19 virus has evolved into a true pandemic. As of April 30th, there are more than 200 countries, areas or territories worldwide that have reported a combined total of over 3,000,000 cases and 210,000 deaths. More than just a global health crisis, the consequences are unprecedented also for the world economy and in the political realm. Although it took relatively long for cases to start being detected in Sub-Saharan Africa, by now 45 countries in the WHO African Region are directly affected, with a total of 23,833 cases. For up-to-date numbers on the spread of COVID-19 in Africa, see for instance this Global Dashboard COVID-19, based on near real-time data from Johns Hopkins University.

At this exact moment, it is difficult to predict whether the spread of the virus in Africa will be as fast as in some other parts of the world, but countries need to be prepared for the worst case scenario. An increasing number of African governments impose a total lock-down of their country, or of potential hot-spots, like crowded low-income areas in urban environments. Due to generally weaker health surveillance and health systems, further spread may be difficult to prevent, diagnose and control. Despite relatively low numbers of cases, already in mid-March the concern among the general population about COVID-19 was high, with 71% of Kenyans, 69% of Nigerians, and 72% of South Africans rating their level of concern as very high in an SMS survey.\(^1\)

Previous epidemics with high case fatality rates, like Ebola, evidently required a rapid and strong pro-active and sustained response from authorities. This COVID-19 epidemic may have a substantially lower case fatality rate, but its spread can be so rapid that the case load, the absolute numbers of people becoming infected and having to be hospitalized, rises beyond the capacity of any health system. This is true for high-income countries and is definitely true for LMICs which have extremely low capacity of Intensive Care units and advanced equipment. Ideally, a response should therefore be preventive, mainly outside the health system, and should not come at the expense of delivering essential health services. Experience from the recent Ebola crises, and other epidemics, shows that unless society-wide mitigating action is taken, the additional death toll amongst people with existing diseases such as malaria, HIV, TB, or as a result of inadequate maternal and child care, can be at least as high as from the outbreak itself. And then we do not even mention the socio-economic impact on generally poor populations, which may come at a significant cost of loss of (quality) life as well.

THE ROLE OF CORDAID

It will evidently be crucial for governments, donors and civil society actors to respond to this outbreak in a coordinated manner. Many African governments have established national taskforces, and major donors such as the World Bank and the Global Fund have already announced that significant new funding will be made available at short notice. International NGOs can also be expected to play a key role in this COVID-19 response. Cordaid, having a large presence in Sub-Saharan Africa, is currently also in the process of adapting its programs and strategies. Due to precautionary measures, the capacity of Cordaid offices to act may at times be somewhat compromised. At the same time, as an organization specialized both in public health and in emergency preparedness, Cordaid is uniquely positioned to make an effective contribution to the COVID-19 response, while at the same time preserving availability, use and quality of vital public health services.

In our view, this is not the time for radically new interventions, or expansion to new countries. Instead, it is the preferred option for Cordaid to build incrementally upon already existing programs, continuing to address health and wellbeing with an emphasis on prevention, awareness raising and reduction of harmful practices. The focus should be on strengthening health systems in a people-centred manner, in the true spirit of “health for all”. This implies a focus on segments in society that are vulnerable, marginalized or hard-to-reach. Cordaid could use its advocacy expertise and programs to promote the dual approach, while using its institutional relationships with major donors to solicit for additional funding. As the countries in which Cordaid operates are prone to intermittent other infectious diseases of potential epidemic proportions, Cordaid could build on its demonstrated competence and develop approaches to prepare the health systems to deal with a crisis.

\(^1\) [https://www.geopoll.com/blog/coronavirus-africa/](https://www.geopoll.com/blog/coronavirus-africa/)
RESULTS BASED FINANCING IN FRAGILITY

Over the past two decades, RBF has become Cordaid’s hallmark approach to health system strengthening, with the objective that essential health services of good quality are available and accessible for all. Currently, Cordaid is, in different roles, involved in the implementation of RBF in Zimbabwe, Burundi, Ethiopia, the Central African Republic, Liberia and the DR Congo. In recent years, Cordaid has also been involved in health system strengthening efforts during Ebola outbreaks, in Sierra Leone (2013-15) and in the DR Congo (2018-20). From that experience, we know that the RBF approach can only be truly successful if basic principles and practices are tailored to the specific context. This is even more true for fragile settings, where operational challenges are many.2 Having been challenged to develop context specific RBF coping mechanisms, it is our experience that appropriate strategies can often be identified. It is crucial however that we only adopt those mechanisms which do not harm the health system at large, but instead create conditions for a transition towards normalcy.

In fragile circumstances, a comparative advantage of the RBF approach is related to the contractual agreements which exist between the performance purchasing agency on the one hand and health service providers, local health authorities and community based organizations (CBOs) on the other hand. Exactly when the level of trust in a society is low, the added value of such contractual relationships is high: a sense of normalcy is retained in an otherwise abnormal situation. The contracted parties have a clear understanding not only of their duties, but also of their rights: if they maintain their performance, despite difficult working conditions, they know in advance exactly which payment they are entitled to. Moreover, the partnership with health facilities, authorities and CBOs, which are well embedded in local society, creates channels to reach communities, including vulnerable groups, which higher government levels may not always have access to.

We believe that the RBF approach is an asset under the current circumstances, as the mechanics of a well-designed RBF program are by nature flexible and allow for additional measures, activities and indicators. Without a complete overhaul of the current implementation practices, adaptations can be made regarding the range of services and (community) activities covered, for instance regarding COVID-19 prevention and infection control, surveillance, health worker and patient safety, and quality of care in general. These measures may partly be generic across countries, but will also depend on the specific country context. Cordaid’s role in implementing such adaptations will naturally also differ from country to country, depending among other on its role in the local RBF program, its relationship with government bodies and its implementation capacity.

A QUICK REFERENCE GUIDE FOR ADAPTATIONS

This document aims to make an inventory of RBF adaptations that can be considered as part of a COVID-19 response, with the dual objective of fighting the spread of the virus and preserving availability and quality of vital public health services. Due to its adaptability, RBF can be part of the solution in this crisis context. This inventory brings together ideas from seven countries, through the members of Cordaid’s Community of Experts on Results Based Financing (CoE RBF). The inventory is by no means exhaustive, and should be regularly supplemented and adjusted. This ‘Quick Reference Guide’, however, will provide the reader with a first inventory of possible measures, categorized (in Table 1) by the phase of the epidemic in a specific context. Measures of a different nature are included in the overview below. They can broadly be grouped into three categories. Firstly, there are ‘additional’ interventions, which aim to specifically address (preparedness for) the epidemic. Secondly, there are ‘stabilizing’ measures, which aim to safeguard continuity of the provision of vital health services and the resilience of the health system at large. Thirdly, there are ‘coping mechanisms’, which aim to provide solutions for practical challenges encountered due to the crisis. A crucial consideration in deciding which adaptations to make are the expected effects for the health system in the long run: some RBF principles may well be compromised temporarily, whereas others are absolutely indispensable. In any case, flexibility is needed, requiring government buy-in, organizational flexibility, strong partnerships and ambitious local staff. Clear communication is also key, informing all actors, that they are now part of a temporary model.

This Quick Reference Guide presents optional adaptations to existing RBF programs, in light of the current COVID-19 crisis and as part of a possible response. These adaptations have been categorized into two groups. The first group seems most applicable in an early phase of the epidemic, with sporadic cases or clusters of cases, and no total lockdown in place. The second group seems most applicable in a later phase, when community transmission is a reality and a total lockdown may be in place. This division is not set in stone, however, and some measures may be equally applicable in both situations. Of course, it is also highly context-specific. In practice, an assessment will have to be made in each program of the most appropriate combination of measures. An overarching objective of the adaptations is to make sure that the different actors within the health system (health facilities, authorities, community based organizations), which may simultaneously be confronted with a multitude of challenges and a loss of regular income, continue to have sufficient funding to operate. Only then can these actors be expected to help fight the epidemic, keep providing essential health services and safeguard the resilience of the system.

### TABLE 1: A QUICK REFERENCE GUIDE FOR ADAPTATIONS TO RBF PROGRAMS AS PART OF A COVID-19 RESPONSE

<table>
<thead>
<tr>
<th>#</th>
<th>DOMAIN</th>
<th>PHASE OF THE EPIDEMIC AND NATURE OF GOVERNMENT MEASURES</th>
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<tbody>
<tr>
<td></td>
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<td>Sporadic Cases or Clusters of Cases – No Total Lockdown</td>
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<tr>
<td>1</td>
<td>COORDINATION WITH AUTHORITIES</td>
<td>• Close communication with the National COVID-19 Taskforce and alignment with the National COVID-19 Preparedness Plan.</td>
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<td>• Presentation of RBF as part of a COVID-19 Response embedded into Health System Strengthening.</td>
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<tr>
<td></td>
<td></td>
<td>• Close communication with RBF Steering or Management Committee on making temporary adaptations.</td>
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<td>• Development of an emergency or fast-track procedure for adaptations.</td>
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<td></td>
<td>• Clear communication to all stakeholders about the temporary nature of adaptations.</td>
</tr>
<tr>
<td>2</td>
<td>QUALITY CHECKLISTS</td>
<td>• Revision of Quality Checklists to include more specific indicators on IPC (Infection Prevention and Control), water, sanitation and hygiene, PPE (Personal Protective Equipment) materials, etc.</td>
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<tr>
<td></td>
<td></td>
<td>• Upward adjustment of the relative weights or prices of indicators in the Quality Checklist related to IPC, WASH, PPE etc. aiming at optimal health worker and patient safety in health facilities and during community sensibilization and communication efforts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Allowing health facilities to deviate from existing business plans to address priorities related to IPC, WASH, PPE, etc.</td>
</tr>
<tr>
<td>3</td>
<td>QUANTITY INDICATORS</td>
<td>• Additional, temporary quantity indicators for health facilities, e.g. for surveillance and active case searching, for referrals to quarantine and/or isolation centres, or for tracing and follow-up of contacts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additional quantity indicators to target vulnerable groups (elderly people; people with underlying conditions; IDPs).</td>
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<tr>
<td></td>
<td></td>
<td>• Upward revision of prices of existing quantity indicators, to counterbalance a lower utilization of health services.</td>
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<tr>
<td></td>
<td></td>
<td>• Additional, temporary quantity indicators for DHMTs, e.g. for the number of facilities meeting IPC standards, for health staff trained (in prevention, surveillance and case management), for provision of PPE materials or for community awareness raising.</td>
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<tr>
<td></td>
<td>COMMUNITY INVOLVEMENT</td>
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| 4 | • Adjustment of community verification surveys to include questions specifically related to the virus outbreak.  
   • No exit interviews at health facilities, but patient tracing in the community may be possible with physical distance.  
   • Introduction of an additional, temporary indicator for CBOs to create community awareness about the virus.  
   • Performance agreements for awareness raising activities with actors who are normally not under the RBF program. | • No physical tracing of patients by CBOs, to be replaced by surveys through telephone or by SMS. |

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<th>VERIFICATION MECHANISMS</th>
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| 5 | • Verifications at low risk institutions, such as rural HCs, may continue, depending on rate of local transmission.  
   • Verifications in high risk institutions like secondary or tertiary hospitals to be postponed to a later date.  
   • Possible introduction of Risk Based Verification; frequency of verifications will depend on previous data accuracy. | • All verifications may have to be delayed or postponed.  
   • Possible engagement of CBOs for partial verifications.  
   • Data collection through electronic means (tablets, e-mails), with verification and correction at a later date.  
   • In worst case scenario, suspension of all verifications. |

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<th>PAYMENT MECHANISMS</th>
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| 6 | • Primary focus on regular and timely subsidy payments.                              | • Renew contracts automatically, or without business plan.  
   • Payments based on reported data or based on an agreed minimum projection from the previous quarter earnings.  
   • Increasing total subsidies through a temporary, additional hardship or crisis bonus to all entities (health facilities, regulators, CBOs) in areas that are heavily affected.  
   • Increasing the maximum percentage of subsidies that may be used for individual salary top-ups for health staff.  
   • Payment through other means (mobile payment systems). |

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<th>ADDITIONAL SUPPORT AND INPUT FINANCING</th>
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| 7 | • Additional assistance to facilities, beyond the direct scope of RBF, for crucial activities related to the availability of PPE and testing materials, WASH (Water, Sanitation and Hygiene), waste management, surveillance and case notification, reporting, contact tracing / follow-up. | • Use of Quality Improvement Bonuses (QIBs) for rapid rehabilitation in specific areas. Conditioned to the realization of affordable and realistic facility initiatives, but not directly reflecting facility performance.  
   • Combination of input-based and output-based financing, with the former gradually giving way to the latter.  
   • Involvement of humanitarian NGOs to treat patients and for provision of free health care to vulnerable groups. |
1. Coordination with Authorities (Institutional Arrangements)

- In many countries, national taskforces have been established and Emergency Preparedness and Response Plans have been developed for the COVID-19 crisis. It is paramount to establish close communication with governments on how best to cooperate: which instructions and emergency measures are in place, which support is most needed?
- It is crucial to investigate how RBF can best interact with the provisional institutional arrangements that are in place in the country during this crisis period. RBF can be presented as an asset to decision-makers under the current circumstances, as it embeds the COVID-19 response into broader and more sustainable health system strengthening. It is critical to think strategically, beyond the crisis period only, and address system weaknesses and deficiencies which are currently aggravating the crisis. RBF should not be presented as the solution to the crisis, as this will create unrealistic expectations, but it can be a possible part of the solution.
- Proposed adaptations will often have to be discussed with and agreed upon by (representatives of) RBF Steering Committees. If there is a specific unit responsible for RBF within the national or sub-national Ministry of Health, communication with this unit is key.
- Given the crisis situation, however, emergency or fast-track procedures may be developed, which enable key actors to respond rapidly to the situation and not lose time because of too much bureaucracy. Clear communication to all about these emergency procedures is key.
- In case the RBF program in a specific country is still at an early stage, it will be even more important to communicate clearly that these additional measures are contingent, temporary and directly related to the emergency situation. Once the crisis alleviates, there will be return to a regular RBF. This is crucial to avoid misconceptions about the nature of full-fledged RBF.

2. Adaptations to Quality Checklists

- Quality Checklists may be revised to include some basic processes specific to COVID-19: infection prevention and control, hygiene and sanitation, availability of PPE materials, etc.
- The relative weight of already existing sections in the Quality Checklists (and/or the prices attached to them) could temporarily be altered, to give more weight to practices relevant for prevention and control of epidemics, to guarantee both health worker and patient safety.
- Prioritization of this kind of urgent IPC requirements also be done by allowing the health facilities to deviate from their existing business plans to address priority requirements.

3. Adaptations to Quantity Indicators

- The package of quantity indicators could be extended. Additional temporary indicators could incentivize activities which for understandable reasons health workers might not be inclined to take up pro-actively, such as the active identification of suspected cases, referral of patients to quarantine and/or isolation centres, and tracing of contacts of COVID-19 positive patients.
- Additional quantity indicators could also be considered that target vulnerable groups (e.g. elderly; people with underlying conditions; IDPs), by paying a higher unit price for services provided to those groups. This could go hand-in-hand with fee waiving for those groups.
- Prices of existing indicators could temporarily be revised to reflect changing priorities, as well as to counterbalance lower utilization of services as patients avoid visiting health facilities.
- At the level of district health authorities, additional indicators could also be considered, such as ‘number of health facilities which meet basic IPC standards’, ‘number of health facility staff trained in COVID-19 suspected case detection’, ‘provision of PPE to health staff’ and the ‘number of community awareness meetings organized (respecting physical distancing)’.

4. Enhanced Community Involvement

- Community verification surveys, as conducted by CBOs, may be adjusted to include a few questions which check whether health facilities are providing COVID-19 related services. For instance: ‘During your visit to the health facility, were you educated about COVID-19?’.
• Exit interviews at health facilities (in programs where this is the practice) may be too risky, but patient tracing in the community may still be possible, if the interviewer keeps a distance.
• An additional indicator could also be introduced for CBOs (or health extension workers), such as to create community awareness. A challenge is a restriction on large gatherings; in such a case health workers need to be equipped with protective materials and could conduct door to door visits. It is essential that CBOs and health extension workers promote continued use of vital health services, such as maternal and child health services.
• In certain contexts, temporary performance agreements for awareness raising activities may also be established with actors who are normally not part of the RBF program (e.g. schools, community or religious leaders, other community organizations, administrative entities).
• Instead of tracing patients and conducting interviews in person, this procedure could also be replaced by the CBO calling the patients or their relatives, or conducting an SMS survey.

5. Adaptations to Verification Mechanisms

With regard to verification, it is of course always risky to make adjustments, as the verification and validation of data directly trigger payments. Some adaptations, however, can be adopted for a certain period, depending on the restrictive measures (from physical distancing to total lockdown) in place.

• In case of limited local transmission, verifications at relatively low risk institutions like rural health centres may continue, especially if there is no local transmission in the area. In most places, a room which is a bit isolated can be found to conduct quantity verifications.
• Verifications in high risk institutions like hospitals (which have a higher volume of patients from a wider geographical area) may have to be postponed to a later date.
• Similarly, use could be made of “risk-based verification”, which does not refer to the risk of transmission, but is a mechanism that has been successfully developed and applied in Zimbabwe. Risk-based verification involves the use of different frequencies of verification per institution and per health service, based on data accuracy found during previous verifications. This also frees staff, often nurses or doctors, who can be assigned other tasks that are critical during an emergency, like supporting measures to guarantee health worker and patient safety.
• In a more serious scenario, all verifications may have to be skipped for a certain period of time, or for instance verification may have to be conducted once per quarter.
• In some contexts, if the regular verification agency can no longer do its work, for instance due to travel restrictions, local CBOs can be engaged to still conduct partial quantity verifications.
• Alternatively, part of the data collection can take place through electronic means (using tablet applications and/or e-mail to report data), which will be verified and corrected later.
• In the worst case scenario, all verifications may have to be suspended. It will be critical however not to leave contracted parties without funding: see Payment Mechanisms below.

6. Adaptations to Payment Mechanisms

• Regular and timely payment of RBF subsidies is of the utmost importance, as irregularity worsens the performance stimulation and is even more harmful when resources are scarce.
• It may be considered to renew RBF contracts with health facilities automatically, or to renew contracts without the need for facilities to develop business plans.
• As mentioned, in the worst case scenario above, all verifications may have to be suspended. Payments could then be made based on reported data, and verified and corrected in arrears, once the situation is safe. This will enable the health facility to continue operating, especially when RBF subsidies make up a great proportion of its revenue. If fraud is foreseen, payments could be guaranteed only to a certain minimum (i.e. 75% or 90% of previous quarter earnings).
• Total subsidies could temporarily be increased, through an additional hardship or crisis bonus to all entities (health facilities, regulators, CBOs), in areas that are heavily affected.
• The maximum percentage of subsidies that may be used for individual salary top-ups can be increased, to provide extra incentive for health workers to remain in their duty station.
• In countries where RBF payments are made in cash, as banks are not functioning everywhere, alternative arrangements may be needed, for instance by using mobile payment systems.
7. Additional Support and Input Financing

- Additional assistance to facilities may be given, beyond the direct scope of RBF. This could entail PPE, interventions related to WASH (water, sanitation and hygiene) and waste management, as well as activities to strengthen surveillance (through training, awareness raising, providing testing materials), case notification, reporting, contact tracing and follow-up.
- Some health system building blocks may require an additional boost to ensure rapid rehabilitation, for instance through the use of Quality Improvement Bonuses (QIB). Similar financial tactics can be applied to incentivize hiring of qualified staff in remote areas or the procurement of expensive equipment. The QIB is usually conditioned to the realization of affordable and realistic facility initiatives, but it does not directly reflect facility performance.
- In case of an acute crisis, with a low availability of essential drugs, medical equipment (such as ventilators) and qualified staff, a combination of output-based and input-based financing may have to be considered. Ideally, over the course of such an intervention, input-based financing would gradually give way to output-based financing (RBF).
- Humanitarian NGOs may simultaneously be involved to treat patients, as an emergency measure while RBF implementation continues. Free health care may also be provided for IDPs. In the past such parallel practices have had short term and long term implications, which – if possible and in good partnership – may have to be factored into the RBF adaptations.

CONCLUDING REMARKS

The adaptation of RBF schemes and adoption of coping mechanisms is not entirely without risks. If verification is not going to be conducted on a regular basis, for instance, it can become an entry gate for fraud by health facilities. The safety of staff could also be compromised in times of lockdown, requiring them to have a letter of approval from the authorities to remain out in the streets. Moreover, the application of temporary, improvised measures could give root to a wrong understanding of the full-fledged application of RBF. Readjusting the scheme later on can then be seen as a trial-and-error method, leading to a negative perception from local and/or national authorities. To mitigate these risks, modifications in the application of RBF principles and practices always need to be well guided. Even an imperfect continuation of RBF often has added value over anarchy or chaos, however, as it can help create a pathway towards future normalization: the long term benefits for the health system outweigh the imperfections.

Many of the adaptations suggested in this document may of course also have budgetary consequences. The extra costs related to new indicators could perhaps be counterbalanced by lower use of regular services, but additional funding might still be needed to support activities which are normally outside the scope of RBF:

- Training of health staff in contracted facilities, as well as training of CBOs and health extension workers, so to capacitate them for sensibilization and information of vulnerable communities.
- Provision of PPE (personal protection equipment) for any health worker, formal or informal (CHWs), in order to guarantee – in as far as this is feasible – protection to health workers and to patients or any clients seeking consultation.
- Optimizing water, sanitation and hygiene (WASH) facilities, including provisions for handwashing, disinfecting rooms and equipment, etc.
- Additional requirements, like tests, devices to measure temperatures, etc.
- Posters, pamphlets, video in waiting rooms to inform patients.

In any scenario, there is a need for strong and very clear communication from the onset, through demonstrated positive engagement of the national and local level RBF steering committees as well as donors, and informing all stakeholders that they are now part of a temporary model. Effort intensive and time consuming reviews of national guidelines for quality of care or RBF project Implementation Manuals should be avoided, as time does not allow for this. Instead, we argue for concise arrangements, which can be introduced as a temporary add-on to the existing program in a country, and provide easy comprehension of what is changing and may still change with the evolution of the epidemic. In the COVID-19 response it is essential to think outside the box.
ABOUT CORDAID

Cordaid is based in the Netherlands and has country offices in 11 countries. It has been fighting poverty and exclusion in the world’s most fragile societies and conflict-stricken areas for a century. It delivers innovative solutions to complex problems by emphasizing sustainability and performance in projects that tackle security and justice, health and economic opportunity. Cordaid is deeply rooted in the Dutch society with more than 268,000 private donors. Cordaid is a founding member of Caritas Internationalis and CIDSE.

CONTACT

Maarten Oranje
RBF Health Expert
maarten.oranje@cordaid.org

Jos Dusseljee
Senior Strategist Health
jos.dusseljee@cordaid.org

Carmen Schakel
Junior RBF Health Expert
carmen.schakel@cordaid.org

Cordaid The Netherlands
Grote Marktstraat 45
2511 BH The Hague
+31(0)70 31 36 300
www.cordaid.org/en

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