Health Workforce in the COVID-19 Response

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COVID-19: Health Workforce Action

- Promoting hygiene
- Testing
- Contact tracing
- Referral
- Treating
- Home Care
- IPC
- Mental health
Effective human resources for health management

- **Tools**
  - (financial, equipment, guidelines)

- **Individual factors**
  - (skills, expertise, motivation)

- **Organizational Environment**
  - (workload, team structure, supervision & management, support services)

- **System-wide factors**
  - (governance & legal framework, roles & responsibilities, institutional linkages)

- **Conducive environment**
  - (socioeconomic development level, political will, cultural factors, favourable geography)*

* Not modifiable by capacity building measures within the health sector

Timely salary/overtime **payment** & paid sick leave (+contract workers) **Incentive structures** to staff COVID-19 & essential health services
Transportation, child/elder care **allowances**

**Appropriate PPE & IPC supplies**, feminine hygiene products, rest areas
**Advice on the use of masks** | **Psychological first aid**

**Infection prevention & control | WASH & waste management**

**Clinical SARS management**: high resource settings | low- and middle resource settings | Home care | Prehospital EMS

**Mental Health**: MHPSS in COVID-19 | mhGAP Humanitarian Intervention Guide

**Risk communication**: Action Plan | Package for healthcare facilities

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The Health Workforce 2030
Prioritise **decent work**: autonomy, teamwork, respect, innovation

**Adapt working conditions:**
Flexible hours to parents of young children | access to child care services
Modifications for older workers

Involve staff in **decision-making** and assessing workplace priorities

Create incentives, including packages of **financial, professional** (mentorship, networking and continuing education) and **quality of life incentives** to encourage willingness to work in COVID-19 environment.

**Bottom line:** Decent work can contribute to making health systems effective and resilient, and to achieving equal access to quality health care.
Individual factors
(skills, expertise, motivation)

Address specialist gaps through organization of care delivery pathways to assign roles, type of worker, team composition

Retrain and upskill staff in management of suspected or confirmed COVID-19 cases, including IPC and familiarizing staff to work in high-demand areas (e.g. infectious disease wards, emergency and intensive care units) to support surge.

Identify where students, university affiliates, community volunteers can perform non-medical support tasks (data management, record keeping, patient intake)

Train & equip CHWs to support surveillance and perform IPC, contact tracing, home visits (including delivery of food, oxygen, medicines), public health promotion, hygiene demonstrations

Train for key capacities: prevention, triage, diagnosis, contact tracing, treatment, supportive care

Web-based just-in-time training (OpenWHO)

Micro-credentialing and remote learning delivery (WHO Academy)

National public health rapid training mechanisms

Resource **Open WHO**, WHO Academy app (launching in April 2020)
WHO Academy: App development informed by survey

WHO COVID-19 Skills Training Survey Summary

Who?
- 169 Countries
- 60% Female
- 39.9% Male
- 0.1% Other

What?
- 10,307 Respondents and growing
- Nurses, Medical Practitioners, Specialists, Public health professionals, students, and many others

Age Groups
- 42% 18-34
- 44% 35-54
- 14% >55

Top 5 skills to improve:
- IPC
- Case Management
- Use of PPE
- Occupational safety
- Risk Communication

85% Access internet on smartphone/tablet
71% refer to WHO guidance
69% refer to Ministry of Health guidance
Only 1/5 feel fully prepared

Top 3 preferred training:
- Online slides & videos
- Interactive webinars
- Mobile learning Apps
WHO Academy app (April 2020)

Home screen

Look for resources

Workshop schedule

General information

News
Create **funded positions** to recruit additional health workers
Licensed retirees, unemployed but qualified health workers, migrant & refugee health professionals, residents

Activate partners: national medical reserve corps, military & veteran health care providers, medically-certified EMTs from NGOs, Red Cross and Red Crescent Movement

Reduce health worker burdens by **optimizing roles & tasks**
Train and repurpose government and other non-health sector workers to support tasks (e.g. facility security, data collection, hotline response, infection prevention and control).

**Redistribute workers** from low-to high-density areas and within facilities.
Engage public & private sector for essential services delivery & surge support

**Resources**
- [COVID-19: Operational guidance for maintaining essential health services during an outbreak](#)
- HRH guidance for COVID-19 response (coming soon)
Balance workloads to avoid burnout including appropriate work hours & breaks and shift rotation. Use health worker surge modeling tools to identify critical tasks and time expenditures.

Optimise tasks & roles:
* Identify clinical EHS interventions for rapid uptraining of non-specialist professionals
* Mix specialist/non-specialist teams for acute COVID-19 care
* Use case management tools like IMCI for community/health facility level adapted use

Provide appropriate supervision in a learning environment. Support on-the-job training through team-based mentoring. Recent graduates providing COVID-19 services should not work beyond their competencies.

Ensure management structure, governance and capacity to reinforce and/or correct recently-acquired knowledge & skills.

Resource WHO health worker surge modeling tools
Ensure supervision and management systems to reinforce IPC and **appropriate PPE**

Systems surveillance measures to **reinforce safety practices** and resources and to quickly address breaches.

**Report** occupational safety and health abuses in a blame-free environment

Notify labour inspectorates of **occupational health illness** & access compensation

Health workers have the right to remove themselves from **unsafe working conditions**

Maximize staff safety, including **mental health and psychosocial support, physical security, stress and substance monitoring**, and **enforced rest periods**.

**Resource** ILO-WHO *Occupational safety and health in public health emergencies*
Temporary licensure to health professionals licensed in other jurisdictions (e.g. refugees, migrants); **Accelerated licensing** of medical and nursing graduates

**Pharmacist waivers** for early & multi-month refills, therapeutic substitution

**Practice indemnity** for COVID-19 health workers

Policy on **health worker infection, disability or death**; return-to-work protocols

**Strengthen information systems** (HMIS, HRIS, CHIS, DMIS) for decision support

Include data on **health worker infections** and fatalities for in-course IPC and PPE correction, contact tracing, and decision-making

**Underscore health system linkage to health workers** delivering essential services and COVID-19 roles in communities including supply, referral & supervision

**System-wide factors** (governance & legal framework, roles & responsibilities, institutional linkages)
Streamline decision-making, use agile approaches and explore unconventional partnerships

Leverage existing intersectoral and intra-ministerial partnerships

Reduce barriers between public & private sector for planning & operations, including allocating health workforce capacity, aligning training and recruitment and coordinating national response

Maintain a collaborative approach with workers & their associations to promote safe, appropriate working conditions and avoid/ manage adverse actions like industrial action by health workers.

Resources
- Guideline on decent work in public health emergency settings
- Rights, roles & responsibilities of health workers during COVID-19, including key considerations for occupational safety & health
Conducive environment – Gender (socioeconomic development level, political will, cultural factors, favourable geography)

**Women** – 70% of the global health workforce - are performing much of the frontline care for COVID-19

**Nurses are 59%** of the workforce; 90% of nurses are female

Female health workers often are recruited for **unpaid roles** in outbreaks & emergencies and are expected to provide 76% of care & domestic work for their families

**Data & understanding of gender issues** enhances understanding of trends & risk factors

Provide **safe & decent working conditions**, including remunerating all care work

**Use gender-sensitive data collection/analysis** and response management approaches

**Include women in COVID-19 planning, decision-making and leadership**

**Resource** Women in Global Health [Five Asks for Global Health Security](https://www.who.int/women)
Policy asks

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Prompt remuneration & overtime/hazard pay, including contract staff

Occupational health/safety, incl. appropriate PPE for HRH COVID-19 practice guidelines & job aids

Training & skills refresher, including on IPC

Appropriate delegation of tasks & roles appropriate to skills

Decent work, including mental health support, decision making roles

Create funded positions to recruit additional health workers

Redistribute HRH from high- to low-incidence areas

Interdisciplinary teams with mentoring; clinical rotation

Supportive supervision & work/rest balance

Regulatory measures to streamline deployment of health workers

Pathways for accelerated licensing, micro-credentialing

Health worker data, incl. infection & death, in information systems

Gender: leadership role, safe work, recognize unpaid work

Innovation: rapid scale-up of digital learning and intersectoral partnerships
“While every country's journey towards universal health coverage is unique, we know that having a competent, motivated and supported health workforce is the backbone of every health system. There is simply no health without health workers.”
– Dr Tedros Adhanom Ghebreyesus