

# Rapid Guidance for Strengthening Human Resources for Health in the context of COVID-19

## Introduction

Health systems can only function with health workers. Improving health service coverage and realizing the right to the enjoyment of the highest attainable standard of health is dependent on the availability, accessibility, acceptability and quality of qualified personnel, and this is even more crucial during pandemics. Investing in human resources for health (HRH) is one part of the broader objectives of health systems strengthening (HSS). HRH are the first line of defence against health crises, and are key to health systems resilience and to implementing the core elements of the International Health Regulations.

Skills development of health workers in responding to public health emergencies (PHE), as well as ensuring their protection and security are also important. PHE imply an acute need for more health personnel across the spectrum of clinical care and public health actions. This briefing note provides guidance for UNICEF and other agencies seeking to support the HRH component of an HSS approach to PHE, such as the COVID-19 pandemic. It proposes concrete actions to consider when designing, planning and implementing health sector responses.

The structure of this HRH-specific document follows UNICEF's original HSS Approach, which referred to HSS actions at national, sub-national or district and sub-district or community levels. It focuses not only on HRH for clinical care and public health functions, but also HRH for procurement and supply chain management, health management information systems and digital health.

## Actions to improve HRH in PHE at different levels of the health system

**1. HRH at community level:** As a PHE evolves, the frontline of preparedness for and response to the outbreak will be at this level. The [three components of primary health care](#) (PHC) are more important at this level. They are: 1. Systematically addressing the broader determinants of health through multisectoral policy and action, 2. Empowered and engaged communities and individuals and 3. Primary care and essential public health functions as the core of integrated health services. Health systems must respond to gaps in the availability/distribution/ skillset and gender balance of the [community health workforce](#). Actions might include context-appropriate capacity building of frontline HRH (community health workers [CHWs] or other cadres of health workers [HWs]), use of CHWs as community educators and mobilizers, contributing to disease surveillance and strengthening service delivery gaps. HRH at community level could be supported through:

- **Capacity assessments** on the ability of the community HRH to absorb the extra volume of work due to the COVID-19 pandemic

- **Training/capacity building** on epidemic preparedness and clinical response (including through mobile or online learning)
- **Training on public health elements** (surveillance, sample collection, notification, contact-tracing and reporting)
- **Training to disseminate standard operating procedures (SOPs)** on infection prevention and control (IPC) and waste management at the community and PHC level
- **Supporting rapid policy development on public-private partnerships** on health service provision by private HWs
- **Engaging CHWs, including private providers** in dissemination of context-appropriate messaging
- **Encouraging community-level HRH to establish a community alert system** using context-appropriate technology
- **Creating a database of trained HRH capacity (including geographic mapping)** that can be easily accessed and deployed to fill service gaps
- **Supporting development/review of available policies** on task-shifting, redeployment or hiring of retirees within context of the available workforce
- **Creating a pool of trained, mobile community health workforce** ready for surge-deployment.

**2. HRH at district level:** Building local health systems capacity to align with other sectors, and to support PHE preparedness is key to decelerate the spread of any epidemic and its impact on local communities. Responses in this area will depend on the decentralization of health sector governance and financing of HRH, consideration of which is covered in another guidance document. District needs on HRH can be addressed through:

- Supporting health managers to undertake **HRH planning and operationalization** to ensure both clinical and public health services are covered at district and sub-district levels, including through surge or other strategies, **across all health systems components**
- **Strengthening the HRH capacity of all departments and directorates** through decentralized management, health and HRH information systems, and functional planning, and through monitoring and evaluation
- **Supporting HRH leadership and management practices** through encouraging meetings, creation of decision space, ensuring technical and managerial capacities or at least appropriate supervision, and incentivising accountability in relation to the health and support workforce
- **Supporting managerial cadres** at district level for HRH planning, financing and implementation.

**3. National HRH Strategy development:** the health workforce has a vital role in building the resilience of communities and health systems to respond to a PHE. The foundation of effective and resilient health services is matching the supply

and skills of HWs to population needs, now and in the future. A PHE may require revision of previous strategies and new approaches to plan, educate, deploy, manage and reward HWs. Effective policies at national levels, with adequate investment to address unmet needs at all levels are needed. National country efforts for addressing COVID-19 HRH needs can be reinforced through short and medium term actions:

- **Supporting rapid national HRH capacity reviews**
- **Working with government to ensure a fit-for-purpose health workforce across all sectors** (clinical, laboratory, management, finance etc.)
- **Supporting quality learning initiatives** for rapid upscaling of HRH skills to match needs, including through use of digital and mobile communications technology
- **Training on public financial management** as required
- **Supporting development of HRH action plans and budgets** appropriate to the situation, including HW welfare policies (workload, compensation, sick leave, protection from abuse, psychosocial support, etc)
- **Developing rapid policy initiatives on HRH capacity** such as rostering, task-shifting or redeployment initiatives, mobilizing retirees, migrants or new recruitment, and surge staff or ancillary workers if needed
- Similarly, **developing long-term policies related to HRH in PHE**
- **Maximizing consideration of gender issues in HRH** including on women's participation and opportunities for leadership, addressing gender bias and inequalities
- **Supporting public sector-wide policy development on HRH issues** such as salaries, career path, standards, stewardship, regulation, promotion and qualifications – all of which might influence the national capacity to respond to PHE
- **Institutionalizing the use of reliable data collection for HRH planning for:**
  - **Financing and payment** (salary level, distribution, performance, non-salary expenditure)
  - **Education** (pool of applicants, institutions, quality of graduates)
  - **Management** (leadership, administration, organizational culture, decentralization)
  - **Policy making** on crosscutting issues (entry into the workforce, migration, emerging health issues, dual practice, absenteeism, private providers etc.)
  - **International recognition of health workers' qualifications** to optimize skills use, increase the benefits from and reduce the negative effects of health worker migration.

#### **Actions to improve HRH in PHE through the health system:**

**4. Data and information management:** Strengthening local HRH management information systems (HMIS), including geographic information systems to monitor the location and activities of HWs on COVID-19, and to facilitate HW engagement, communication and performance management can be supported through:

- **Development/agreement of national and subnational indicators:** e.g. Density level of HRH (#, categories), distribution (skill-mix, geo-location, sector, gender)
- **Facilitate analysis of country context, disease patterns, and HR needs**
- **Facilitate the use of digital technologies** to enhance access to health services, improve the responsiveness of health systems to the needs of individuals and communities, and improve the delivery of health services
  - **Support the use of cost-effective information and communication technologies (ICT)** to enhance data collection, health education, people-centred health services and HMIS

- **Support emerging cadres of health workers** enabled by ICT
- **Integration of data into the National HMIS**
  - **Strengthen institutional capacity to analyse data** for health labour market analysis
  - **Facilitate active engagement** of communities, HWs, employers, training institutions and professional and regulatory bodies to strength data architecture
- Promote the progressive implementation and reporting of **National Health Workforce Accounts**.

**5. Supply Chain Management:** the COVID-19 pandemic poses increasing pressure on health supply chains. Preventing, detecting and responding to shortages of health products is a major challenge during the COVID-19 pandemic. With the introduction of new health products, specialized skills to ensure their quality, safety and efficacy and their efficient procurement and supply is needed. A workforce that is fit-for- purpose in procurement and supply chain management, with skills to forecast needs, to develop procurement processes, for warehousing and distribution, stock management, maintenance and more is critical.iii

Efforts for improving the health supply chain workforce can include:

- **Assess Supply Chain Management (SCM) HR situation and prioritize interventions** based on their current level of maturity, targets, and available resources to be included in national policies and plans, the ability of the health supply chain HR to absorb the extra workload, and support the expansion of the workforce
- **Provide education, training and professional development to address the specific technical competencies for dealing with COVID-19 products** specificities and the appropriate competencies for procurement and supply chain management are in place
- **Build capacity in new era skills** such as data science, analytics, outsourcing, contracting, monitoring, and supply chain performance across the public and private sectors
- **Build effective capacity to manage strategic purchasing and procurement**
- **Model the required national and sub-national capacity in strategic procurement, market shaping, financial management, and budgeting**
- **Support the inclusion of needed procurement and supply chain management cadres**
- **Foster new career pathways** for supply chain professionals across sectors
- **Work with** the International Association of Public Health Logisticians (IAPHL) to build a network of regional logisticians that are available to respond to pandemics.

**6. Private Sector Engagement:** there is no prescription for a perfect mix of public and private health-care provision, and demand for both public and private systems are higher during pandemics. Health systems organized around clinical specialties and hospitals would need to shift towards prevention and primary care for the general population, and reserve hospital services for severe cases requiring specialized care. Business models are emerging as a private-sector, socially oriented solution to serve the unserved. The following activities are proposed to be considered in COVID-19 programming while engaging with the private sector providers:

- **Support geo-mapping of private health care providers** that can respond to COVID-19
- **Disseminate information about their regulation**, and special measures that might apply during the COVID-19 pandemic
- **Develop financing approaches** to incentivize private provider engagement in PHEs



- **Include private providers** in COVID-19 preparedness, response and mitigation strategies
- **Shift service models** towards prevention and efficient provision of quality, affordable, integrated, community-based people centred PHC, including by private providers; reserve wards for the very sick
- **Seek co-investment by the private sector and establish public-private HRH mix**
- **Develop guidance on private sector participation** in pandemic preparedness and response
- **Engage with public and private sectors**, civil society, trade unions, health worker associations, nongovernmental organizations, regulatory bodies and training institutions

**7. Quality of Care:** Quality of health care is “*the extent to which health care services provided to individuals and patients population improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred*”<sup>iv</sup>. In emergencies, there are avoidable risks for patients, and human resources are key to achieve results that should go beyond coverage in order to be translated into reduction of excess morbidity and mortality for new-born, children and mothers. The following activities are proposed to be considered in programming:

- **Increase emphasis on frontline workers, particularly for primary care**
- **Support health workers improvement performance** by combining training with other components, such as supervision or group problem solving, or implementing certain multifaceted strategies<sup>v</sup>
- **Implement supportive supervision strategies**<sup>vi</sup>: appropriate supervisor–supervisee ratio allowing meaningful and regular support; ensuring supervisors receive adequate training; coaching and mentoring of HWs; use of observation of service delivery, performance data and community feedback; prioritization of improving the quality of supervision
- **Establishment of rapid response teams trained on public health measures, risk communication and contact tracing sample collection to relieve HWs affected by the pandemic.** Support accreditation mechanisms for health training institutions
- **Task-shifting, task-sharing and redistribution of health workforce:**
  - Consider changing roles in response to shifting needs and staff availability
  - Tasks can be shifting up or down in the hierarchy with advantages and disadvantage, consider context specificities and opportunities
  - Train front-line workers with limited pre-service training on IMCI, iCCM and supervision
  - Consider burden and diversity of tasks required to impact safety and effectiveness
  - **Re-distribute health workforce capacity including re-assignment and task-sharing**<sup>vii</sup>: re-assign staff from non-affected areas, establish accelerated training and early certification options and ensure supportive supervision; identify high-impact clinical interventions for which rapid training would facilitate task sharing. Consider expansion of scopes of practices, provide online training on clinical decision-making, management etc.; train and repurpose government and other workers from the non-health sector for supporting activities (admin, maintenance, etc.)
- **Support key IPC activities, according to scenario**<sup>viii</sup>:
  - No cases: Usual staff. Train all staff for safe COVID-19 recognition and care.
  - Sporadic cases: Activate IPC task force. Additional staff called in and trained.
  - Clusters of cases: Staff extension (supervision of larger number of staff). Expanded care team model with task shifting or task sharing, and relevant changes in responsibility.

- Community transmission: Make every effort to ensure enough staff available. Expanded care team model and additional emergency medical teams.

## **8. Financing, public financial management and social budgeting:**

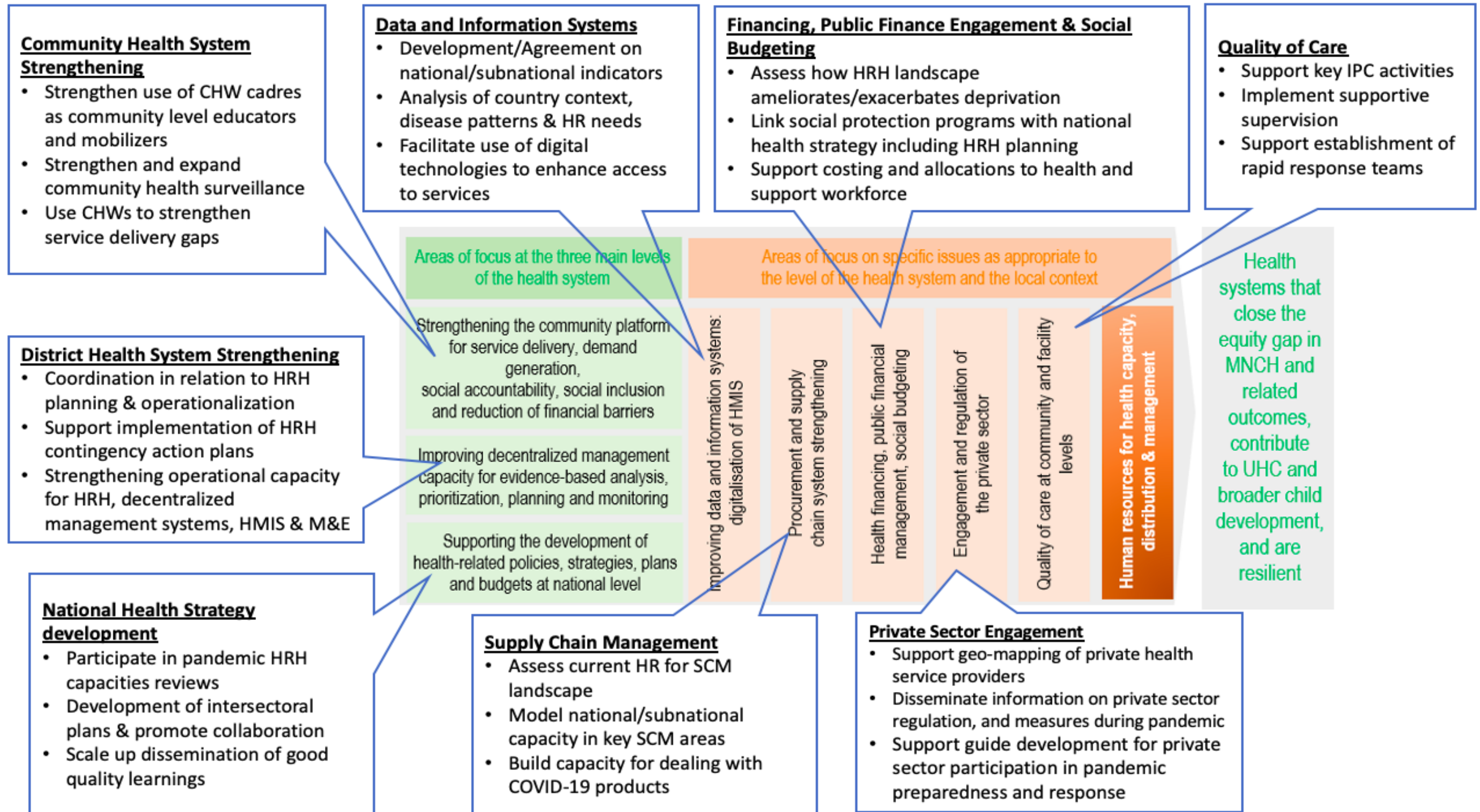
ensuring business continuity by the health and support workforce throughout the COVID-19 pandemic requires extraordinary and flexible financial resources and mobilisation mechanisms. It is therefore important to identify how additional HRH can help highlight the gaps and barriers to accessing needed health and social services. Countries need to make extra effort to narrow the gaps in deprivation and ensure communities are not denied access to services due to HRH related issues. These activities are proposed for programming and implementation:

- **Assess how the current national/sub-national HRH landscape is affecting health service access and household deprivation** in the pandemic context
- **Support development of clear guidelines on additional financing and incentives** to encourage participation of private sector, retired or expatriate personnel
- **Encourage funding for HRH surge deployment strategies**
- **Mobilize funding from domestic and international sources, including the private sector**, for health services and social budgeting initiatives, including for related HRH
- **Support costing and allocations** to health and support workforce.
- **Promote investing in the right skills, decent working conditions and appropriate numbers** of HRH
- **Link social protection programs with national health strategy** including HRH planning
- In coordination with national authorities and partners, **prioritize provision of incentives** (fair contracts, hazard allowances, insurance) to retain the HRH workforce during the PHE
- **Support public finance management**, timely payment of and equity related to HRH
- Facilitate **societal dialogue and political commitment** to drive financing to strengthen HRH.
- Ensure **collective action on financing** for HRH is taken in **low-income and fragile countries**.

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# Health Systems Strengthening through Human Resources for Health in the COVID-19 context



<sup>i</sup> WHO Global strategy on HRH. Workforce 2030.

<sup>ii</sup> Working for health and growth: investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. High-Level Commission on Health Employment and Economic Growth. ISBN 978 92 4 151130 8 © World Health Organization 2016

<sup>iii</sup> The Health Supply Chain Workforce, the missing link to Universal Health Coverage. Briefing note, side event WHA 2020 (under development)

<sup>iv</sup> WHO. Standards for improving quality of maternal and newborn care in health facilities (p.14)

<sup>v</sup> BMJ 2018;362:k2813 <http://dx.doi.org/10.1136/bmj.k2813>

<sup>vi</sup> <https://www.who.int/management/supervision/en/>

<sup>vii</sup> COVID-19: operational guidance for maintaining core health services during outbreak.

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<sup>viii</sup> Operational considerations for case management of COVID-19 in health facility and community: interim guidance.