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**CHECKLIST FOR THE MANAGEMENT OF HUMAN RESOURCES FOR HEALTH
IN RESPONSE TO COVID-19, 6 MAY 2020**

INTRODUCTION

In order to address the COVID-19 pandemic, countries and health institutions must have the capacity to respond with human resources that are sufficient in quantity and possess the skills and capacities necessary to meet the needs of the population in a timely, relevant, efficient, and effective manner.

Effective management of human resources will allow health systems to respond in a timely manner, improve health care outcomes, rationalize the use of resources, and reduce the stress on staff.

The COVID-19 pandemic presents challenges to ensure the availability of health personnel in areas of high demand with the necessary capacities to respond adequately to increased demand and expansion of services as well as the possible reduction in available personnel due to, among other things, illness, risk situations, and personal or family issues.

Planning of human resources is essential to ensure preparedness for response, enhance surge capacity, and ensure a sufficient supply of health workers that are more efficient and productive, providing them with the training, protections, rights, recognition, and tools necessary to undertake their roles.

In order to plan appropriately, the following areas should be prioritized:

1- Establish a process to forecast human resources' staffing needs and the possible mobilization of human resources;
2- Protect health personnel and support workers in health institutions, including consideration for their mental health, psychosocial, and personal and family needs;
3- Provide appropriate and up-to-date training and maintain communication with health workers;
4- Activate or strengthen the health services network, communication and community participation in countries

This checklist is designed to complement the actions and interventions related to the management of human resources for health (HRH) described in the document, *Framework for the response of integrated health services delivery networks to COVID-19*.

It is intended for use by PAHO/WHO Health systems and services advisors, PAHO/WHO incident command members, national health authorities (including HRH directors and managers), and directors of health services and networks. It is important to note that not all items will be applicable to all countries, contexts, levels or functions; respondents can skip items or mark not applicable (N/A) as appropriate. A detailed explanation of the items presented is provided after the checklist.

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**CHECKLIST FOR THE MANAGEMENT OF HUMAN RESOURCES FOR HEALTH
IN RESPONSE TO COVID-19**

Mapping availability, needs and gaps in health workforce capacity				
	Yes	No	In progress	N/A
1. Mapping of essential health worker needs, including for scaling up				
2. Mapping of health worker availability according to levels of care				
3. Establish centralized roster or database of all available health workforce by level of care				
Recruitment of additional health workers				
	Yes	No	In progress	N/A
4. Temporary deployment of private sector professionals to public sector facilities				
5. Activation of other health provider networks				
6. Establish pathways for accelerated training and early licensing of medical and nursing graduates				
7. Deployment of recent health care graduates as support personnel in community activities, home visits, patient orientation, data collection, and general examinations				
8. Outreach to retired health workers and/or health workers working outside the health sector				
9. Training and repurposing of government and other workers from non-health sectors, and volunteers to undertake support tasks and functions in health facilities				
10. Establish incentives and domestic support measures to enhance staff flexibility for shift work				
Reorganization and role distribution of health workforce				
	Yes	No	In progress	N/A
1. Assign roles based on the organization of care delivery in response to the emergency				
2. Temporary re-distribution of staff to other areas of the country where most needed				
3. Redistribute personnel to other areas or functions of the health facility where most needed				
4. Training, repurposing, and utilization of professionals in different capacities (task-shifting)				

5. Assign generalist health workers to:
   a. address the needs of those with minor symptoms in health facilities, ambulatory or home-based settings, or congregate care facilities; and/or
   b. address conditions other than COVID-19.				

6. Alternative models for delivery of care have been evaluated for rapid implementation				
7. Strengthen the functions of basic health teams and family health teams to identify vulnerable, at-risk populations and follow up infection containment and control through information, education, and promotion				

Reorganization and role distribution of health workforce (cont'd)				
	Yes	No	In progress	N/A
8. There is clear definition of the roles and functions for each professional (protocols and procedures)				
9. Additional shifts and other staff scheduling arrangements implemented				
10. Use of web-based and other telemedicine platforms implemented				
11. Consider the potential consequences of health professionals engaging in multiple employment (total hours worked; risk of transferring infection between institutions, etc.)				
12. Call centers or hotlines established				
Contractual, legal, administrative and other considerations to enable rapid response				
	Yes	No	In progress	N/A
1. Determine categories of health workers best targeted for the measures under consideration				
2. Review previous country experience with the measures under consideration				
3. Review existing legal frameworks, norms, agreements, or mechanisms and feasibility for adaptation				
4. Review and adapt as needed existing administrative procedures and contractual mechanisms				
5. Ensure that policies and regulations are in place to allow health workers to deliver COVID-19 interventions and for liability coverage				
6. Review legal implications of the different contractual mechanisms under consideration				
7. Review requirements for licensure and certification of professionals (specialized/non-specialized personnel)				
8. Review norms for any existing limitations to the exercise of certain professions or their scope of practice				
9. Review liability, insurance, and clinical indemnity arrangements required for changes of assignment across medical sub-specialties and/or task sharing or substitution measures being considered				
10. Review training requirements to support measures under consideration				
11. Implement appropriate coordination and supervision mechanisms				
12. Financial resources available and accessible				
13. Financial and/or non-financial incentives identified				
14. Review regulations regarding provision of care by health personnel from other countries and possible establishment of agreements with other countries				
15. Policies and regulations to manage volunteer workers are in place				
16. Cultural and/or linguistic competencies are taken into account				
Communication and coordination				
	Yes	No	In progress	N/A
1. Communication mechanisms established to ensure a workforce notification system is in place				
2. Communication mechanisms established with professional associations and others				

Communication and coordination (cont'd)				
	Yes	No	In progress	N/A
3. Communication and cooperation facilitated between management, health workers, and/or their representatives				
Training and skills enhancement for health workers				
	Yes	No	In progress	N/A
1. All health workforce in community and hospital-based services are provided appropriate COVID-19 training (online, or in designated community training facilities)				
2. Training plan developed and adopted, including provisions for ongoing training, updating skills and competencies				
3. Health workforce is trained and up to date in basic life support according to WHO Basic Emergency Care				
4. Rapid training mechanisms and job aids for key capacities are in place and/or available				
5. Access to existing web-based training courses on COVID-19 is available to healthcare workers				
6. Adequate supported supervision structures and capacity to reinforce and support rapidly acquired knowledge and skills are in place.				
7. Systems established to monitor and ensure the proper acquisition and application (practice) of the knowledge, skills, and competencies needed to respond to COVID-19				
Safety and protection of health workers				
	Yes	No	In progress	N/A
1. Preventive and protective measures, including administrative controls, taken to minimize occupational safety and health (OSH) risks				
2. Information, instruction, and training on OSH provided				
3. Secure and allocate PPE to health workforce providing frontline services (in hospitals and communities), considering risk of exposure				
4. Health workforce is properly trained in the rational use and disposal of PPE				
5. Appropriate work hours and enforced rest periods ensured and space made available for the same				
6. Optional accommodation arrangements made available for hospital-based health workers to reduce time spent travelling to/from home and protect health workers' families from indirect exposure				
7. Health workers in high-risk categories for COVID-19 complications are reassigned to tasks/settings that reduce risk of exposure				
8. Partnering more experienced with inexperienced colleagues is included in plan				
9. WHO document, *Coronavirus Disease (COVID-19) Outbreak: Rights, roles and responsibilities of health workers, including key considerations for occupational safety and health* has been made available to all health workers				
10. Protocols for the management and monitoring of suspected and confirmed cases among the human resources involved in the COVID-19 response have been activated				

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Safety and protection of health workers (cont'd)				
	Yes	**No**	**In progress**	**N/A**
11. Mechanisms for reporting of incidents and symptoms by health workers are in place				
12. All health workers are aware of how to identify and report any symptoms				
13. Health workers understand when they must self-isolate				
14. Protocols established to assure safe return to work of health workers following quarantine or sick leave				
Mental health and psychosocial support for health workers				
	Yes	**No**	**In progress**	**N/A**
1. A dedicated hot line for psychological support to health workers has been established and health workers are informed				
2. Work schedules and working hours have been reviewed to enable flexibility and workload distribution				
3. Supervisors encourage and monitor breaks				
4. Monitoring of health workers for illness, stress, and burn-out implemented				
5. Psychological first aid training is available for volunteers and community members to support staff in high stress areas				
6. Childcare and other care support options for health workers are in place				
7. Buddy system to provide support, monitor stress, and reinforce safety procedures is encouraged				
8. Workers are aware of and access is facilitated to mental health and psychosocial support services				
9. Responders receive training and orientation on how best to provide basic emotional and practical support				

DETAILED EXPLANATION

Mapping availability, needs and gaps in health workforce capacity:

1. Map health worker requirements and availability (including profile, level of care, critical tasks) for WHO transmission scenarios, utilizing tools that are available from PAHO, WHO, and/or other reputable sources. Utilize available information (registries, databases) on human resources for health in the country. To the extent possible, this information should be organized according to profile, specialty, training, current status (active, retired, etc.), demographics (sex, age), location, and potential availability. This will enable the identification of qualified candidates and potential recruitment of additional health workers. Potential sources of the above information are HRH databases, registration and certification records, professional associations, etc.
2. Consider setting up a centralized roster or database of all available health workforce according to level of care at the appropriate level (municipal/district/parish, provincial/state, regional, national) and designating a function for updating contact information and potential health care service capacity of all people willing and capable to serve.

Recruitment of additional health workers: Countries may wish to consider the following sources for temporary health workforce surge capacity and other essential health care services:

1. Establish agreements with the private sector for temporary deployment to public sector.
2. Activate other health provider networks such as national medical reserve corps, military and veteran health care providers and medically-certified EMTs from non-governmental organizations and the International Federation of the Red Cross and Red Crescent (IFRC).
3. Where appropriate, consider establishing pathways for accelerated training and early licensing of medical and nursing graduates.
4. Deploy recent graduates awaiting internship and students in their final undergraduate year (professional practice or social service) as support personnel in community activities, home visits, patient orientation, data collection, and general examinations.
5. Call on retired health workers and/or health workers working outside the health sector for specific tasks. For example, intensivists or specialists could be used to provide virtual consultations to limit their exposure.
6. Train and repurpose government and other workers from non-health sectors, and volunteers to undertake support tasks and functions in health facilities that may be compromised (e.g., administration, maintenance, facility security, data collection, hotline response, infection prevention and control, other support services for staff and patients, etc.).
7. Establish incentives and domestic support measures (e.g. travel, childcare, care of ill, disabled or elderly family members) that could enhance staff flexibility for shift work.

Reorganization and role distribution of health workforce

1. Review overall organization of care delivery to appropriately assign roles. Health workers with the credentials, skills, and training for higher level care should be assigned to roles according to their capacity.
2. Redistribute staff temporarily from non-affected or less-affected national and sub-national areas to other health services, districts, or areas of the country where they are most needed.
3. Redistribute personnel from one area of the health facility to another or to other functions where they are most needed.
4. Consider training, repurposing, and utilization of professionals in different capacities (task-shifting):
   a. Enhance the capacities of pediatric intensivists and emergency care physicians for the management of adults to assist and support under the supervision of adult intensive care physicians.

b. Reorient certain specialities, such as internists, anesthesiologists, surgeons, nurses, and other health professionals to manage specific treatments for critical COVID-19 patients (intubation, ventilation, respiratory therapy, others).

c. Redistribute functions among professionals that are not on the first line of COVID-19 control (occupational therapists, otorhinolaryngologists, ophthalmologists, dermatologists, and other specialties) to the first level of care or second-level hospitals to boost capacity in these facilities for non COVID-19 patients.

d. Ensure the existence of health professionals to care for people with chronic noncommunicable diseases (CNCD) and other non COVID-19 conditions.

5. Assign health workers with more general skill sets, those repurposed from other health delivery settings, community health workers, community first aid responders, other lay providers, and recent medical graduates under appropriate supervision to: (1) address the needs of those with minor symptoms in health facilities, ambulatory or home-based settings, or congregate care facilities designed to isolate all cases; and/or (2) address conditions other than COVID-19.

6. Evaluate alternative models for delivery of care, including identification of simple high-impact clinical interventions for which rapid up-training would facilitate safe task sharing and expansion of scope of practice.

7. Strengthen the functions of basic health teams and family health teams to identify vulnerable, at-risk populations and follow up infection containment and control through information, education, and promotion.

8. Ensure that there is clear definition of the roles and functions for each professional (protocols and procedures).

9. Coordinate shifts of health workers to ensure adequate coverage and allow sufficient downtime for overworked personnel. Consider increasing the shifts of part-time staff to full-time or additional hours, balancing occupational safety and health to ensure quality care and prevent infection.

10. Consider the potential consequences of health professionals engaging in multiple employment (total hours worked; risk of transferring infection between institutions, etc.).

11. Consider the use of web-based and other telemedicine platforms to provide direct clinical services to patients and clinical decision-making support to service providers who address the needs of individuals with mild COVID-19 symptoms.

12. Establish a call center and/or emergency hotline to respond to COVID-19. Personnel should be duly trained to provide direction and respond to community questions, concerns, and doubts. This function can be undertaken by university students in health careers, health professionals and specialists (active or retirees), among others.

Contractual, legal, administrative and related issues to enable rapid response

Decisions will be based on the situation, context, and experience of each country as well as the characteristics of its health system. In reviewing options, the country may wish to consider the following questions:

1. What **profiles** of health workers are most needed?
2. Which **categories** of health workers are best targeted for the measures under consideration?
3. Has the country had **previous experience** with the above measures and what was the outcome of the same?
4. What **legal frameworks, norms, agreements, or mechanisms** exist in relation to the various options? Are they likely to facilitate or hinder the option(s) under consideration? Can they be adapted if necessary?
5. What **administrative procedures and contractual mechanisms** are currently available or can be adapted as necessary to facilitate the hiring and/or mobilization of personnel, and/or changes in the worker profile (task shifting, task sharing, role expansion)?
6. What **policies and regulations** must be in place to allow health workers to deliver COVID-19 interventions and for liability coverage?

7. What are the *legal implications* of the different contractual mechanisms under consideration (both for the institution and for the health worker)?
8. What are the requirements in terms of *licensure and certification* of professionals? For specialized/non-specialized personnel?
9. Are there norms regarding the *scope of practice* permitted according to different professions?
10. What *liability, insurance, and clinical indemnity arrangements* should be considered as regards changes of assignment across medical sub-specialties and/or in line with agreed task sharing or substitution measures?
11. What *type of training* and *amount of time* is needed to implement the measures being considered?
12. What type of *coordination and supervision* mechanisms need to be in place? Is the system equipped to implement these?
13. What *financial resources* are available or can be accessed?
14. What *financial and/or non-financial incentives* can be utilized?
15. Do any regulations exist regarding provision of care by health personnel from *other countries*? If yes, can *agreements* be established with other countries for the mobilization human resources?
16. What policies or regulations exist or need to be in place for *volunteer workers* (vetting, accepting, rejecting, liability issues, etc.)?
17. Are *cultural and/or linguistic competencies* a consideration, particularly when deploying to other areas or regions?

Communication and coordination

1. Establish or reinforce communication mechanisms to ensure a workforce notification system is in place to regularly and frequently inform the health workforce of changes in demands, service delivery arrangements, referral pathways, training opportunities, etc.
2. Work with professional associations and others to maximize communication 'reach'.
3. Facilitate communication and cooperation between management, health workers, and/or their representatives.

Training and skills enhancement for health workers

1. Ensure all health workforce in community and hospital-based services are provided with appropriate COVID-19 training (online, or in designated community training facilities).
2. Develop and adopt a training plan to address COVID-19, including making provisions for ongoing training, and updating skills and competencies as needed.
3. Ensure that all of the health workforce is trained and up to date in basic life support according to WHO Basic Emergency Care.
4. Initiate rapid training mechanisms and job aids for key capacities, including diagnosis, triage, clinical management responsibilities, and essential infection prevention and control.
5. Provide workers with access to existing web-based training courses on COVID-19, including on the Open WHO platform and PAHO's Virtual Campus for Public Health.
6. Mobilize adequate supported supervision structures and capacity to reinforce and support rapidly acquired knowledge and skills.
7. Establish systems to monitor and ensure the proper acquisition and application (practice) of the knowledge, skills, and competencies needed to respond to COVID-19.

Safety and protection of health workers

1. Ensure necessary preventive and protective measures, including administrative controls, taken to minimize occupational safety and health (OSH) risks.

2. Provide information, instruction, and training on OSH.
3. Secure and allocate PPE for the health workforce providing frontline services (in hospitals and communities), considering risk of exposure.
4. Ensure the health workforce is properly trained in terms of the rational use and disposal of PPE.
5. Ensure appropriate work hours and enforced rest periods, including provision of appropriate space for the same during shift.
6. Consider optional accommodation arrangements for hospital-based health workers to reduce time spent travelling to/from home and to protect health workers' families from indirect exposure.
7. Consider reassignment of health workers in high-risk categories for COVID-19 complications to tasks/settings that reduce risk of exposure, including back-filling arrangements to support continuity of essential health care services, while releasing other health workers less at risk to provide care for patients with the virus.
8. Partner more experienced with inexperienced colleagues.
9. Ensure health workers are aware of the WHO document, *Coronavirus Disease (COVID-19) Outbreak: Rights, roles and responsibilities of health workers, including key considerations for occupational safety and health.*
10. Implement protocols and systems for the management and monitoring of suspected and confirmed cases among the human resources involved in the COVID-19 response.
11. Encourage reporting of incidents and symptoms by health workers by providing a blame-free environment and support as needed (psychosocial, financial, sick leave, other).
12. Ensure all health workers are aware of how to identify and report any symptoms.
13. Ensure health workers understand when they must self-isolate.
14. Establish protocols to assure safe return to work of health workers following quarantine or sick leave.

Mental health and psychosocial support for health workers

1. Establish a dedicated hot line for psychological support and inform workers regarding the same.
2. Review work schedules, permit flexible working hours, and ensure distributed workload to the extent possible.
3. Initiate, encourage, and monitor breaks.
4. Monitor health workers for illness, stress, and burn-out.
5. Consider introducing psychological first aid training for volunteers and community members to support staff in high stress areas, using digital and other platforms.
6. Consider childcare and other care support options (care of ill, disabled, or elderly family members) for health workers.
7. Use buddy system to provide support, monitor stress, and reinforce safety procedures.
8. Ensure that workers are aware of and facilitate access to mental health and psychosocial support services.
9. Orient responders on how best to provide basic emotional and practical support.

PAHO/HSS/HR/COVID-19/20-0011