

Knowledge to **Action** Briefs

Ask #4: Recruitment, training, equal and fair pay, and safe working conditions, including personal protective equipment, for front-line health workers, notably midwives and nurses

These seven knowledge-to-action briefs support partners to carry forward the PMNCH [Call to Action on COVID-19](#), which aims to increase investment and policy support to mitigate the devastating effects of the COVID-19 pandemic on the health of women, children and adolescents, and the societies and economies that support them. The knowledge-to-action briefs synthesize relevant evidence to the COVID-19 Call to Action, focusing on: 1) key impacts of COVID-19; 2) policies and mitigation strategies; and 3) strategic gaps in knowledge and action, including in humanitarian and fragile settings.



Background

Women comprise 70% of the global health workforce and, during health emergencies, make up some of the most visible front-line cadres.¹ Past epidemics have shown that front-line health workers are at primary risk of infection. This increased risk takes a major toll on their physical and mental health and well-being. In July 2014, at the peak of the Ebola outbreak in West Africa, health workers accounted for 12% of all Ebola cases. Overall, health workers were between 21 and 32 times more likely to be infected by Ebola than people in the general population.² In West Africa, male health workers were more likely to be infected than their female colleagues; however, research from the SARS and MERS outbreaks noted high rates of infection among nursing staff, the majority of whom were young women.³⁻⁶ In many countries women are over-represented in nursing, midwifery and community health work, as well as auxiliary work such as cleaning and laundering. Women are also over-represented in long-term care facilities and the broader care industry.

Key impacts

There is increasing evidence of the impact of COVID-19 on health workers around the world.

Female-male ratio of COVID-19 among health workers

Despite men being slightly over-represented in COVID-19 cases among the general population, among health workers with COVID-19, women are far more likely to be infected than men. For example, the ratio of infection between female and male health

workers is 75%:25% in Spain, 68%:32% in France, 73%:27% in the United States of America and 72%:28% in Germany.⁷

Gendered dimensions of mental health

During past epidemics (SARS, H1N1, MERS), female health workers suffered a higher incidence of mental health issues than their male colleagues. Studies of the mental health impact of COVID-19 have also demonstrated a disproportionate strain on women on the front line: they are more likely than their male colleagues to experience increased stress, anxiety, depression, sleep disruption, impaired physiological, interpersonal and cognitive responses, post-traumatic stress syndrome and burn out.

Workplace safety

Even before COVID-19, labour rights advocates had pointed out that personal protective equipment (PPE) and other safety equipment are not designed to fit women's bodies. Female health workers are also at far greater risk of workplace violence than their male colleagues. There is anecdotal evidence of female nurses and community health workers in various countries around the world being targeted by co-workers, communities and patients' families.

Long-term care facilities

The global paid workforce in long-term care facilities is estimated at around 381 million people, of whom 65% are women.⁷ The COVID-19 death toll among residents in these facilities in both Europe and North America has been staggering, accounting for 30% to 50% of all COVID-19 deaths in some countries.⁸⁻¹⁰ The European Centre for Disease Control and Prevention noted in a COVID-19 policy document that "the health and safety of staff working at long-term care facilities is paramount", but the gender dimension of this work, and the gendered mental and physical risks for workers in this sector, have not been a focus.¹⁰

Equity

The increased and gendered risks of COVID-19 to health workers are compounded by their intersection with lack of equity. Ethnic minority health workers in many countries are over-represented in both health and long-term care work, and they are

contracting and dying of COVID-19 in far greater numbers than their non-minority counterparts. In the United Kingdom of Great Britain and Northern Ireland, while people from Black, Asian or minority ethnic (BAME) communities represent 13% of the population in the United Kingdom of Great Britain and Northern Ireland, they make up 21% of the health workforce and account for 63% of COVID-19 health worker fatalities.¹¹ In the United States of America, 5% of doctors and 10% of nurses are African American, but they account for 21% of COVID-19 health worker fatalities.¹²

Actionable interventions and solutions to mitigate impact

Addressing the global shortage of personal protective equipment

The COVID-19 pandemic has resulted in catastrophic global shortages of PPE. During the West Africa Ebola outbreak, the World Bank-funded Ebola Emergency Response Project (EERP) made procurement and distribution of PPE a Phase I priority. COVID-19 has resulted in similar prioritization by governments and donors. There have been attempts, including by the African Centers for Disease Control and Prevention, to create a centralized mechanism to prevent hoarding, price gouging and export restrictions and to distribute PPE supplies fairly and equitably to low- and middle-income countries. In some countries, private sector enterprises have switched production from textiles, plastics and alcoholic beverages to PPE and disinfectant so as to overcome bottlenecks in global supply and keep people employed.

Financial incentivization

The EERP also focused on financial and non-financial incentives and rewards for health workers in the Ebola outbreak. These included: hazard pay (Liberia and Sierra Leone) or indemnity pay (Guinea) to both paid and voluntary health workers; guaranteed medical care for exposed/infected health workers; death benefits to families in cases of loss of life; health worker training (infection control, triage and zoning, care and treatment); stigma mitigation workshops; and advocacy. Similar incentives to support public sector health workers around the world during the COVID-19 pandemic are being discussed by governments and donors.

Non-financial incentives

Other measures used in past epidemics (Ebola, SARS) include: 1) “Eagle Eye Observers”, health workers dedicated to overseeing the donning and disposal of PPE; 2) food and living support for staff unable to return home; 3) prioritization of health workers for routine testing; 4) opportunity to participate in vaccine and drug trials; and 5) guaranteed hospital beds for health workers who fall ill.¹³

Psychological support

Many countries are seeking to introduce or expand psychological support mechanisms, such as screening for anxiety, depression, exhaustion, distress and post-traumatic stress syndrome, both on the front line and remotely. Resilience interventions are also being piloted, such as one-on-one peer support, small group discussions, pastoral counselling and hotlines.

Flattening the curve

The World Bank’s Pandemic Emergency Financing Facility emerged in the aftermath of the Ebola outbreak to help low- and middle-income countries respond early to global health emergencies. This Facility, together with other World Bank measures including reprogramming existing grants, has enabled some countries to empower and protect health workers responding to COVID-19, flatten the curve of new cases and prevent health services from being overwhelmed.¹⁴

Priority knowledge gap

While COVID-19 data about the general population disaggregated by age, sex and ethnic background are increasingly available, such data about health workers are harder to find. For example, the COVID-19 infection rate among young female NHS health workers in the United Kingdom is almost twice as high as among their peers outside the health workforce, with high fatalities among female nursing and support staff. And, as noted above, far more BAME than non-BAME NHS workers are dying. However, in the absence of information about how both gender and ethnicity are driving health worker fatality rates, it is difficult to identify the risk factors behind these deaths.

Although COVID-19 deaths in long-term care facilities constitute an alarming proportion of deaths in several countries, the pandemic’s impact on care workers in those facilities has not been sufficiently measured. Most of the global care workforce is female, and much of the work they do is poorly paid. In many countries, the majority of this work is also undertaken by ethnic minorities, but almost no evidence is yet available about the intersection between ethnicity, class, gender and work in long-term care facilities and their combined effect on the risk of infection and death by COVID-19.



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