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Note by the Secretary-General

The Secretary-General hereby transmits a report prepared by the Director-General of the World Health Organization, pursuant to General Assembly resolution 69/132.

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Report of the Director-General of the World Health Organization on protection of health workers

Summary

The General Assembly in its resolution 69/132 addressed the issue of the health workforce as part of building resilient national health systems and advancing the attainment of universal health coverage. It particularly looked at protection of health workers, recognizing that attacks upon medical and health personnel result in long-lasting impacts, including the loss of life, human suffering, the weakening of the ability of health systems to deliver essential life-saving services and setbacks to health development.

Attacks on health and medical personnel, health facilities and means of transportation seriously affect access to health care, depriving patients of treatment and interrupting measures to prevent and control contagious diseases. Doctors, nurses and other health workers must be allowed to carry out their lifesaving humane and humanitarian work free of threats of violence and insecurity.

Addressing violence against health workers and ensuring their protection against physical and psychological threats, as well as their exposure to a hazardous working environment requires a strong political message of the unacceptability of such acts. Unchecked, it often provokes absenteeism of health workers and even leaving their jobs thus exacerbating the continuing and growing need across the world of building a well-educated, motivated health workforce, sufficient in numbers to respond to the needs of populations in all countries.

I. Introduction

1. The General Assembly, in its resolution 69/132, reaffirmed the commitment of Member States to the achievement of all Millennium Development Goals, stressing that health-related goals are key to achieving all the Goals. The resolution also recognized that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development, but that challenges in global health remain and demand persistent attention.

2. One of the challenges in global health recognized through resolution 69/132 is the relevance of the health workforce as a key element of a resilient national health system. Additionally, the resolution stressed that respect for the integrity and safety of medical and health personnel in carrying out their duties and of their means of transport and installations enhanced not only the development of resilient health systems and advancement of the attainment of universal health coverage, but also the right to enjoyment of the highest attainable standard of physical and mental health.

3. The resolution reaffirmed the role of the World Health Organization (WHO) as the directing and coordinating authority on international health work and acknowledged its key role, with other relevant international organizations, in the development and implementation of preventive measures to promote safety of medical and health personnel, their means of transport and installations and respect for each of their professional codes of ethics.

4. In addressing the issue of the protection of health workers, the General Assembly looked into several elements: one is the issue of physical and psychological attacks or threats upon medical and health personnel. Physical attacks and other violent acts not only have an immediate impact on the people affected, but also weaken the ability of the health system to deliver essential life-saving services. These attacks, threats or other ways of preventing medical and health personnel from fulfilling their medical duties happen in armed conflicts and emergency situations, as well as in the regular day-to-day exercise of their duties.

5. In resolution 69/132, the General Assembly also addressed the issue of exposure of health workers to hazardous working environments, such as in situations when acting to prevent, detect and respond to infectious diseases, or working in hospitals which may suffer structural damage as a result of, among other things, natural disasters such as earthquakes or tsunamis. Furthermore, the issues of upholding respect for the integrity of medical and health personnel in carrying out their duties and of the effective training, retention and equitable distribution of the health workforce were also deemed important in this context.

6. The General Assembly requested the Secretary-General, in close collaboration with the Director-General of WHO, to submit a report on the protection of health workers, which compiles and analyses the experiences of Member States and presents recommendations for action to be taken by relevant stakeholders, including appropriate preventive measures.

II. Violence in armed conflicts and emergency situations

7. Most of today's conflicts are associated with widespread human rights abuses and violation of international humanitarian law. Of particular concern is the

increased targeting of humanitarian staff and attacks on health workers, health facilities and patients. In addition, health workers may become the targets of collective or political violence.

8. These attacks severely inhibit access and the right to health care, and weaken health systems. They increase the risk in working in these environments, add to related operating costs, and require additional expert capacity (e.g., negotiating access).[1]

9. The General Assembly, in its resolution 69/132, reaffirmed and urged full respect for the rules and principles of international humanitarian law, including the provisions of the four Geneva Conventions of 1949, and the Additional Protocols thereto of 1977 and 2005, as applicable, as well as international customary law concerned with the protection of medical personnel and humanitarian personnel exclusively engaged in medical duties, and their means of transport and equipment, as well as hospitals and other medical facilities.

10. In spite of the legal instrument and customary law, the attacks on medical and health personnel, health-care facilities, vehicles and patients persist. Global data on attacks on health exist. However, there is no standardized data collection methodology nor central repository of reporting on statistics on violence in health care. Data is collected by different entities, for different purposes, and different geographic focus and are of different quality. Thus, it is difficult to quantify the full extent of the problem.

11. A WHO report commissioned in 2014 based on a review of open source secondary data revealed that in that year alone attacks on health were recorded in 32 countries. Data collected by the International Committee of the Red Cross between January 2012 and December 2014 recorded 2,398 incidents in 11 countries.[2]

12. Attacks can be categorized into several categories: (a) violence against health-care facilities; (b) violence against medical and health personnel; (c) violence against means of transport, medical vehicles; (d) violence against patients, the wounded and the sick; and (e) violence against medical and health institutions and official bodies, such as ministries of health, medical academic institutions and others.

13. A number of international governmental and non-governmental organizations (NGOs) are actively addressing the issue of attacks on medical and health personnel, their means of transport and installations, including to identify appropriate preventive measures to enhance and promote the safety and protection of health facilities, personnel, and their transport, as well as patients.

14. Responding to the call of its member States in Resolution 65.20 of the World Health Assembly in 2012, WHO has taken the lead in convening a wide array of interested partners to develop a methodology and tools for the systematic collection of data on attacks on health facilities, health workers, health transport and patients in complex humanitarian emergencies. The tools facilitate data collection, analysis and reporting and provide electronic means for simplified and secured data capture,

[1] WHO, *WHO's Six-Year Strategic Plan to Minimize the Health Impact of Emergencies and Disasters 2014-2019*; available from http://apps.who.int/iris/bitstream/10665/171852/1/WHO_PEC_ERM_ERX_2015.6_STR_eng.pdf?ua=1&ua=1.

[2] ICRC, *Violent incidents affecting the delivery of health care: Health care in danger, January 2012 to December 2014*. Available from: www.icrc.org/eng/assets/files/publications/icrc-002-4237.pdf

management and reporting, as well as standard operating procedures and rules for secured and ethical data management. Following extensive consultations, the methodology has now been agreed and is currently being field-tested.

15. The Director-General of WHO has been an outspoken advocate for the right to health and has made numerous statements to highlight the problem of the frequency of attacks on health-care workers, facilities, transport and patients. At the sixty-eighth World Health Assembly, in May 2015, the Director-General urged collective action to stop such attacks. During the plenary session, the Director-General lit a candle in a ceremony to honour and remember the health workers who have died while caring for those in need. At a major side event, the Director-General underscored the WHO commitment to taking all possible action to end attacks on health care.

16. Across the organization, WHO continually advocates for the right to health and systematically reminds all parties to conflict to protect health personnel, facilities and their means of transport, and to uphold their obligations under international humanitarian law.

17. WHO now has dedicated staff working to gain a better understanding of the extent and the nature of the problem of attacks on health care and to identify and promote preventive measures and practical solutions. WHO will continue to advocate for the protection of health-care workers and will continue to assist member States to develop appropriate preventive measures and more resilient health systems.

18. The Health Care in Danger campaign of the International Committee of the Red Cross (ICRC) is an ICRC-led, Red Cross and Red Crescent Movement-wide initiative that aims to address the widespread and severe impact of illegal and sometimes violent acts that obstruct the delivery of health care, damage or destroy facilities and vehicles, and injure or kill health-care workers and patients, in armed conflicts and other emergencies.[3] The project, which is scheduled to run from 2011 to 2015, has been focusing on strengthening protection for the sick and wounded in these situations through the adoption of specific measures designed to help to ensure that they have safe access to effective and impartial health care. Over this period, the ICRC and National Red Cross and Red Crescent Societies will continue to urge States parties to the Geneva Conventions, the health-care community at large and others concerned to devise concrete solutions and commit themselves to their implementation.[4]

19. Closely aligned with ICRC-Health Care in Danger, in 2012, Médecins sans Frontières launched its Medical Care Under Fire[5] project to also address the issue of violence against health, which is an internal process to collect data and share best practices. Together with the ICRC Health Care in Danger and other important initiatives identified within this report, consensus has built regarding the urgency and imperative of collectively addressing increased violence to health-care workers.

20. Other potential sources of data on violence to health care include: the Aid Worker Security Database, which records major incidents of violence against aid

[3] ICRC, “Violence against health care must end”, *Health Care in Danger*. Available from: www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-health-care-in-danger-project.htm.

[4] ICRC, *Health care in danger: questions and answers*. Available from: www.icrc.org/eng/resources/documents/faq/health-care-in-danger-faq-2011-08-05.htm.

[5] Médecins sans Frontières, *Medical care under fire*. Available from: www.msf.org/topics/medical-care-under-fire.

workers, with incident reports from 1997 to the present; the Armed Conflict Location and Event Data Project has data on political violence for developing States in Africa and has initiated the Humanitarian Data Exchange; Physicians for Human Rights works to stop mass atrocities and acts that cause severe physical or mental harm to individuals; the Council on Foreign Relations sponsors an interactive map that visually plots global outbreaks of measles, mumps, whooping cough, polio, rubella and other diseases that are easily preventable by inexpensive and effective vaccines; the Oxford Research Group maintains a casualty reporting web-based platform with over 40 members of the network that collect, record and memorialize the casualties of conflict.

III. Violence at workplace in the health sector

21. Health workers are at high risk of violence all over the world. Between 8 and 38 per cent of health workers suffer physical violence at some point in their careers.[6] Many more are threatened or exposed to verbal aggression. Most violence is perpetrated by patients and visitors. Categories of health workers most at risk include nurses and other staff directly involved in patient care, emergency room staff and paramedics.

22. Violence against health workers is unacceptable. In addition to having a negative impact on the psychological and physical well-being of health-care staff, it also affects their job motivation. As a consequence, this violence compromises the quality of care and puts health-care provision at risk. It also leads to immense financial loss in the health sector.

23. Health workers, in the course of their daily work, often have direct contact with people in distress and experiencing stress and violence. Combined with risk of violence, levels of occupational stress can be higher and lead to mental health problems, higher sickness rates and ultimately loss of staff.

24. Interventions to prevent violence against health workers in non-emergency settings focus on strategies to better manage violent patients and high-risk visitors. More research is needed to evaluate the effectiveness of these programmes, in particular in low-resource settings.

25. WHO, the International Labour Organization (ILO), International Council of Nurses (ICN) and Public Services International (PSI) jointly developed Framework guidelines for addressing workplace violence in the health sector[7] to support the development of violence-prevention policies in non-emergency settings, as well as a questionnaire and study protocol to research the magnitude and consequences of violence in such settings.

26. The Framework guidelines address both physical and psychological violence, including acts which are referred to as assault/attack, abuse, bullying/mobbing, different forms of harassment, including sexual and racial harassment, threats, and others. In terms of the scope, the Guidelines consider a workplace any health-care

[6] WHO, *Violence and Injury Prevention*, “Violence against health workers”, available from: www.who.int/violence_injury_prevention/violence/workplace/en/.

[7] ILO, ICN, WHO, PSI, “Framework guidelines for addressing workplace violence in the health sector”, available from: www.who.int/violence_injury_prevention/violence/activities/workplace/en/.

facility, whatever the size, location or type of services provided, as well as any place where health services are provided outside the health-care facility, e.g., ambulance services or home care.

27. The Guidelines are not prescriptive, but can be used as a reference tool to facilitate the development of policies and other instruments to address concrete responses targeting specific situations and needs. They can also promote dialogue and consultations among relevant stakeholders, such as government, employers and health-care workers, as well as professional and other NGOs active in the area of workplace violence.

28. It is important to note that workplace violence is a structural, strategic problem rooted in social, economic, organizational, cultural and individual factors, showing complex interrelationships. Immediate responses include preventive measures such as security measures and improvement of the physical environment; and support to victims in the event of violent incidents, including medical and psychological assistance, as well as peer and management support, legal aid and rehabilitation measures.

29. Nevertheless, addressing workplace violence in the health sector requires a comprehensive response which favours an integrated, participative, cultural and gender-sensitive, non-discriminatory and systematic approach. In order to operationalize the Framework guidelines, WHO, ILO, ICN and PSI in 2005 prepared a training manual for addressing workplace violence in the health section.

IV. Safety of hospitals and health facilities

30. Emergencies and disaster often cause damage and destruction of hospitals and other parts of the health infrastructure, resulting in loss of life of health personnel and weakening the ability of health systems to deliver health services. Ensuring the safety of hospitals and their accessibility and functionality, saves lives and allows health and medical personnel to perform at maximum capacity, immediately following a disaster, rather than being one of its major casualties.

31. Typhoon Haiyan that hit the Central Philippines in 2013 damaged over 2,000 health facilities,[8] including destroying more than 600. Increased preparedness across the health sector significantly contributed to the fact that no casualties were reported in the majority of affected areas during Typhoon Ruby in the Philippines in 2014. Promoting the safety of hospitals and health facilities is a key element in reducing mortality and injuries during natural disasters.

32. However, a number of activities that increase the protection of health of populations during emergencies are of a cross-sectoral nature and beyond the domain of the health systems. A clear example includes the work on the Safe Hospitals Initiative, which denotes a clear commitment of governments at all levels and communities to make hospitals safer in the face of disasters. It includes the work on key drivers of risk such as environmental issues, as well as urbanization, land use and building codes. Over the past several years as part of this initiative, 79 countries have taken action to increase the safety of their hospitals in disasters.

[8] See *Outbreaks and emergencies*, available from: www.wpro.who.int/outbreaks_emergencies/haiyan/en/.

33. Some of the initiatives built around the International Strategy for Disaster Reduction that gathered WHO and other United Nation system organizations include 2008-2009 World Disaster Reduction Campaign on Hospitals Safe from Disasters, the 2010-2011 Campaign on Making Cities Resilient: My City is Getting Ready, World Health Day 2008 on Climate Change and Health, World Health Day 2009 on Hospitals Safe in Emergencies, World Health Day 2010 on Urban Health Matters, among others.

34. Member States increasingly demonstrate the importance they place on reducing risks to health during emergencies and disasters. A clear sign of a strong political commitment was the adoption of the Sendai Framework for Disaster Risk Reduction 2015-2030 by 187 Member States gathered at the Third World Conference for Disaster Risk Reduction in March 2015, in Sendai, Japan.[9] This important framework puts health at the centre of global policy and action to reduce disaster risks for the next 15 years.

35. The Sendai Framework recognizes that a "substantial reduction of disaster risk requires perseverance and persistence, with a more explicit focus on people and their health and livelihoods".[10] It calls for action by Member States to integrate disaster risk management into health care at all levels, and for the resilience of national health systems, hospitals and health facilities.

36. WHO, in collaboration with the United Nations Office for Disaster Risk Reduction and other United Nations bodies, NGOs, academic institutions and other partners, supports country implementation of the Sendai Framework, by providing assistance for strengthening country capacities for emergency and disaster risk management for health.

37. Among three new major initiatives announced in the framework of supporting the commitments adopted in Sendai, WHO released in 2015 a new Comprehensive Safe Hospital Framework[11] for reducing disaster damage to this critical aspect of a community's emergency and health infrastructure, which is one of the key targets under discussion in Sendai.

38. The Framework uses "safe hospitals" as a reference to all types of health facilities and their functionalities, including health centres, laboratories, clinics (including those that provide prevention services and health promotion), small and medium-sized hospitals, and referral hospitals. It stresses that countries and communities "need to prioritize the protection of new and existing hospitals and other health facilities from identified hazards and should ensure the physical integrity of buildings, equipment and critical hospital systems".[12]

V. International Health Regulations

39. Global capacity to prevent, detect and respond to infectious diseases hinges upon having strong, sustainable and resilient health systems capable of implementing the

[9] Sendai Framework, available from: www.preventionweb.net/files/43291_sendaiframeworkfordrren.pdf.

[10] Sendai Framework, para. 16.

[11] WHO, *Comprehensive Safe Hospital Framework*. Available from: www.who.int/hac/techguidance/comprehensive_safe_hospital_framework.pdf?ua=1.

[12] Ibid., p. 1.

International Health Regulations,[13] including pandemic preparedness measures. The General Assembly, in its resolution 69/132 invited WHO to provide technical support to Member States, upon request, in order to strengthen their capacity to deal with public health emergencies and the implementation of the International Health Regulations.

40. In the past years, the world has faced health threats that have challenged global peace and security. These crises have called for the involvement of many actors supporting countries to save lives in the light of unexpected outbreaks and to improve responses and preparedness for future crises.

41. The emergence of epidemic- and pandemic-prone infections such as Ebola and other viral haemorrhagic fevers, Middle East respiratory syndrome coronavirus (MERS-CoV), influenza A (H1N1) 2009, severe acute respiratory syndrome (SARS), and avian influenza highlight the need for efficient identification and management of transmission risks of emerging diseases in health-care settings. Health-care facilities can act as amplifiers of the outbreaks, increasing the number of cases occurring and placing health-care workers at increased risk of becoming infected and at transmitting infections to other patients, colleagues and visitors. Measures are needed to improve the overall safety culture in facilities together with specific measures to protect health-care workers while caring for patients and the deceased with a confirmed diagnosis of infection, and also while conducting triage or caring for any patient.

42. The International Health Regulations (2005),[14] which entered into force in 2007, are a landmark instrument for WHO, as well as for the world. They are binding for all 194 States members of WHO and are instrumental in helping countries work together to save lives and livelihoods caused by the international spread of diseases and other health risks.

43. It is a legal framework which provides collective defences to detect disease events and to respond to public health risks and emergencies that can have devastating impacts on human health and economies.[15] The successful implementation of the International Health Regulations will contribute significantly to enhancing national and global public health security against the multiple and varied public health risks which have the potential to be rapidly spread through globalized travel and trade.

44. Under article 2, the purposes of the International Health Regulations (2005) are “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade”. One of the innovative issues in the International Health Regulations (2005) is that it is no longer limited to specific diseases as in the previous frameworks, but covers “illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans”.

45. As part of the preparedness measures, States parties are required to ensure that their national health surveillance and response capacities meet certain functional

[13] WHO, *International Health Regulations (2005), Second edition, 2008*.
[14] Ibid.
[15] WHO, *The International Health Regulations (2005), IHR Brief No. 1*. Available from: http://www.who.int/ihr/publications/ihrbrief1en.pdf?ua=1

criteria and have a set time frame in which to meet these standards. They include: core public health capacities for surveillance and response: appointing a National Focal Point for International Health Regulations: minimum key sanitary and health capacity requirements for international points of entry that have been designated by countries, among others.

46. When the events occur, the International Health Regulations have a broad scope as they require State parties to notify WHO on a potentially wide range of events on the basis of defined criteria indicating that the event may constitute a public health emergency of international concern. They are also obliged to inform WHO of significant evidence of public health risks outside their territory that may cause disease to spread internationally.

47. These reporting procedures seek to expand the flow of timely and accurate information to WHO about potential public health emergencies of international concern. WHO, as a neutral authority, with crucial technical expertise, can access information, recommend actions and facilitate technical assistance.

48. The role of WHO is supported by an Emergency Committee to advise the Director-General of WHO in determining whether a particular event is a public health emergency of international concern and to provide advice on any appropriate temporary measures. Additionally, an International Health Regulations Review Committee is tasked with advising the Director-General on technical matters relating to standing recommendations, the functioning of the International Health Regulations and amendments.

49. In 2009 influenza A (H1N1) exposed vulnerabilities in global and national capacities. H1N1 was the first major test for the International Health Regulations since it came into force in 2007. The International Health Regulations Review Committee recognized[16] the vulnerabilities in responding to public health emergencies: States parties did not fulfil their International Health Regulations obligations regarding strengthening and developing core national and local capacities. Recommendations of the Review Committee also addressed the measures to improve global preparedness through research; establishing a more extensive global public health workforce and closing the gap between available resources and real needs.

50. The Ebola outbreak exposed the vulnerability not just of the national health systems but has also questioned the role of the global community in health emergencies, including WHO as the lead agency in health. The report of the Ebola Interim Assessment Panel highlighted again the shortcomings of the instrument and of its implementation. It highlighted that nearly a quarter of the States members of WHO established bans and measures to restrict international travels affecting populations in crisis.

51. At its sixty-eighth session, building on the work done by the Panel and discussions during the 2015 Executive Board special session on the Ebola emergency, the World Health Assembly requested the Director-General of WHO to establish an International Health Regulations Review Committee[17] whose objectives would be to: (a) assess the effectiveness of the International Health Regulations; (b) review the

[16] See WHA64/10.

[17] Report of the First Meeting of the Review Committee on the Role of the International Health Regulations (2005) in the *Ebola Outbreak and Response*, available from www.who.int/ihr/review-committee-2016/IHRReviewCommittee_FirstMeetingReport.pdf?ua=1.

status of implementation from the previous Review Committee in 2011[18] and, (c) recommend steps to improve the functioning, transparency, effectiveness and efficiency of the International Health Regulations (2005), including the WHO response.[19]

52. The Committee met for first time in August 2015 and agreed on a tentative schedule for the following months. Several issues were raised during the discussion which will guide further work of the Committee and member States. Vulnerabilities in the implementation of the regulations were identified as well as the lack of understanding of the instrument at many levels of the countries. Other issues included the absence of a formal alert level of health risk; the need to strengthen capacities at the country level; the need for active engagement of other actors including community, among others. Technical subcommittees will continue to work on country capacities, compliance and governance and general International Health Regulations issues. The final report of the Review Committee will be submitted at the sixty-ninth session of the World Health Assembly, in May 2016.

VI. Ebola response

53. The General Assembly in its resolution 69/132 expressed deep concern about the outbreak of the Ebola virus disease in West Africa and recognized that the outbreak demonstrated the urgency of having strong health systems capable of implementing the International Health Regulations, pandemic preparedness and universal health coverage that promotes universal access to health services, which would assist in the prevention and detection of possible outbreaks.

54. The Ebola virus disease outbreak in West Africa is unprecedented in the high number of doctors, nurses and other health workers who have been infected. As at 2 September 2015, a total of 881 confirmed infections of health workers were reported from Guinea, Liberia and Sierra Leone since the start of the outbreak, with 513 reported deaths.[20] Health workers were between 21 and 32 times more likely to be infected with Ebola than people in the general adult population. The reasons were: insufficient measures for infection prevention and control and for protection of occupational health and safety in health-care facilities; shortage of staff; and poor conditions of employment of the health workforce.[21]

55. The heavy toll on health-care workers in this outbreak had a number of consequences that further impeded control efforts. It depleted one of the most vital assets during the control of any outbreak. When fear drives staff to refuse to come to work, it can force the closure of health facilities. When hospitals close, other common and urgent medical needs, such as safe childbirth and treatment for malaria, are neglected. When large numbers of health-care workers become infected, anxiety grows in the community. In some areas, patients with any ailment

[18] See footnote 16.

[19] See WHA68/DIV./3, available from: http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_DIV3-en.pdf.

[20] WHO, “Ebola Situation Report”, 2 September 2015. Available from: http://apps.who.int/iris/bitstream/10665/183955/1/roadmapsitrep_2Sept2015_eng.pdf?ua=1

[21] WHO, *Health worker Ebola infections in Guinea, Liberia and Sierra Leone, A preliminary report, 21 May 2015*. Available from: http://apps.who.int/iris/bitstream/10665/171823/1/WHO_EVD_SDS_REPORT_2015.1_eng.pdf?ua=1.

perceive hospitals as places where they will be infected with Ebola, reducing access to general health care.[22]

56. WHO and partners have worked with ministries of health, managers and health workers to put in place infection prevention and control, and occupational health and safety strategies and supplies to prevent health-worker infections and improve patient safety and working conditions in health-care facilities. As a result, the infections of health workers as a proportion of all cases dropped from 12 per cent in July 2014 to a low of 1 per cent in February 2015.[23]

57. The lesson learned is that strengthening the resilience of health services in the face of epidemics and outbreaks requires providing decent employment conditions and protection of the safety, health and welfare of the health workforce. This includes providing the most basic measures for management of occupational health and safety, infection prevention and control, and adequate supply of water and sanitation in all health-care facilities. Countries need to develop national programmes for the protection of occupational health and safety of health workers,[24] including regulations, training of safety officers in each facility, provision of vaccinations, safer devices, personal protective equipment and providing health workers with basic occupational health services. WHO and ILO have developed recommendations and practical tools for strengthening the capacities of countries for improving working conditions and protecting occupational health and safety in health-care facilities.[25]

58. As part of its core functions, WHO actively works with partner institutions and specialized networks in developing strategies, technical guidance and training packages for filling gaps in knowledge and improving competencies of health-care workers on how to provide good quality care while practising personal safety. WHO also supports the overall outbreak response operations by identifying and deploying experts as needed and by contributing to public health risk assessments and technical advice on staff safety. Several recommendations and practical tools are available on the Internet, including for the clinical management of Ebola virus disease and MERS-CoV.

59. During the Ebola outbreak in West Africa, WHO and partners implemented three-phase training on clinical management of the Ebola virus disease in the three affected countries. Over 3,000 local, national and international health-care workers completed phases 1 (classroom sessions) and 2 (practice in simulated Ebola Treatment Units training; over 1,000 health-care workers completed mentored clinical practice inside Treatment Units). Training for non-Ebola Treatment Units settings on

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[22] WHO, “Unprecedented number of medical staff infected with Ebola — Situation assessment — 25 August 2014”. Available from: http://www.who.int/mediacentre/news/ebola/25-august-2014/en/.

[23] WHO, *Health worker Ebola infections in Guinea, Liberia and Sierra Leone, A preliminary report, 21 May 2015*. Available from: http://apps.who.int/iris/bitstream/10665/171823/1/WHO_EVD_SDS_REPORT_2015.1_eng.pdf?ua=1.

[24] Resolution WHA 60.26. “Workers’ health: global plan of action” in: *Sixtieth World Health Assembly*, Resolutions and decisions: annexes. Geneva, World Health Organization, 2007 (WHASS1/2006–WHA60/2007/REC/1), Resolutions: 94-99. Available from: http://www.who.int/occupational_health/publications/global_plan/en/.

[25] WHO and ILO. “Ebola virus disease: occupational safety and health”. Joint WHO/ILO briefing note for workers and employers. Available from: http://www.who.int/occupational_health/publications/ebola_osh/en/.

triage and staff safety measures is currently being implemented in countries at risk of developing Ebola outbreaks, as part of national preparedness plans.

60. The experience with the Ebola virus disease in West Africa has reaffirmed the crucial role of quality care not only for the well-being and survival of patients but also for the well-being of health-care workers themselves and for building trust among affected communities and engaging them in the response.

61. The Ebola outbreak also highlighted the impact of cultural beliefs and behavioural practices at the community level for the spread of a disease, as well as for the safety and security of medical and health personnel, including community health workers and burial personnel. For example, having noted that funeral and burial practices in West Africa are exceptionally high-risk and adherence to ancestral funeral and burial rites had been singled out as fuelling large explosions of new cases, a new protocol[26] was issued in November 2014.

62. This new protocol emphasized dignified burials that respect religious rituals in both Christian and Muslim funerals. The protocol itself was developed by an interdisciplinary team from WHO and UNAIDS, in partnership with the International Federation of Red Crescent Societies (IFRC) and faith-based organizations, including the World Council of Churches, Islamic Relief, Caritas Internationalis and World Vision. The protocol was implemented by burial teams managed by IFRC, Ministries of Health, an NGO consortium including World Vision, Catholic Relief Services, the Catholic Agency for Overseas Development (CAFOD), and Concern Worldwide, in collaboration with local religious leaders and families.

VII. Building resilient national health systems and strengthening national capacities through the health workforce

63. Progress towards universal health coverage and the attainment of the health-related targets of the sustainable development goals call for all people to receive the quality health services they need without suffering financial hardship. This entails substantial and strategic investments, not least in the health and social workforce as an essential component of national health systems.

64. Currently, there is a mismatch between the demand and supply of health and social care workers; this is particularly acute in low- and middle-income countries, where deficits of skilled health professionals are expected to rise to millions in the coming decades, particularly in sub-Saharan Africa. If no action is taken, this situation will have a negative effect on achieving national socioeconomic priorities and goals, weakening public health systems and increasingly exposing countries to emerging health threats.

65. In both high-income and emerging economies an increase in demand for skilled labour has been observed since the year 2000. Evidence suggests that this will continue owing to a number of key drivers, including demographic and epidemiological changes, technological advances, and increased demand for equitable access to a broader range of quality health and social services. These

[26] WHO: “How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola virus disease”. Available from: www.who.int/csr/resources/publications/ebola/safe-burial-protocol/en/.

economic and social policy drivers will stimulate the global, regional and subregional labour markets for qualified health workers and prompt new investments in creating employment.

66. Given the increased demand for skilled labour, many countries will continue to rely on foreign-trained health workers and this is likely to continue to grow. Health workers' migration and mobility is an additional dimension affecting global, regional and subregional health labour markets, particularly given the increasing liberalization of rules related to skilled migration as well as the suboptimal working conditions, among other push factors, in many low- and middle-income countries.

67. Health workforce migration and mobility and freedom of movement of health personnel among countries members of the Association of Southeast Asian Nations (ASEAN), the Caribbean Community (CARICOM), the Southern Common Market (MERCOSUR) and the European Union bring greater attention to issues around ethical recruitment of migrant health personnel and to mutual recognition of professional qualifications.

68. The WHO Global Code of Practice on International Recruitment of Health Personnel,[27] a multilateral framework for tackling shortages in the global health workforce and addressing challenges associated with the international mobility of health workers, promotes voluntary principles and practice for the ethical international recruitment of health personnel, considering the rights, obligations and expectations of source countries, migrant countries and migrant health personnel. The increased mobility and migration of health workers make the substantive principles and provisions of the Global Code increasingly essential to health system strengthening worldwide.

69. Current experiences with the Ebola outbreak showed that the deficit and absence of community-based practitioners — from lay workers to skilled health professionals — have exposed the fragility of the present systems. As efforts continue to ensure the delivery of essential health services, equally important is the medium- to long-term focus to finance and implement evidence-based models of care aligned with the prevailing burden of disease and aspirations for universal health coverage.

70. Building resilient health systems necessitates strategic investments in human resources for health taking into consideration the realities of the health labour market dynamics. This implies going beyond classical strategies that aim at only increasing production to also formulating strategies for effective recruitment, deployment and retention and for improved health worker performance. In reality, this includes reforms that seek to improve health personnel's working conditions, fair and transparent remuneration policies, incentives packages for equitable deployment, transformational education strategies, and monitoring and oversight.

71. The ILO Decent Work Agenda[28] is based on employment creation, rights at work, social protection (health care and retirement security) and social dialogue. National platforms with involvement of key national actors, such as relevant ministries, professional associations and trade unions are key to address decent work deficits and contribute to positive changes in employment terms and conditions (remuneration policies, salary levels, incentive packages, among others). Similarly, regulatory bodies play an important role in establishing frameworks that

[27] WHA63.16, annex. Available from: www.who.int/hrh/migration/code/code_en.pdf?ua=1.

[28] Available from: www.ilo.org/global/about-the-ilo/decent-work-agenda/lang--en/index.htm.

govern professional ethics and practice and ensure quality health services. Promoting and maintaining positive practice environments that support decent work lead to a positive impact on patients' health outcomes and on overall quality of service delivery.

72. WHO has developed a Global Strategy on Human Resources for Health: Workforce 2030[29] to support all member States and partners to address health workforce challenges to progress towards universal health coverage. The strategy highlights the increasing evidence that the health workforce offers a triple return on investment: (a) triggers broader socioeconomic development with positive spillover effects on the attainment of the United Nations sustainable development goals, including education, and gender equality, and on the creation of decent employment opportunities and sustainable economic growth; (b) offers a first line of defence for individual countries to meet the International Health Regulations (2005) and promotes global health security, and; (c) drives improvement in population health outcomes. The strategy will be submitted to the World Health Assembly at its sixty-ninth, in May 2016.

73. In fragile States and countries in chronic emergencies, the Strategy calls for additional protection of health workers from violence and harm as part of a broader agenda of positive practice environments which also guarantees occupational health and safety and work.

VIII. Recommendations

74. **Health worker protection is key to the capability of health systems to respond to health emergencies and meet routine health-care needs. Health worker protection and support must be at the core of emergency response, preparedness and efforts to build a resilient health system.**[30]

75. **Global health security hinges on a fit-for-purpose health workforce within a resilient health system. A skilled, trained, equipped and supported health workforce is the first line of defence for countries to fulfil the requirements of the International Health Regulations. This calls for a clear understanding of implications of the global health security agenda on the health workforce (required capabilities, workforce requirements and workforce strategies to strengthen performance); and investments in long-term health workforce development to strengthen overall health system capacity to ensure sustainability of the International Health Regulations functions. This approach contributes to the global health emergency workforce conceptual plan by focusing on the domestic health workforce as the primary frontline responder in "at risk" countries.**

76. **A concerted multisectoral response, within and beyond the health sector, cutting across the development, diplomatic, education, financial, humanitarian and security agendas is critical for health workforce development, protection and security. The assurances of the International Monetary Fund debt relief and an increase in fiscal space for health care must be translated into new**

[29] Available from: www.who.int/hrh/resources/GlobalStrategyHumanResourcesHealth_Workforce2030Table2-3.pdf?ua=1.

[30] See footnote 23.

investment in health worker employment, especially for women in rural areas, to catalyse the social and economic benefits this generates.

77. **Health workers at the frontline of the fight against public health emergencies must be supported, through the provision of personal protective equipment, supplies and training to conduct their work and maximize their occupational health and safety. They should be provided appropriate employment contracts, remuneration and benefits for themselves and their families. The same principles should be applied to mitigate occupational risks to health workers from the infection, prevention and control of other communicable diseases.**

78. **Maximizing safety and protection of health personnel also demands enhanced education and training curricula which aim at the acquisition of essential competencies and skills needed to adequately perform the International Health Regulations functions (in particular disease surveillance, laboratory diagnostics and public health management). This would need to cover pre-service education (medical schools and other health professionals institutions); in-service, and continuing professional education programmes, including e-learning approaches.**

79. **Building a sustainable fit-for-purpose health workforce requires strengthening the content and implementation of health workforce plans as part of national health policies, strategies and plans. Concerted effort is needed to strengthen multisectoral dialogues among all actors that influence health workforce issues in countries, such as ministries of health, labour, education and finance, other constituencies and the private sector to address public sector rules and practices that hinder the adoption of adequate reward systems, working conditions and career structures for health workers.**

80. **Health workforce data is a precondition for understanding the health labour market for designing evidence-based policy and planning. Strengthening human resources for health data availability and mapping of the number, locations and competencies of all health workers engaged in the provision of essential health services is a prerequisite for strengthening national, regional and global health workforce capacity for emergency preparedness, health security and essential health services. The WHO new concept of national health workforce accounts calls for investments in strengthening country analytical capacities of human resources for health and health system data on the basis of policies and guidelines for standardization and interoperability of human resources for health.**