Continuity of Essential Health Services in Ukraine during the COVID-19 Pandemic

Key findings from two surveys conducted in April and November 2021

Policy brief
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ABSTRACT

The COVID-19 pandemic has increased pressure on Ukraine’s primary health-care (PHC) system. To measure the impact of the pandemic on the PHC system and on the continuity of essential health services, two cohorts of 250 PHC facilities were surveyed in March–April 2021 and November 2021. This policy brief outlines the key results from the two rounds of the survey. Most PHC facilities reported some degree of disruption to their services, but the survey results showed that the PHC system has generally maintained the continuity of essential health services during the pandemic. This policy brief outlines policy considerations for strengthening COVID-19 preparedness at facility level.

Keywords: COVID-19; ESSENTIAL HEALTH SERVICES; PRIMARY HEALTH CARE; UKRAINE
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Jarno Habicht, WHO Country Office in Ukraine, was the conceptual and technical lead. The policy brief was produced by Óscar Brito Fernandes, Niek Klazinga and Dionne Kringos (Health Services and Systems Research Unit, Department of Public and Occupational Health, WHO Collaborating Centre for Quality and Equity in Primary Health Care Systems, Amsterdam University Medical Centres, Netherlands) and Anastasia Bugnon, Tomas Roubal and Julia Novak from the WHO Country Office in Ukraine. The team owes a debt of gratitude to WHO staff members who provided technical contributions: Yoonjoung Choi, Dirk Horemans and Chelsea Maria Taylor (WHO headquarters), Antoni Dedeu (WHO European Centre for Primary Health Care) and experts from Info Sapiens, Andrii Kravchenko and Inna Volosevych, who collected data.

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## ABBREVIATIONS

<table>
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<th>Abbreviation</th>
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<tr>
<td>COVID-19</td>
<td>Coronavirus disease 2019</td>
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<tr>
<td>IPC</td>
<td>Infection prevention and control</td>
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<tr>
<td>NCD</td>
<td>Noncommunicable disease</td>
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<td>PHC</td>
<td>Primary health care</td>
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The COVID-19 pandemic has increased pressure on Ukraine's primary health-care (PHC) facilities. To measure the impact of the pandemic on the PHC system and on the continuity of essential health services, two cohorts of 250 PHC facilities were surveyed in March–April 2021 and November 2021. This policy brief outlines the key results from the two rounds of the survey and suggests policy considerations and recommended actions for strengthening COVID-19 preparedness at PHC level. Overall, the data suggest that the PHC sector effectively absorbed the impact of the pandemic, and was able to adapt and respond quickly to variations in the epidemiological context and in the use of PHC services. The key policy recommended actions based on the survey findings are to:

- monitor the implementation of restoration plans to clear backlogs, with a particular focus on noncommunicable diseases (NCDs);
- ensure the availability of vaccines, diagnostic testing, personal protective equipment (PPE) and oxygen concentrators;
- accelerate the rollout and sustain the implementation of telemedicine and encourage uptake of the ePrescription system;
- adopt infection prevention and control (IPC) guidelines to ensure the safety of staff and service users;
- implement measures to support the long-term well-being of PHC staff;
- maintain the confidence of PHC facilities to manage people with suspected or mild COVID-19, including rehabilitation; and
- strengthen capacity-building for the COVID-19 response through continued staff training.

The content of the policy brief does not reflect the effects of the Russian Federation's war in Ukraine.
INTRODUCTION

The first COVID-19 case in Ukraine was recorded on 3 March 2020, and WHO made the assessment that COVID-19 can be characterized as a pandemic on 11 March 2020. Health systems worldwide faced numerous challenges in responding to different phases of the pandemic (1). PHC has an essential role in health emergencies; however, several studies have revealed an alarmingly low level of preparedness for dealing with such situations (2–4). Even countries with a high coverage of essential health services faced shortages of both staff and PPE, and had to tackle vaccine hesitancy. Supply chains were disrupted, and continuous adaptations of health services to changes in the country context were implemented in the light of further evidence and knowledge of the disease (5).

After more than three years, the pandemic is still creating challenges for health systems. New SARS-CoV-2 (sub)variants are causing novel waves of the pandemic and, thereby, increasing the strain on PHC facilities; despite this, health systems are committed to addressing backlogs, strengthening emergency preparedness plans, and learning how to manage the health-care needs of people with long COVID (long-term health problems following acute SARS-CoV-2 infection). Maintaining essential health services is critical for health system functioning and to ensure that populations have access to care that responds to their needs. In previous waves of the pandemic, critical disruptions to essential health services endangered population health, most notably for vulnerable people. Hence, disruptions to essential health services must be closely monitored in order to inform timely decision-making on necessary adaptations to the PHC system.

In Ukraine, slightly over 5.3 million confirmed cases of COVID-19 were reported to WHO from March 2020 to December 2022 (6). WHO has been using a survey (Continuity of essential health services: facility assessment tool) to assess the capacity of PHC facilities to provide continuity of essential health services globally during the pandemic, including in Ukraine (7). The facility assessment tool can support decision-making by stakeholders at the meso and macro levels (such as health-care managers and governments) by highlighting areas where adaptation to and investment in essential health services are needed. The tool covers various aspects of essential health services: health workforce; financial management; service delivery and utilization; IPC measures; availability of therapeutics, diagnostics and supplies; and vaccine readiness.
The tool provides immediate insights from key informants (such as PHC managers) on the extent of disruption to a set of tracer services within a rapidly changing context, and the main causes of disruption. The survey also identifies the challenges to ensuring continued access to services and essential resources for the COVID-19 response (including PPE and COVID-19 diagnostics, therapeutics and vaccines), along with strategies to mitigate these. Despite the time lag between the development of the pandemic in Ukraine and the results of the survey, the findings can inform decision-makers of the current challenges and of which aspects of PHC need to be strengthened to ensure the continuity of essential health services.

Methodology

Two separate cohorts of 250 PHC facilities in Ukraine were surveyed using the WHO Continuity of essential health services: facility assessment tool. The survey is part of a comprehensive set of health service capacity assessment tools designed to support different aspects of maintaining essential health services while managing patients with COVID-19. In Ukraine, the first cohort of PHC facilities was surveyed from mid-March to mid-April 2021 and the second cohort in November 2021. For each survey, 250 of the 1550 PHC facilities (maximum theoretical sample error: 5.7%) that had previously been identified by public officials at the National Health Service of Ukraine were selected using a probability-proportional-to-size method. The sample was selected based on the number of doctors working at each facility, stratified by urban and rural areas across five macro-regions (central, eastern, northern, southern and western Ukraine) and the city of Kyiv. The same proportion of doctors was included in each stratum to reduce bias towards smaller facilities. Oversampling of PHC facilities was performed in rural areas in order to obtain at least 50 facilities in rural settings to allow for sufficient analysis, and then statistical weighting was applied to reduce the proportion of rural PHC facilities in the final results. Info Sapiens, a Kyiv-based third-party company, conducted computer-assisted telephone interviews with PHC managers. Survey results were synthesized and interpreted by researchers from the Amsterdam University Medical Centers (as a part of the mission of the WHO Collaborating Center for Quality and Equity in Primary Health Care Systems) and experts in the WHO Country Office in Ukraine.

This policy brief interprets key results from two rounds of the Continuity of essential health services survey on the evolving challenges to PHC facilities during the COVID-19 pandemic and provides consolidated insights into the performance of PHC services that may contribute to strengthening COVID-19 preparedness.

1 Health service capacity assessment tools (including pulse surveys and rapid assessments) are listed on the WHO website (8).
RESULTS AND DISCUSSION

Supply of COVID-19 vaccines

In November 2021, most PHC facilities (86%) were administering COVID-19 vaccines. The vaccine cold chain and storage systems were reported to function well in 96% of PHC facilities, and syringes and sharp containers were readily available in almost all facilities. Vaccines were readily available in most public PHC facilities (95%), but only one third of private PHC facilities administered COVID-19 vaccines. The gap between public and private PHC facilities relates to the financial incentives scheme in which private facilities opted to prioritize providing other vaccines in the vaccination programme. Therefore, strengthening partnerships between public and private PHC facilities may help to address COVID-19 vaccine hesitancy and increase vaccine uptake in the population. Although COVID-19 vaccines seem to be readily available, it is important to closely monitor potential disruptions to the supply chain, notably, inefficiencies in cold chain management.

From April to November 2021, the availability of other vaccines in PHC facilities seemed to be stable. Exceptions were the vaccine offering protection against diphtheria and the pentavalent vaccine offering protection against diphtheria, tetanus, pertussis, hepatitis B and Haemophilus influenzae type b. The availability of these vaccines from April to November 2021 decreased by 7% and 9%, respectively, but they were available in the large majority of PHC facilities (85%). These results suggest that the impact of the COVID-19 pandemic on routine vaccination programmes was lower in Ukraine than reported internationally. For example, studies included in a literature review estimated that three quarters of 82 countries had suspended their vaccination campaigns and that in the WHO European Region during the first months of the pandemic, routine vaccinations were halted in 22% of infants (9). Consistent with this, another literature review reported a reduction in vaccination coverage and a decline in the total number of vaccines administered (10). In early 2022 disruptions in immunization services were still occurring internationally in PHC settings, as found by the WHO Global pulse survey on the continuity of essential health services during the COVID-19 pandemic (11).
About two thirds of PHC facilities reported receiving instructions about the seasonal influenza vaccine for winter 2021–2022. However, only one third (34%) of PHC facilities reported having the influenza vaccine. This low availability is explained by the fact that this vaccine is paid for out of pocket, and uptake is usually low.

**Availability of diagnostic tests**

The availability of selected tracer diagnostics (e.g. urine protein, urine glucose and blood glucose dipsticks, and urine pregnancy tests) was reduced during April–November 2021. Although availability remained high in many PHC facilities, monitoring stocks of selected tracer diagnostics is the key to ensuring sufficient availability. Similarly, despite the importance of ensuring adequate availability of oxygen concentrators, survey data showed that this was variable. A quarter of surveyed PHC facilities did not have oxygen concentrators, and the situation was worse in rural and privately owned facilities. It was previously suggested to develop a regulatory framework for delivering oxygen therapy at PHC facilities to ensure the availability of this equipment and proper training for PHC staff.

**PHC staff training**

In November 2021 almost all PHC facilities had provided specific staff training on COVID-19 topics over the past three months, notably training on COVID-19 vaccine management, including vaccine storage and administration, informing the authorities of potential adverse events, and informing the public about how to act in case of an adverse event. However, staff training on COVID-19 topics was reduced from April to November 2021 (Fig. 1). For example, training in the management of emergency conditions decreased by fourteen percentage points (55%), and training in the proper use of PPE decreased by six percentage points (83%). On the one hand, this could signal that the training provided earlier has been sufficient for staff to perform their tasks effectively and safely; on the other hand, staff availability for training could have been slightly reduced as disruption in service provision was less prominent in November 2021.

A primary response to COVID-19 in Ukraine was the shift to telehealth, following the trend seen in many other countries. Although this has many advantages, such as ensuring access to care, it also creates challenges for health service users and PHC staff that should not be overlooked (12,13). Therefore, staff training in telehealth provision is a critical measure. In April 2021 more than four fifths of PHC facilities reported providing staff training in telehealth; however, in November 2021 the proportion had decreased by 44%. Regular staff training programmes covering topics that may hinder care quality (e.g. telediagnosis) can build staff trust in the routine use of telehealth.
Although 89% of PHC facilities considered the training provided to address the needs of staff, a need for training in the treatment options for mild SARS-CoV-2 infection was noted. Specific guidance for PHC facilities in treating people with mild COVID-19 could help to reduce treatment discrepancies and unnecessary hospital visits. In the WHO Global pulse survey on continuity of essential health services during the COVID-19 pandemic, key informants in half of participating countries in the WHO European Region (53%; 13 out of 24) identified health-workforce challenges during November–December 2021 as the main bottleneck for continuity of essential health services. These challenges were mainly related to health worker recruitment, retention and training (11). Ensuring that PHC staff are adequately trained will facilitate a better response to the public’s concerns, care needs and priorities. Specific training programmes can be designed to support medical redeployment (14,15), increase the capacity of community health workers to adequately manage the COVID-19 pandemic in their community (16) or support the correct use of PPE (17).
Clearing backlogs in essential health services

Most PHC facilities (90%) had continued to deliver care during the COVID-19 pandemic without reducing the range or volume of services or suspending services. This was achieved by adapting the care delivery strategy to, for example, provide comprehensive care in a single visit for people with multimorbidity, prioritize consultations for high-risk patients and use telemedicine (Fig. 2). Some changes should be retained and made routinely available as part of a broader strategy to address backlogs and potential equity issues (18). Between April and November 2021, survey data suggest that many PHC facilities had halted care delivery strategies that had been implemented during the pandemic. For example, there was a 28% reduction in the proportion of PHC facilities providing care in a single comprehensive visit for people with multimorbidity and prioritizing consultations for high-risk patients. Conversely, the use of telemedicine among PHC facilities had increased by 15 percentage points (a percentage change of 24%) to 77% between April and November 2021. For three quarters of PHC facilities in Ukraine, telehealth corresponds to a phone consultation by a doctor or nurse: video consultations are used less frequently because doctors are cautious about diagnosing via video.

Fig. 2. Use of care delivery strategies implemented during the COVID-19 pandemic, April–November 2021
In 73% of the European countries surveyed in the WHO Global pulse survey on the continuity of essential health services during the COVID-19 pandemic, key investments were related to digital health technologies and infrastructures (11). The most common service delivery modifications were to enhance telemedicine (85%), implement novel approaches to renewing prescriptions and dispensing medicines (69%), provide home-based care (54%) and expand the facility’s service hours (46).

In Ukraine, as in other countries, public use of PHC facilities was limited owing to mistrust and fear of being infected with SARS-CoV-2. One fifth of PHC facilities reported this as the main reason for the decreased demand. However, a third of PHC facilities reported an increased volume of care related to tackling COVID-19 outbreaks. The key drivers of change in the number of outpatient visits were the same for both PHC facilities that used telehealth as a service delivery strategy and those that did not.

In November 2021 the overall number of reproductive health, maternal and newborn consultations improved but still lagged behind those of previous years. Conversely, consultations on sexually transmitted infections and tuberculosis decreased between April and November 2021. Consultation numbers have been increasing for child health, but numbers for family planning and contraception and for antenatal and postnatal care remain lower than in previous years. Although improvements are noticeable, the recovery in consultation numbers seems slow for NCDs; therefore, it is critical to implement restoration plans for missed visits. Although most PHC facilities (92–98%) have developed a service restoration plan, the rate of implementation has been low since April 2021 (Fig. 3). However, there are signs of improvement. In April 2021 only 11% of rural facilities had implemented restoration plans for pregnancy and 25% for NCDs. However, in November 2021 the respective values were 61% and 50%.

Fig. 3. Geographical inequities in implementing restoration plans for essential health services, September–November 2021

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2 Data collection for the second cohort was in November 2021. Some questions asked about events/experiences within the last 3 months, that is since September 2021, so some data are presented as from September–November 2021.
Adoption of IPC guidelines

In November 2021 most staff (86%) working in the surveyed PHC facilities were fully vaccinated against COVID-19. Evidence suggests that the risk of SARS-CoV-2 infection in front-line health-care workers can be up to threefold higher than in the general community (19). As of 8 May 2020, Ukraine reported the eighth largest absolute number of SARS-CoV-2 infections among health-care workers in the WHO European Region (2660 cases of infection and 19 deaths reported) (20).

PHC facilities reported that the infection rate among staff decreased by 30% between April and November 2021 (Fig. 4). In November 2021, the SARS-CoV-2 infection rate in nurses and doctors was 3.8% and 3.5%, respectively. Although infection among health personnel can disrupt service delivery, only 8% of PHC facilities reported absences for medical reasons related to COVID-19 (including caring for family members with COVID-19).

Fig. 4. SARS-CoV-2 infection rates in PHC staff, April–November 2021

Implementing IPC measures is key to controlling the spread of COVID-19 in PHC facilities and fostering a COVID-19-safe environment. In April 2021 the large majority of PHC facilities self-reported having implemented several IPC guidelines. However, WHO visits to PHC facilities in six oblasts in September–October 2021 found poor implementation of IPC measures. Survey data from November 2021 also suggest that some COVID-19 IPC measures had been relaxed (Fig. 5). This may signal false confidence in managing the virus within PHC facilities.
In November 2021, all PHC facilities in urban settings were providing PPE to their staff; among PHC facilities in a rural setting, this share was 97%. Overall, 99% of the PHC facilities surveyed were providing PPE to staff in November 2021, which represents a four percentage point increase relative to April 2021. In November 2021, surgical masks and examination gloves were the most used PPE (97%) among PHC facilities that were providing PPE (Fig. 6).

Fig. 6. Use of PPE at PHC facilities, April–November 2021
Respirator masks (57%) and face shields (68%) were the least used, although improvements were noticeable from April to November 2021 (13 and 3 percentage points higher in November 2021 compared to April 2021, respectively). This could signal either the low availability of specific PPE or the fact that PHC staff are accustomed to using surgical masks and examination gloves in their clinical practice.

**Staff confidence in managing suspected or mild COVID-19**

One third of PHC facilities did not have a focal point responsible for coordinating COVID-19 services. Of those that did, two fifths used standard operating procedures. Lack of a focal point can lead to uncoordinated responses and result in low-value care for people with COVID-19.

From April to November 2021, referrals to specialized care as a strategy for managing patients with (suspected) COVID-19 more than halved (from 97% to 43%). This indicates increased confidence among PHC facilities in managing people with suspected or mild COVID-19, and can alleviate stress on hospital services. Management of people with suspected or mild COVID-19 in PHC facilities can be strengthened if diagnostic testing is available. Almost three quarters (71%) of PHC facilities collected specimens and conducted on-site polymerase chain reaction or rapid diagnostic testing for COVID-19.

**Staff well-being and continuity of care**

From September to November 2021, PHC facilities did not experience a major disruption in services: 1% of PHC facilities reported closing temporarily and a third (36%) reduced their service hours because of a COVID-19 outbreak. Overall, only 3% of PHC facilities (all in urban areas) experienced disruptions to their regular service delivery. These achievements are mainly due to the commitment of staff, and show that PHC facilities can respond to the challenges caused by variations in the epidemiological context.

COVID-19 has increased the PHC workload and disrupted the capacity to provide care services. The most common staff management strategies used by facilities have been to expand working hours and reassign responsibilities to different staff members within the facility. This has enabled both PHC facilities and their staff to quickly adapt to a new and changing work environment based on new processes and procedures. International evidence indicates an increased prevalence of anxiety, depression, post-traumatic stress disorder, and psychological and mental distress in the general population (21); the same is found among health-care professionals (22). Hence, monitoring staff well-being is critical to ensuring the continuity of care. PHC staff training in mental health and psychosocial support was lacking in April 2021, and in November 2021 many PHC facilities said that this area needs to be strengthened. For example, monitoring the well-being of PHC staff via survey could help to identify targeted interventions to improve their well-being.
Policy considerations

This policy brief on the performance of PHC facilities during the COVID-19 pandemic in Ukraine is based on survey data collected in March–April and November 2021. Overall, the findings show that PHC was managing to absorb the impact of the pandemic, indicating that services and staff can quickly adapt to the changing epidemiological context. However, they do not reflect the effects of the more-infectious SARS-CoV-2 omicron subvariants (which raises concerns about future waves of the disease) or, most importantly, the impact of the Russian Federation’s war in Ukraine.

Internationally, in early 2022 disruptions were still reported in all health-care settings, notably PHC, as suggested by findings of the WHO Global pulse survey on the continuity of essential health services during the COVID-19 pandemic. Most surveyed countries (87 out of 95; 92%) reported bottlenecks related to COVID-19 diagnostics, therapeutics, vaccination and PPE access. During November–December 2021, in half of the surveyed countries in the WHO European Region (13 out of 24; 53%), key informants identified health-workforce challenges as the main bottleneck for continuity of essential health services, notably health worker recruitment, retention and training. Key investments were related to strengthening health-workforce capacity and access to medicines and supplies in 82% of the European countries surveyed, followed by digital health technologies and infrastructures in 73%. The most frequent service delivery modifications were related to enhancing telemedicine (85%), novel approaches to renewing prescriptions and dispensing medicines (69%), provision of home-based care (54%) and expansion of facility hours (46%).

Overall, the priority needs of countries participating in the WHO Global pulse survey are aligned with those identified in Ukraine (see the policy considerations). However, unlike in the WHO Global pulse survey, the survey data in Ukraine were collected by interviewing a representative sample of PHC managers and recording the first-hand experiences of PHC facilities across the country.

COVID-19 is a health threat worldwide, but the risk is disproportionately high for those living in conflict zones. The war in Ukraine is significantly disrupting critical supply chains and affecting infrastructure, health-care workers, and the function of key PHC services for NCDs, immunization programmes and care for specific populations (e.g. maternal, newborn and child care). This challenges the continuity of essential health services. In addition, population movements (external or internal displacement) and overcrowding in temporary shelters increase the risk of waterborne and respiratory disease outbreaks. Given this context, further assessment is needed to understand how the war in Ukraine has affected PHC facilities and their COVID-19 preparedness.
Policy considerations are proposed based on the results of the two rounds of a survey on the continuity of essential health services in 2021 in the context of the COVID-19 pandemic.

- Monitor the implementation of restoration plans to clear backlogs, with a particular focus on NCDs.
  - PHC facilities have adapted their care delivery strategy during the pandemic; some of the changes should be retained and made routinely available (such as telemedicine and ePrescription) as part of a broader strategy to address backlogs.
  - The implementation of restoration plans for missed visits is slow, particularly for people with chronic NCDs. After a resource assessment, PHC facilities should ensure the continuity of essential health services based on priority tiers informed by people's needs, with coordinated care provision to at-risk groups. However, the rollout of these plans may be hampered by limited data, notably on the number of people with NCDs.

- Ensure the availability of vaccines, diagnostic testing, PPE and oxygen concentrators.
  - In general, COVID-19 vaccines are readily available. Strengthen vaccination rates at privately owned facilities by introducing a more attractive financial incentive scheme to support the national vaccination strategy (ensuring adequate focus on risk groups and the vaccination schedule).
  - Although there is no sign of disruption to the national vaccination programme, it is essential to monitor vaccine stock using an effective monitoring system. Vaccination uptake has increased since the earlier stages of the pandemic; guaranteeing the vaccine supply chain should counter backlogs in the national vaccination programme. A similar monitoring system could be applied for diagnostic testing.
  - The availability of oxygen concentrators is lower in rural and privately owned facilities. Development of a regulatory framework for oxygen therapy through PHC by the Ministry of Health could improve the availability of this service.

- Accelerate the rollout and sustain the implementation of telemedicine.
  - PHC facilities have adopted various service delivery strategies to improve the uptake of telemedicine. Telemedicine can be used as a care delivery strategy to address backlogs; however, for this, PHC facilities need to have access to adequate technology (e.g. computers, video software, reliable internet connection) combined with training in telediagnosis for doctors. A public campaign to inform the public about the availability of telemedicine should be developed to build trust in the quality of telehealth care.
  - Promote the uptake of the ePrescription system to save the time and resources of PHC staff by facilitating the prescription of medicines.
• Adopt IPC guidelines to ensure the safety of health-care staff and service users.
  • Expand IPC plans and measures to minimize work-related SARS-CoV-2 infections in health staff. Some COVID-19 IPC measures have been relaxed. COVID-19 screening of health workers and COVID-19 testing capacity should be strengthened to keep PHC staff safe. Proper mechanisms should be in place to ensure that adequate PPE is available to those who need it when they need it.
  • Establish a safe-environment communication campaign for PHC facilities to ensure accountability for both PHC facilities and health workers in implementing COVID-19 IPC measures.

• Implement measures to support the long-term well-being of PHC staff.
  • The lack of significant disruption to PHC services is greatly attributable to staff accepting an increasing workload and quickly adapting to a changing work environment, and demonstrates that PHC can respond to challenges caused by a changing epidemiological context.
  • However, a prolonged need for such high levels of commitment may negatively impact the well-being of PHC staff. Adequate resources to support the long-term well-being of health workers are critical for capacity-building.
  • Development of a survey to monitor PHC staff well-being can inform targeted interventions and strengthen capacity-building.

• Maintain the confidence of PHC facilities to manage people with suspected or mild COVID-19, including rehabilitation.
  • Foster PHC staff confidence in treating people with suspected or confirmed COVID-19 and post-COVID-19 conditions.
  • Ensure that sufficient rapid diagnostic tests are widely available across PHC facilities. Closely monitor rural PHC facilities regarding the availability and use of tools (notably, rapid diagnostic tests) to support the management of people with suspected COVID-19.
  • Designate a focal point to coordinate COVID-19 services at each facility, ensure streamlined communication between health authorities and PHC facilities, strengthen the confidence of PHC and enforce IPC measures.

• Strengthen capacity-building in response to COVID-19 through continued staff training.
  • The survey flagged a need for staff training in the treatment options for mild SARS-CoV-2 infection. Treatment guidance for people with mild COVID-19 could help to reduce the discrepancies in COVID-19 treatments that were previously noted in WHO site visits to PHC facilities in six oblasts in September–October 2021.
  • Training in telehealth provision should focus on any aspects that may hinder care quality (e.g. telediagnosis); it is essential to build staff trust (doctors and nurses) in the routine use of telehealth.
  • Provide training in mental health and psychosocial support for health workers based on a needs assessment for mental health support to inform initiatives and investments.


3 All references accessed 20 August 2022.


The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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