



BRIEFING NOTE

IMPACT OF THE COVID-19 PANDEMIC ON HEALTHCARE WORKERS IN UKRAINE

February 2021¹

Summary

Healthcare workers are at the forefront of Ukraine's response to COVID-19, risking their lives and their physical and mental health. The conditions of work of healthcare workers not only affect their own rights, but also impact the rights of health service users, including their access to and quality of health services.

This briefing note examines the impact of the pandemic and the Government's response to it on the rights of healthcare workers in Ukraine, of which 83 per cent are women. It looks, in particular at the right to just and favourable conditions of work, to social security and to effective participation, and how their situation affects essential health services. The briefing note contains recommendations to the Government and local authorities to this end.

Healthcare workers in Ukraine are underpaid, receiving salaries, which are below the national average. In many cases, healthcare workers, especially at middle and junior levels, receive a minimum wage that does not provide for a decent living for them and their families. Temporary bonuses introduced by the Government have partly remedied the situation for some healthcare workers involved in the COVID-19 response, but also raised concerns about lack of pay security, transparency, accountability, equal pay for work of equal value and a further contribution to the gender pay gap.

Healthcare workers lack healthy and safe working conditions, in particular due to lack of sufficient personal protective equipment, effective infection prevention and control mechanism at the workplace and mental health and psychosocial support services. Health care workers also suffer from increased workloads and insufficient time for rest. At the same time, those with other caring responsibilities, mainly women due to prevalent gender roles in Ukraine, face the increased burden of unpaid care work, especially during periods when the Government suspended care and education services in response to COVID-19.

Health care workers also lack adequate social protection. Out of the more than 60,000 cases of health care workers infected by COVID-19 by February 2021, only a small percentage have been recognized by the authorities as work-related, impeding the workers' right to compensation.

A lack of effective dialogue between the authorities and health care workers and exclusion of healthcare workers from government policy-making prevents the authorities from developing and implementing effective policy measures aimed at protection of healthcare workers during the pandemic and beyond. Healthcare trade unions stated they were not effectively consulted about the Government's COVID-19 response in healthcare at the national and local levels, nor about the ongoing healthcare reform process. Furthermore, HRMMU is alarmed about

¹ This note includes information and data as of 14 February 2021.

cases of reprisals against healthcare workers who publicly exposed the poor preparedness and response of the healthcare sector for the COVID-19 crisis.

Dangerous working conditions and inadequate wages and social security, including for work-related illness, disability or death, have led to healthcare workers leaving their jobs. Given that Ukraine faced a shortage of healthcare workers before the pandemic, their departure is likely to further negatively impact the population's right to health. This in turn will likely impact the chance of Ukraine being able to meet Sustainable Development Goal 3 on ensuring healthy lives and promoting well-being at all ages.

The International Covenant on Economic, Social and Cultural Rights, in particular Articles 7 and 9, guarantees the right to work and to the enjoyment of just and favourable conditions of work, including remuneration which provides all workers, as a minimum, with fair wages and equal remuneration for work of equal value without distinction of any kind, a decent living for themselves and their families, safety and healthy working conditions, and rest and reasonable limitation of working hours, and the right to social security, in particular social insurance. The International Covenant on Civil and Political Rights also guarantees the right to participate in public affairs and the freedoms of opinion and expression, peaceful assembly and association.

In line with its international human rights obligations and national commitments, including the Sustainable Development Goals, Ukraine should significantly increase its investments in the health sector to improve working conditions for healthcare workers, including by providing them with decent pay and improved occupational safety and health and social security, and by ensuring an effective mechanism of consultations with healthcare workers at various levels, including through trade unions.

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Introduction

1. Throughout the global COVID-19 crisis, the United Nations Human Rights Monitoring Mission in Ukraine (HRMMU)² has been monitoring the human rights impact of the pandemic as well as the Ukrainian authorities' response, with a focus on individuals and groups in marginalized and vulnerable situations, in line with the realization of the 2030 Agenda for Sustainable Development and UN commitment to leave no one behind.

2. Healthcare workers³ have been particularly vulnerable during the COVID-19 pandemic due to their high risk of exposure to the virus. According to the World Health Organization (WHO), while healthcare workers represent two to three per cent of the global population, they accounted for around 14 per cent of reported COVID-19 cases.⁴

3. The risk of exposure of healthcare workers is often exacerbated by a lack of the protection and support essential for performing their work in a safe and healthy environment, such as quality personal protective equipment (PPE), effective infection prevention and control procedures and policies in place at the workplace, sufficient time for rest, and mental health and social support services. A shortage of healthcare workers also requires existing staff to work longer hours, and suffer from higher stress levels. Furthermore, the stigma associated with having COVID-19, especially during the first months of the pandemic, contributed to anxiety, depression and insomnia among healthcare workers.⁵

4. Women bear a disproportionate burden of the COVID-19 health crisis, both globally and in Ukraine, due to several factors. Women are more likely to be employed in occupations which are more exposed to the virus. They constitute 67 per cent of all healthcare workers worldwide,⁶ and 83 per cent of the workers in the health sector in Ukraine.⁷ Within this, women comprise 90 per cent of care occupations, such as nursing professionals (the number for Ukraine is not available).⁸ Women healthcare workers often grapple with the additional burden and stress of unpaid care work within their households, work which falls disproportionately on women due to traditional gender roles. Such demands intensified when many countries,

² HRMMU was deployed on 14 March 2014 to monitor and report on the human rights situation throughout Ukraine and to propose recommendations to the Government and other actors to address human rights concerns. HRMMU implements the Office of the High Commissioner for Human Rights (OHCHR) mandate to protect and promote human rights in Ukraine.

³ "Health care workers" includes not only medical staff, such as doctors, nurses and paramedics, but also laboratory staff and others who work in health care services, including drivers, cleaners, administrative and maintenance staff. WHO, *Keep health workers safe to keep patients safe: WHO*, News release, 17 September 2020, available at www.who.int/news/item/17-09-2020-keep-health-workers-safe-to-keep-patients-safe-who.

⁵ Khanal, P., Devkota, N., Dahal, M. et al., "Mental health impacts among health workers during COVID-19 in a low resource setting: a cross-sectional survey from Nepal", *Global Health* 16, 89 (2020), available at <https://doi.org/10.1186/s12992-020-00621-z>. On the stigmatization of healthcare workers during the COVID-19 pandemic, see WHO, *Attacks on health care in the context of COVID-19*, 30 July 2020, available at www.who.int/news-room/feature-stories/detail/attacks-on-health-care-in-the-context-of-covid-19.

⁶ Mathieu Boniol et al., *Gender equity in the health workforce: Analysis of 104 countries*, WHO, Health Workforce Working paper 1, 2019, available at <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?sequence=1&isAllowed=y>.

⁷ State Statistics Service of Ukraine, *Жінки і чоловіки в Україні. Статистичний збірник [Women and men in Ukraine. Statistical Collection]*, Kyiv, 2019, p. 61, available at https://ukrstat.org/uk/druk/publicat/kat_u/2019/zb/09/zb_gch2018.pdf.

⁸ WHO, *State of the world's nursing 2020: Investing in Education, Jobs and Leadership*, April 2020, p. 6 and 15, available at <https://apps.who.int/iris/rest/bitstreams/1274201/retrieve>.

including Ukraine, suspended childcare services and schools, and usual support from grandparents or friends was not available due to social distancing.⁹

5. When there are unsafe and degrading working conditions and lack of social security, health systems fail to attract and retain skilled staff, contributing to shortages of healthcare workers, which has a negative impact on the availability and quality of health services. A sufficient number of skilled healthcare workers is essential to achieve universal health coverage.¹⁰

6. This note describes HRMMU findings regarding the impact of the COVID19 crisis on the human rights of healthcare workers, and consequently, on essential health services in Ukraine¹¹, and recommends measures to better respect, protect and promote human rights, in particular, the right to just and favourable conditions of work, the right to social protection, and the right to effective participation including freedom of expression, as guaranteed by international human rights instruments applicable in Ukraine.¹²

Methodology

7. Between October 2020 and February 2021, HRMMU conducted 66 semi-structured interviews with 66 healthcare workers (16 men and 50 women), mainly from Chernivtsi, Donetsk, Dnipropetrovsk, Ivano-Frankivsk, Kharkiv, Kherson, Kyiv, Luhansk, Mykolaiv, Odesa, Poltava, Zaporizhzhia and Zhytomyr regions.¹³ They included doctors, managers of health facilities, nurses, junior nurses, paramedics, drivers and laboratory staff from public healthcare facilities. Together with the International Labour Organisation (ILO), HRMMU also met with the leaders of two healthcare trade unions. HRMMU also analysed data collected by various Government agencies, such as the State Statistics Service, the National Health Service, the Social Insurance Fund and the State Labour Service, and participated in various webinars organised by international organizations and non-governmental organizations focused on health care issues. HRMMU is grateful to ILO and WHO in Ukraine for their valuable contributions to this Briefing Note.

⁹ See Ines Miyamoto, 'COVID-19 Healthcare Workers: 70 per cent are Women', *Security Nexus*, 13 May 2020, p. 2, available at www.jstor.org/stable/resrep24863; Sol East, Tim Laurence and Elva López Mourelo, *COVID-19 and the situation of female health workers in Argentina*, ILO, UN-Women and UNFPA, September 2020, available at www.ilo.org/wcmsp5/groups/public/---americas/---ro-lima/---ilo-buenos_aires/documents/publication/wcms_759696.pdf.

¹⁰ Economic and Social Council, *Report of the United Nations High Commissioner for Human Rights*, 2019 session 27 July 2018–26 July 2019, Agenda item 19 (f), para. 22-23, available at <https://undocs.org/E/2019/52>. See also United Nations in Ukraine, *UN Policy Options: Universal Health Coverage*, 17 December 2020, available at https://ukraine.un.org/sites/default/files/2020-12/UN%20Policy%20Paper%20on%20UHC_final%20ENG.pdf.

¹¹ This note exclusively covers Government-controlled territory. The Autonomous Republic of Crimea and the city of Sevastopol, Ukraine, temporarily occupied by the Russian Federation (Crimea), as well as territory controlled by self-proclaimed 'Donetsk people's republic' and self-proclaimed 'Luhansk people's republic' is not covered in this note. HRMMU received information which alleges that in Crimea, healthcare staff do not receive additional payments promised by the occupation authorities of the Russian Federation, who are pressuring doctors and civil servants to vaccinate people with the Russian vaccine or risk dismissal. However, it was not possible to verify these allegations due to HRMMU's lack of access to the peninsula. In territory controlled by self-proclaimed 'republics', the shortage of specialised healthcare staff is a particular concern that may result in degrading work conditions for the remaining staff. The average age of healthcare workers is high in AGCT, which makes them a risk group. See OCHA, *Humanitarian Needs Overview Ukraine*, February 2021, p. 72, available at www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/hno_2021-eng_-_2021-02-09.pdf.

¹² Including the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR).

¹³ A third of the interviews were conducted with healthcare staff in Donetsk and Luhansk regions.

Background

8. According to the State Statistics Service of Ukraine, 735,000 workers were employed in the healthcare sector as of December 2020. Women represent 83 per cent of healthcare workers.
9. Towards the beginning of the pandemic, in May 2020, nearly 20 per cent of all persons who tested positive for COVID-19 in Ukraine were healthcare workers. By January 2021, this had fallen to below five per cent of total cases. Eighty-four per cent of healthcare workers tested positive for COVID-19 were women, which corresponds closely to the percentage of women working in the healthcare sector. As of 14 February 2021, 62,453 healthcare workers had been confirmed to be infected with COVID-19 in Ukraine, 559 of whom had died.¹⁴

COVID-19 INFECTIONS AMONG HEALTHCARE WORKERS IN UKRAINE			
	Women	Men	Total
Confirmed	52754	9699	62453
Lethal	377	182	559

Source: National Health Service of Ukraine, as of 14 February 2021

10. Historically, the share of total government spending allocated to healthcare, and as a percentage of Gross Domestic Product (GDP) in Ukraine, has been well below the WHO European Region average.¹⁵ For four consecutive years, Ukraine has failed to meet its national commitment, approved by law in 2017, to contribute no less than five per cent of its GDP to the healthcare sector.¹⁶ In fact, despite economic growth from 2015 to 2020, the share of health expenditure in the State budget decreased.¹⁷ To compare, Poland and the Baltic States spent between 6.3 and 6.8 per cent of their GDP on health in 2019,¹⁸ while Ukraine spent three per cent.
11. At the same time, Ukraine has one of the highest private household “out-of-pocket” expenses for health services from countries in Europe.¹⁹ Out-of-pocket expenses constituted

¹⁴ According to the National Health Service of Ukraine. See <https://nszu.gov.ua/e-data/dashboard/covid19>.

¹⁵ See WHO, *Budgetary Space for Health in Ukraine. Policy document to support budget preparation dialogue for 2021*, Health Policy Paper Series No. 20/01, July 2020, Table 3, 4 and Figure 4, available at http://www.euro.who.int/__data/assets/pdf_file/0007/463327/UKR-Budgetary-space-for-health.pdf.

¹⁶ According to the Law of Ukraine ‘On State Financial Guarantees of Healthcare Services to the Population’ No. 2168-VIII from 19 October 2017, Art. 4 (5). In 2019, Ukraine spent three per cent of GDP on healthcare and 8.8 per cent of its total consolidated budget. The planned spending on healthcare for 2020 was three per cent of GDP and 9.6 of its consolidated budget in 2020. See WHO, *Budgetary Space for Health in Ukraine*, Table 3. The State Budget for 2021, approved by the Parliament in December 2020, allocates 156.2 billion UAH (approx. \$5.5 billion) to healthcare, 11.8 per cent of State expenditure. This is an increase from 132 billion UAH (approx. \$4.65 billion) in 2019. The Ministry of Health had asked for nearly twice as much: 296 billion UAH (approx. \$10.4 billion), including salary increases for healthcare workers and vaccination costs. The funding envisaged for the COVID-19 vaccine was 2.6 billion UAH (approx. \$91.55 million), half the sum requested by the Ministry of Health. According to the speaker of Parliament, COVID-19 vaccines and salary bonuses were not will be funded through a special COVID-19 fund, rather than the State budget. See also United Nations in Ukraine, *UN Policy Options: Universal Health Coverage*, 2020.

¹⁷ WHO, *Budgetary Space for Health in Ukraine*, July 2020, p. 2.

¹⁸ See Statista, “Total expenditure on health as a share of GDP in selected European countries in 2019”, June 2020, available at www.statista.com/statistics/428309/healthcare-expenditure-as-a-share-of-gdp-in-selected-occd-countries.

¹⁹ WHO, Out-of-pocket expenditures, 2020, see https://gateway.euro.who.int/en/indicators/h2020_29-out-of-pocket-expenditures/visualizations/#id=17097. The last year for which the data is available is 2014. Private household out-of-pocket expenditure as a proportion of total health expenditure is a core indicator of health financing systems. It contributes to the understanding of the relative weight of direct payments by households in total health expenditure.

46 per cent of total health expenditure in Ukraine compared to 27 per cent in the WHO European Region and 17 per cent in the European Union countries.

12. The International Covenant on Economic, Social and Cultural Rights (ICESCR) guarantees the right to the enjoyment of just and favourable conditions of work (article 7) , which includes inter alia fair and equal remuneration providing a decent standard of living, safe and healthy working conditions, and reasonable limitation of working hours allowing for rest and leisure.²⁰ The enjoyment just and favourable conditions of work is both a prerequisite for, and result of, the enjoyment of other Covenant rights, for example, the right to the highest attainable standard of physical and mental health.²¹ The ICESCR also recognizes the right to social security, in particular social insurance (article 9). It encompasses the right to access and maintain benefits, whether in cash or in kind, without discrimination in order to secure protection, including in case of loss of income due to sickness, disability, employment injury, or death of a family member.²² The rights to just and favourable work conditions and to social protection are also recognised by the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (Art. 11) and other international and regional human rights legal instruments,²³ including conventions of the ILO ratified by Ukraine.²⁴
13. In 2014, the Committee on Economic, Social and Cultural Rights (CESCR) recommended that the Government prioritize healthcare in the national budget and progressively increase the healthcare expenditure as a proportion of GDP to improve the availability, accessibility and quality of healthcare.²⁵ This was also recommended in the context of the Universal Periodic Review of Ukraine.²⁶ Allocating adequate budget resources is of paramount importance for States to meet their obligation towards the full realisation of the right to health. Insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly those in situations of vulnerability, violates the obligation to fulfil the right to health of everyone.²⁷

²⁰ See Committee on Economic, Social and Cultural Rights (CESCR), General comment No. 23 (2016) on the right to just and favourable conditions of work (article 7 of the International Covenant on Economic, Social and Cultural Rights), 27 April 2016, E/C.12/GC/23, para 6.

²¹ Ibid., para.1.

²² CESCR, General Comment No. 19, Article 9, The right to social security, 4 February 2008, E/C.12/GC/19, para. 2.

²³ Other international treaties include the International Convention on the Elimination of All Forms of Racial Discrimination (Art. 5); Convention on the Rights of the Child (Art. 32 and Art. 26); and the Convention on the Rights of Persons with Disabilities (Art. 27 and Art. 28). The regional human rights instrument referred to here is the European Social Charter (Revised) ratified by Ukraine in 2006.

²⁴ Including the Equal Remuneration Convention, 1951 (No. 100); Discrimination (Employment and Occupation) Convention, 1958 (No. 111); ; Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87); Right to Organise and Collective Bargaining Convention, 1949 (No. 98); Social Security (Minimum Standards) Convention, 1952 (No. 102); Maternity Protection Convention (Revised), 1952 (No. 103); Forty-Hour Week Convention, 1935 (No. 47); Weekly Rest (Commerce and Offices) Convention, 1957 (No. 106); Minimum Wage Fixing Convention, 1970 (No. 131); Holidays with Pay Convention (Revised), 1970 (No. 132); Occupational Safety and Health Convention, 1981 (No. 155).

²⁵ CESCR, Concluding observations on the sixth periodic report of Ukraine, 13 June 2014, para. 19, available at www.refworld.org/docid/53c78ad94.html.

²⁶ Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Ukraine, 26 February–23 March 2018*, available at <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G18/000/33/PDF/G1800033.pdf?OpenElement>.

²⁷ CESCR, General comment No. 14 (2000) on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) 11 August 2000, E/C.12/2000/4, paras. 33 and 52.

14. In addition to its obligations under international human rights law, Ukraine has also committed to the implementation of the Sustainable Development Goals (SDGs), which include:

- SDG 1 on eradicating poverty, which includes access to social protection and basic services;
- SDG 3 on access to healthcare, including universal health coverage, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all;
- SDG 5 on achieving gender equality and empowering all women and girls, which includes the elimination of all forms of discrimination against women and girls and equal access to economic resources and;
- SDG 8 on decent work and economic growth, notably target 8.5 on achieving full and productive employment and decent work for all women and men and equal pay for work of equal value and target 8.8 on protecting labour rights and promote safe and secure working environments for all workers.

15. Following the adoption of the Law ‘On State Financial Guarantees of Healthcare Services to the Population’ in 2017, Ukraine started to reform health financing to improve access, quality and efficiency of health services.²⁸ In 2018-2019, the financing of the primary healthcare system was changed: healthcare providers started to receive money per patient treated and patients could freely choose their family doctor. The National Health Service was created to contract health services, including among public and private providers, with greater competition to encourage better quality services. The reform of the primary healthcare system led to higher salaries for medical workers, but also an increased workload.²⁹ On 1 April 2020, the reform of the secondary and tertiary healthcare system was launched. The same principle was implemented to ensure that hospitals receive funds based on the number of patients treated rather than funding facilities with few patients but a large number of hospital beds, and that patients could choose the facilities offering the best care. The reform also envisaged an important role for local authorities to maintain and equip healthcare facilities. The reform, however, raised concerns, including from healthcare staff affected by the closure of hospitals. Concerns were also raised about accessibility of healthcare, especially for rural populations, which is a long standing problem in Ukraine, as well as funding for psychiatric care and tuberculosis treatment and prevention.

²⁸ See WHO and the World Bank, *Ukraine: Review of Health Financing Reforms 2016-2019*. WHO-World Bank Joint Report Summary, 2019, available at www.euro.who.int/__data/assets/pdf_file/0020/414551/WHO-WB-Joint-Report_Summary_Web.pdf.

²⁹ Research assessing the impact of the healthcare reform process in Ukraine on healthcare workers is scarce. A study conducted in 2018 on the impact of the reform process on primary healthcare services shows that the greatest expectations about the primary healthcare reform were a salary increase (96 per cent of respondents), a decrease in paperwork (68 per cent), and increased funding of equipment and supplies (62 per cent). The respondents working in healthcare named an increased workload (77 per cent) and increased salaries (69 per cent) as the main results of the reform. See Олександра Бетлій, *Реформа первинної ланки охорони здоров'я: що думають медичні працівники?* [Oleksandra Betlii, *The Primary Healthcare Reform Process: What Do Medical Workers Think?*], Kyiv: The Institute for Economic Research and Policy Consulting, 2019, pp. 8-9, available at www.ier.com.ua/files/Public_events/2019/RFR_Healthcare/Betliy_healthcare_ref_pp.pdf.

Issues of concern

1. Remuneration

“Our base salary is 2,600 UAH [\$92]. It’s only when you add hazard payments and other bonuses, that we receive the minimum wage as a result... But even if the pay is low, everyone is happy to have a job. This is a small town and there are hardly any jobs, especially for women.” – A nurse from Donetsk region, November 2020.

16. The right to just and favourable conditions of work includes remuneration that corresponds to the minimum criteria such as fair wages, equal remuneration for work of equal value without distinction of any kind, with, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, and that would ensure a decent living for workers and their families, in line with Article 7 (a, (i) and (ii)) of the ICESCR and Article 11 (1 (d)) of CEDAW.
17. The term ‘remuneration’ goes beyond the notion of ‘wage’ or ‘salary’ and ‘includes additional direct or indirect allowances in cash or in kind paid by the employer to the employee such as grants, contributions to health insurance, housing and food allowances, and on-site affordable childcare facilities’.³⁰ A fair wage reflects numerous criteria, including the output of the work, the responsibilities of the worker, the level of skill and education required to perform the work, specific hardships related to the work, and the impact of the work on the health and safety of the worker and on the worker’s personal and family life.³¹
18. Workers should receive equal remuneration when they perform the same or similar jobs, or when their work is different but of equal value when assessed by objective criteria such as skills, responsibilities and effort required by the worker, as well as working conditions. The evaluation can also draw on a comparison of rates of remuneration across organizations, enterprises and professions.³² Whether remuneration provides a decent living must be measured against factors such as ‘the cost of living and other prevailing economic and social conditions’ and it ‘must be sufficient to enable the workers and their families to enjoy other rights in the Covenant, such as social security, healthcare, education and an adequate standard of living, including food, water and sanitation, housing, clothing and additional expenses such as commuting costs’.³³
19. According to the State Statistics Service of Ukraine, the average salary in the health sector is significantly below the average Ukrainian salary. In 2020, the average monthly salary in the healthcare sector was 8,995 UAH (approx. \$317), while the average salary in Ukraine was 11,591 UAH (approx. \$408).³⁴ Many healthcare workers reported receiving the minimum wage (5,000 UAH, approx. \$176) or even less. A number of interviewees, especially women, said that they cannot afford to quit their jobs because of a lack of employment opportunities. For example, a paramedic in a first aid point in a village situated

³⁰ CESCR, General comment No. 23 on the right to just and favourable conditions of work, para .7.

³¹ Ibid., para. 10

³² Ibid., para. 12.

³³ Ibid., para. 18.

³⁴ See www.ukrstat.gov.ua/operativ/operativ2020/gdn/Zarp_ek_p/Zarp_ek_p2020_ue.xlsx.

on the contact line in the Donetsk region who receives a monthly salary of around 5,000 UAH, stated she could not quit because there were no other jobs in the area. When she and her family members were infected with COVID-19, they had to pay out of pocket for costly prescription medicine (up to 10,000 UAH, approx. \$352) and received no financial support or compensation from her employer. An ambulance driver in Zaporizhzhia, who earned 5,500 UAH (approx. \$194) a month, while an average salary of a driver is three times higher, told HRMMU that he was looking for another job.³⁵ Nurses working in rural first aid centres in the Zhytomyr region said that they were paid 3,600 UAH (approx. \$127) a month. The vast majority of healthcare workers interviewed by HRMMU said that their salaries were far from enough to provide a decent living for them and their families.

20. The interviewees also reported that salaries in the private health sector were many times higher than in public facilities. In Kyiv, for example, remuneration for the same job in a private facility may be up to 10 times higher than in a public facility. As a result, staff tended to leave the public sector for private clinics, and it was difficult to recruit new staff to public facilities, with smaller towns and rural areas being particularly affected. Similarly, a number of interviewees mentioned that staff, especially young graduates, left Ukraine to work abroad in Central European countries.
21. In 2020, in order to encourage healthcare workers to remain in public health services and to work with COVID-19 patients, the Government introduced two types of temporary bonuses. The COVID-19 bonuses introduced in March were to be paid to staff recognized by the State as involved in the COVID-19 response (e.g. those working in the infectious diseases departments of public hospitals that receive funding from the National Health Service specifically for COVID-19), and could amount to up to 300 per cent of the worker's salary.³⁶ Bonuses introduced in June were meant to cover healthcare staff in COVID-19 and essential non-COVID-19 public health services, with the exception of those in primary healthcare, such as family doctors and nurses, for the period between September and December 2020.³⁷ In addition, the latter also excluded certain healthcare professionals with non-medical degrees, such as biologists and biochemists working in laboratories running COVID-19 tests, ambulance drivers, and support staff such as engineers or accountants.³⁸ Following advocacy by the Trade Union of Healthcare Workers urging that specialists with

³⁵ In January 2021, 15,500 UAH (approx. \$545), according to the Work Ukraine job portal, see www.work.ua/salary-водій.

³⁶ Кабінет Міністрів України, Деякі питання оплати праці медичних та інших працівників, які безпосередньо зайняті на роботах з ліквідації гострої респіраторної хвороби COVID-19, спричиненої коронавірусом SARS-CoV-2, Постанова від 23 березня 2020 р. № 246 [Cabinet of Ministers of Ukraine, Some questions of remuneration of medical and other workers directly involved in the treatment of COVID-19-related acute respiratory diseases caused by SARS-CoV-2 coronavirus, Resolution from 23 March 2020 No. 246], available at <https://zakon.rada.gov.ua/laws/show/246-2020-п#Text>.

³⁷ Кабінет Міністрів України, Деякі питання оплати праці медичних та інших працівників закладів охорони здоров'я, Постанова від 19 червня 2020 р. № 610 [Cabinet of Ministers of Ukraine, Some questions of remuneration of medical and other workers working in healthcare establishments, Resolution of 19 June 2020 No. 610], available at www.kmu.gov.ua/npas/deyaki-pitannya-oplati-praci-medichnih-ta-inshih-pracivnikiv-zakladiv-ohoroni-zdorovya?fbclid=IwAR0cT-VpeaSY28DSWO46H9jQjywwDfy9cC8wwt2e_gaxN-SEz_MYtRQ43yc.

³⁸ Міністерство охорони здоров'я України, Про затвердження переліку типів закладів охорони здоров'я та переліку посад медичних та інших працівників, для яких встановлюються доплати до заробітної плати медичним та іншим працівникам закладів охорони здоров'я, які надають медичну допомогу хворим на гостру респіраторну хворобу COVID-19, спричинену коронавірусом SARS-CoV-2, та тим, що забезпечують життєдіяльність населення, що мають право на встановлення доплати до заробітної плати з 01 вересня 2020 року до 31 грудня 2020 року, Наказ 03.09.2020 № 2021 [Ministry of Health of Ukraine. The approval of the list of healthcare institutions and of healthcare workers and other workers who have salary bonuses for the provision of medical assistance to people infected with COVID-19 caused by the SARS-CoV-2 coronavirus, and those who ensure essential activities of the population and have the right to salary bonuses from 1 September 2020 to 31 December 2020, Order 03.09.2020 № 2021], available at <https://zakon.rada.gov.ua/laws/show/z0901-20#Text>.

non-medical degrees be included,³⁹ legislative changes were approved by Parliament in December 2020 that extended bonuses to staff with non-medical higher education degrees.⁴⁰

22. The June bonuses were also more generous to doctors than mid-level and junior healthcare staff.⁴¹ This provision deepened the existing gender pay gap as there were more women among mid-level and junior staff (for example, nearly all nurses are women⁴²). This may further exacerbate existing inequalities and perpetuate structural gender discrimination and segregation in education and work. According to the State Statistics Service of Ukraine, as of 2018, women employed in the healthcare sector received, on average, 89 per cent of the salary paid to men, a reflection of the fact they are overrepresented among mid-level and junior staff.⁴³
23. Many interviewees noted that the Government's criteria for temporary bonuses failed to ensure equal pay for work of equal value. Many healthcare workers expressed frustration about being ineligible for COVID-19-related bonuses, while still performing a job that greatly exposed them to the risk of contracting the virus (such as staff in primary healthcare, staff handling used PPE, paramedics working in an ambulance not specifically dedicated to COVID-19 patients, staff working in non-COVID-19 departments in hospitals, laboratory staff with non-medical degrees).
24. Staff in primary healthcare services complained that they were not paid COVID-19 related bonuses despite being involved in treating COVID-19 patients.⁴⁴ Such practice demotivates healthcare workers fighting the pandemic. Many interviewees among healthcare management told HRMMU they had complained, but the National Health Service had allegedly reasoned that primary healthcare staff should treat COVID-19 patients only by phone or online. However, many patients with COVID-19 symptoms visit family doctors and undergo tests or an X-ray exam, or need home-based care. According to the director of

³⁹ Професійна спілка працівників охорони здоров'я України, Лист Прем'єр-міністру України Денису Шмигалю Про вдосконалення положень законодавства [Professional Union of Healthcare Workers of Ukraine, Letter to Prime Minister Denys Shmyhal], 21 October 2020, http://medprof.org.ua/novini/novini/?tx_ttnews%5Btt_news%5D=8190&cHash=741de2b9eb.

⁴⁰ Закон України "Про внесення зміни до статті 77 Основ законодавства України про охорону здоров'я щодо пільг та підвищення оплати праці професіоналів з вищою немедичною освітою, які працюють в системі охорони здоров'я" [Law of Ukraine "On amendments to Article 77 of the Fundamentals of the legislation on healthcare regarding privileges and remuneration increases for professionals with non-medical higher education degrees who work in healthcare"], 18 December 2020, № 1123-IX, available at <https://zakon.rada.gov.ua/laws/show/1123-20#Text>.

⁴¹ The bonuses should amount to 70 per cent of a doctor's salary, while for mid-level personnel and junior nurses respectively 50 per cent and 25 per cent of the minimum wage established by the State Budget Law for 2020.

⁴² This estimation comes from interviews with healthcare staff. Ukraine does not report gender-disaggregated data on health professions. See WHO, *State of The World's Nursing: Ukraine, 2020*, <https://apps.who.int/nhwaportal/Sown/Files?name=UKR>.

⁴³ State Statistics Service of Ukraine, *Жінки і чоловіки в Україні [Women and men in Ukraine]*, p. 58 and 61.

⁴⁴ On 14 January 2021, the Ministry of Health adopted a new regulation that defines the list of public healthcare facilities (to be updated regularly) providing primary, emergency and inpatient secondary (specialized) and tertiary (highly specialized) medical care for patients with COVID-19. It also expanded the list of healthcare professions to include family doctors and nurses practicing family healthcare. See Міністерство охорони здоров'я, Про затвердження Переліку державних і комунальних закладів охорони здоров'я, що надають первинну, екстрену, а також в стаціонарних умовах вторинну (спеціалізовану) і третинну (високоспеціалізовану) медичну допомогу пацієнтам з гострою респіраторною хворобою COVID-19, спричиною коронавірусом SARS-CoV-2, а також медичних працівників таких закладів [Ministry of Health, On the approval of the List of State and communal healthcare establishments which provide primary, emergency and inpatient secondary (specialised) and tertiary (highly specialised) medical assistance to patients with COVID-19-related acute respiratory diseases caused by the SARS-CoV-2 coronavirus, and medical workers of such establishments], 14 January 2021, No 1, available at <https://moz.gov.ua/uploads/ckeditor/документи/Керівник%20робіт/2021/01/15/Розпорядження%20№%201.pdf>.

a primary healthcare facility in Bakhmut, Donetsk region, as of December 2020, family doctors had provided home treatment to more than 800 COVID-19-infected persons. Nurses in a rural ambulance clinic near the contact line complained to HRMMU that although they served five villages along the contact line in Luhansk region, and thus responded to suspected COVID-19 cases⁴⁵, they were not eligible for COVID-19 bonuses, as they were providing primary health care services.

25. HRMMU interviewed staff in Toretsk, Donetsk region, who worked with patients hospitalised with pneumonia until their PCR test results came back. If the patients tested positive, they were moved to an infectious disease department. Despite providing the initial care for such patients, they were not eligible for the COVID-19 bonuses.⁴⁶
26. While the Government allowed for COVID-19 bonuses in the amount of *up to* 300 per cent of salary, the decision regarding which staff members would receive bonuses and the amount of the bonus was left to hospital management. This led to complaints that such decisions often lacked transparency, seemed arbitrary and left room for corrupt practices. In Kharkiv, an ambulance crew member told HRMMU that crew members were required to collect many documents, including the confirmation of a patient's hospitalisation and positive COVID-19 test results, in order to receive bonuses. HRMMU received allegations that the management of one of the ambulance sub-stations at the Center for Emergency Medical Care and Medicine of Catastrophes in Kharkiv demanded COVID-19-designated ambulance crews to return a percentage of their COVID-19 bonus money as kickbacks.⁴⁷
27. One of the heads of regional trade unions of healthcare workers recounted that the State Audit Service scrutinized cases when hospital management granted COVID-19 bonuses amounting to a 300 per cent increase in salary to its staff involved in the COVID-19 response. The State Audit Service reprimanded one of the hospitals in the Luhansk region about its decision to increase staff salaries by 300 per cent, as other hospitals in the region had only increased staff salaries by 150-200 per cent. Such an approach seems to lack transparency and clarity given that the Government allowed for bonuses 'up to 300 per cent' of a salary and it means that hospital management may cut back on these payments, contributing to pay insecurity of healthcare workers.
28. Some interviewees complained that even with the bonuses on top of their pay, the amount received did not adequately reflect the increased workload of healthcare workers involved in COVID-19 response. According to a representative of a primary healthcare centre in Donetsk region, mobile brigade teams who carry out COVID-19 tests received bonuses for the increased workload if they performed 150 tests and more per month, as envisaged by the Government. Each team actually carried out more than a thousand tests, but the bonus did not increase with the workload. The heads of healthcare trade unions in several regions reported that the vast majority of healthcare personnel involved in the COVID-19 response worked 200 to 300 per cent overtime, but they were not fully compensated because existing regulations envisage that the workload should not exceed 150 per cent.

2. Safe and healthy working conditions

⁴⁵ The nearest family doctor was located 30 km away and the wait for an ambulance was at least 90 minutes.

⁴⁶ HRMMU interview, November 2020.

⁴⁷ HRMMU interviews, November 2020 and January 2021.

“Health workers have to use a single disposable mask for several days, although these masks are not made to be used for more than two hours.” – A doctor commenting on the lack of PPE in a settlement near the contact line, October 2020.

“A paramedic has to take a rag and a bucket with water and remove the dirt. The driver washes his cabin – that’s all the disinfection there is. I don’t know where the budget money allocated for disinfecting ambulances went.” – A former ambulance driver from Kharkiv describing his ambulance crew work conditions in the first half of 2020.

29. Safe and healthy working conditions are another fundamental element of the right to just and favourable conditions of work, in line with article 7 (b) of the ICESCR. It is the duty of the State “to adopt a national policy for the prevention of accidents and work-related health injury by minimizing hazards in the working environment and ensuring broad participation in the formulation, implementation and review of such a policy, in particular of workers, employers and their representative organizations.”⁴⁸ This also means that workers should be able to monitor working conditions without fear of reprisal.⁴⁹ Workers affected by a preventable occupational accident or disease should have the right to a remedy, including adequate compensation to cover costs of treatment, loss of earnings and other costs, as well as access to rehabilitation services.⁵⁰
30. The lack of sufficient quality PPE was a particular concern during the first few months of the pandemic, when healthcare staff had to rely on private donations. While supplies generally increased by autumn of 2020, healthcare staff in rural and conflict-affected areas still suffered from a lack of sufficient amounts of quality PPE, antiseptic and disinfectant. For example, in a settlement near the contact line in the Luhansk region, there was reportedly only one fully protective reusable suit for three staff to share.⁵¹ Scarce supply was also reported by staff in Lysychansk, Sievierodonetsk, Odesa and Zaporizhzhia in late 2020.⁵²
31. Along with use of PPE, other prevention strategies, such as engineering arrangements and administrative controls that are also applied in healthcare settings are equally important to reduce infection among healthcare workers.⁵³ In one Kharkiv hospital, healthcare staff raised concerns about the lack of adequate separation of “clean” zones (where healthcare workers can remain without PPE) and those with COVID-19 patients, leading to cross-contamination of healthcare workers. A number of healthcare workers also mentioned that the buildings of the infectious diseases hospitals where they worked were dilapidated and designed in a way that did not allow for proper infection control.
32. The lack of mental health and psychosocial support services is a key concern. Many interviewees reported that the increased workload, lack of medicine and equipment to properly treat patients and difficult working conditions contributed to stress, anxiety, depression and burnout among healthcare workers. A number of healthcare managers told

⁴⁸ CESCR, General comment No. 23 on the right to just and favourable conditions of work, para 25.

⁴⁹ Ibid., para. 26.

⁵⁰ Ibid., para. 29.

⁵¹ HRMMU interview with a healthcare worker, November 2020.

⁵² HRMMU interviews, October-November 2020.

⁵³ WHO and ILO, *Occupational safety and health in public health emergencies: A manual for protecting health workers and responders*, Geneva, 2018, p. 59, available at www.who.int/occupational_health/publications/safety-health-public-health-emergencies/en/.

HRMMU that although they observed an increased need for mental health and psychosocial support for their staff, they were unaware of any available assistance and counselling. Even the few interviewees who knew of access to an in-house psychologist within their facility reported that there was no systematic and targeted campaign to raise awareness among staff regarding mental health and burn-out among healthcare workers.

33. Mental health needs seemed to be completely neglected in occupational health and safety management in Ukraine, despite the fact that workers responding to outbreaks and emergencies encountered many sources of stress.⁵⁴ Mental health conditions were not on the list of occupational diseases approved by the Cabinet of Ministers. A survey of healthcare workers in Ukraine conducted in April-May 2020 by the Institute of Psychiatry of the Kyiv Taras Shevchenko University showed almost half felt stress because they could infect their family members and friends with COVID-19, 47.8 per cent felt stress because they lacked sufficient PPE and 47.6 per cent felt stress witnessing patients die of COVID-19.⁵⁵
34. Healthcare staff with caring responsibilities also lacked social services to assist them in their caring responsibilities. Due to traditional gender roles still prevalent in society, women carry the main burden of unpaid care work, such as cooking, cleaning, and taking care of children and older family members, some of which increased during the pandemic. Given that 83 per cent of healthcare workers in Ukraine are women, unequal distribution of unpaid domestic and care responsibilities between men and women in the family has further contributed to their overall exhaustion during the pandemic. A laboratory worker told HRMMU that when schools were closed, it was particularly difficult for her to take care of her children and she had to find time to call them regularly, run home to check on them and to cook enough food for them to eat for the day.⁵⁶
35. HRMMU is concerned that healthcare staff are not being sufficiently tested for COVID-19. In May 2020, regular mandatory testing of healthcare workers involved in the COVID-19 response was introduced by law for the period of the quarantine and two months after it.⁵⁷ On 17 September 2020, the Ministry of Health recommended healthcare facilities test their

⁵⁴ A study conducted in England showed that intensive care unit workers treating COVID-19 patients developed post-traumatic stress disorder and suicidal thoughts. Another study shows that women healthcare workers involved in COVID-19 response in China who also have caring responsibilities were particularly prone to mental health issues. They also faced a considerable dilemma, which existed between prioritising working and family care and between family care and avoidance of contact with family members. See Kate Kelland, “Critical care staff suffer trauma and severe anxiety due to COVID-19 - UK study”, 13 January 2021, available at www.reuters.com/article/health-coronavirus-mentalhealth/critical-care-staff-suffer-trauma-and-severe-anxiety-due-to-covid-19-uk-study-idUSL8N2JN2IE; Li G., Miao J., Wang H., et al., “Psychological impact on women health workers involved in COVID-19 outbreak in Wuhan: a cross-sectional study”, *J Neurol Neurosurg Psychiatry* 2020 (91), p. 895, available at <https://jnnp.bmj.com/content/jnnp/91/8/895.full.pdf>.

⁵⁵ Ірина Пінчук, “Медикам слід навчитися бути здоровими егоїстами — лікар-психіатр Ірина Пінчук про те, як вистояти у боротьбі з коронавірусом [Healthcare staff should learn to be health egoists: Psychiatrist Iryna Pinchuk speaks about how to persevere in the fight against the coronavirus]”, *Racurs*, 15 December 2020, available at <https://racurs.ua/ua/2783-medykam-potribno-navchytysya-buty-zdorovymy-egoyistamy-likar-psyhiatr-iryna-pinchuk-pro-te.html>.

⁵⁶ For similar observations, see also UN Women, *Rapid gender assessment of the situation and needs of women in the context of COVID-19 in Ukraine*, p. 61-62, available at https://www2.unwomen.org/-/media/field%20office%20eca/attachments/publications/2020/06/rapid%20gender%20assessment_eng-min.pdf?la=en&vs=3646.

⁵⁷ Закон України «Про захист населення від інфекційних хвороб» (Відомості Верховної Ради України (ВВР), 2000, № 29, ст. 228), ст. 35¹, [Law of Ukraine “On the protection of the population against infectious diseases” (Verkhovna Rada of Ukraine Journal, 2000, No.29, art. 228), Art 35-1], available at <https://zakon.rada.gov.ua/laws/show/1645-14#Text>.

staff involved in the COVID-19 response for antibodies.⁵⁸ Despite this, a number of interviewees said that healthcare workers in their facilities could only take a COVID-19 test if they had symptoms. Further, interviewees also reported that COVID-19 test results were often delayed, in some places by up to nine days, making efforts to prevent, treat and control the disease significantly less effective.

36. HRMMU also received allegations of violence against female healthcare workers in the workplace, although not resulting from the pandemic. Ambulance staff, among which are many women, were sometimes attacked by intoxicated patients. In Kharkiv, one female interviewee complained that when they pressed the panic button, their calls for help were not taken seriously by senior doctors and security services or police were not dispatched. Gender-based violence in the workplace further undermines the health and well-being of healthcare workers, impacting on the health system's capacity to respond to the pandemic, which is already overstretched.

3. Rest

“I’m working 76 hours a week. We need more personnel and [I’m so tired from working that] all I want to do is sleep...” – A female frontline healthcare worker in Kramatorsk, November 2020.

“Instead of 12-hour shifts, in fact we worked 15-16 hour shifts, with no lunch breaks, no bathroom breaks, we had to pee on street corners.” – Former ambulance driver from Kharkiv who resigned due to unbearable working conditions.

“The workload is immense. There is no possibility to take leave and no psychosocial support. There is no time for 15-20 minute breaks. There are days when we don’t have time to go to the toilet or to drink water.” – A nurse from Toretsk, Donetsk region, November 2020.

37. Rest and leisure, limitation of working hours and paid periodic holidays help workers to maintain an appropriate work-life balance and to avoid work-related stress, accidents and disease. The ICESCR requires States to set minimum standards that must be respected and cannot be denied or reduced on the basis of economic or productivity arguments.⁵⁹ There should be daily and weekly rest periods which are particularly important for those whose tasks affect the live and health of themselves and others. Workers should be paid for overtime hours worked above the weekly maximum permitted hours.⁶⁰

⁵⁸ Міністерство охорони здоров'я України, Про внесення змін до Стандартів медичної допомоги «Коронавірусна хвороба (COVID-19)», Наказ № 2122 [Ministry of Health of Ukraine, On amending the standards of medical assistance “Coronavirus disease (COVID-19)”, Order No 2122], 17 September 2020, available at <https://moz.gov.ua/article/ministry-mandates/nakaz-moz-ukraini-vid-17092020--2122pro-vnesennja-zmin-do-standartiv-medichnoi-dopomogi-koronavirusna-hvoroba-covid-19>.

⁵⁹ ICESCR, art. 7(d) and CESCR, General comment No. 23 on the right to just and favourable conditions of work, para. 34.

⁶⁰ Ibid., para. 37

38. A number of healthcare workers reported longer working hours and more consecutive shifts than the typical forty-hour work week. Others said that they did not have proper breaks to eat or drink something or even go to the toilet during their shift, which is additionally problematic for women who are menstruating. Some interviewees stated they were informally instructed not to take leave during the pandemic. Working longer hours may increase the risk of work injuries and accidents and can contribute to poor health.⁶¹
39. The increased workload was often attributed to staff shortages due to COVID-19 infections among colleagues as well as a high number of vacant positions. Many interviewees pointed out that staff shortages existed before the pandemic due to low salaries and poor financing of the healthcare sector. Some hospitals had to reduce staff due to lack of funding, after healthcare funding modalities changed following the healthcare reform process. During the pandemic, healthcare staff left their positions because they either belong to high-risk groups (older persons or those with underlying health conditions) or could not cope with stress caused by the increased amount of work and poor working conditions, including low pay and inadequate protection of their safety and health.
40. Staff shortages are particularly acute in eastern Ukraine where the conflict has weakened the health infrastructure.⁶² A hospital healthcare worker in Kramatorsk told HRMMU that due to severe staff shortages, the average workweek is 76 hours. After multiple complaints to the city healthcare authorities, ten nurses resigned due to the difficult working conditions in the hospital. In Toretsk, a town near the contact line in Donetsk region, a healthcare professional complained that with 30 per cent of the staff sick with COVID-19, the remaining staff were overworked.
41. Some healthcare workers also reported that their facilities lacked properly designed rooms for rest, sanitary facilities and kitchens for staff, and any refurbishment or acquisition of equipment (such as microwaves, fridges, coffee machines and sofas) was funded by donations from private companies.

⁶¹ WHO and ILO, *Occupational safety and health in public health emergencies*, p. 47.

⁶² WHO and Health Cluster Ukraine, *Donetska & Luhanska Oblasts Eastern Ukraine Public Health Situation Analysis (PHSA) –Long-form*, 28 January 2021, p. 43, available at www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/eastern_ukraine_phsa_28_january_2021.pdf; OCHA, *Humanitarian Needs Overview Ukraine*, February 2021, p. 30.

4. Social security

“What can I say – there were three PPE suits for the whole department, one shift was taking them off and the next one was putting them on.” – Junior nurse from Kharkiv who quit her job after having complications from COVID-19 and did not receive any kind of compensation, December 2020.

“The higher a doctor’s position, the more likely they are to have insurance. No junior nurse has insurance.” – A healthcare worker describes how the lack of funds affects staff’s ability to buy additional insurance for COVID-19, November 2020.

42. The right of everyone to social security, including social insurance, is recognized by article 9 of the ICESCR. Social insurance generally involves compulsory contributions from beneficiaries, employers and, sometimes, the State, in conjunction with the payment of benefits and administrative expenses from a common fund. It aims to provide income to persons who are no longer earning due to old age, sickness, injury or unemployment.⁶³ The right to social security is closely linked to the right to safe and healthy working conditions, and in particular the right to compensation in case of work-related injury or disease.
43. Ukraine has ratified the ILO Social Security (Minimum Standards) Convention of 1952 (No. 102), which provides guidance on various benefits applicable to workers during emergencies, including benefits for medical care, sickness, employment injury and survivor’s benefit. The ILO recommends that affected workers have the right to compensation, rehabilitation and curative services not only in case of infections but also in case of mental and behavioural disorders, if acquired through occupational exposure.⁶⁴ Whereas an epidemiological investigation of individual cases would normally document the occupational or residential source of exposure to highly infectious disease agents, ILO and WHO recommend that for those workers with a high level of contact with sources of such hazards, the occupational cause of the exposure can be recognized as plausible without an epidemiological investigation.⁶⁵
44. COVID-19 infections among healthcare workers in Ukraine have rarely been considered as work-related, depriving staff of compensation. Although the Cabinet of Ministers included COVID-19 on the list of work-related diseases and the Ministry of Health included almost every medical profession on the list of medical staff “directly involved to combat the epidemic”, the application of this legislation and, in particular the procedure to establish the link between the infection and work, is cumbersome and lacks transparency.⁶⁶

⁶³ See Committee on Economic, Social and Cultural Rights, General Comment No. 19, Article 9, The right to social security, 4 February 2008, E/C.12/GC/19, para. 4.

⁶⁴ ILO, *Recommendation No. 194 - List of Occupational Diseases Recommendation*, 2002, available at www.ilo.org/dyn/normlex/de/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312532.

⁶⁵ WHO and ILO, *Occupational safety and health in public health emergencies*, p. 6.

⁶⁶ The composition of the specialized commission, according to the Cabinet of Minister’s Resolution “On the Procedure to Investigate Work-related Accidents and Diseases”, consists of an official from the State Labour Organization, and representatives from the Social Insurance Fund, the concerned organization’s management, a representative of a trade union, the local city/village council, and the State Emergency Service, as well as a professional responsible for hygiene at work, etc. Representatives of trade unions complained to HRMMU that there was a lack of specialists (e.g. epidemiologists, professional pathologists) to form such commissions. The investigation procedures prescribed for the functioning of these commissions are also long and contain multiple steps (e.g. determining how the person concerned used PPE, followed work instructions, examination of work documents, requesting information from medical facilities regarding the COVID-19 infected medical staff, requesting additional tests etc). All these steps and procedures negatively affect healthcare personnel’s ability to prove the link between their COVID-19 infection and

45. As of 31 December 2020, the State Labour Service had been notified of 35,040 cases of COVID-19 infections among healthcare workers, while the investigations to establish the link between the infection and work had been completed in only 26 per cent of cases (9,159). In some regions, the rate of completed investigation rates was even lower than the national average. For example, in Zaporizhzhia and Kherson regions, investigations were completed in only six per cent of cases, while in Zakarpattia and Kyrovohrad regions, investigations had been completed in 11 per cent of cases.⁶⁷ In some cases, investigations had taken as long as five months.⁶⁸
46. The State Labour Service reported it was not always notified in a timely fashion about cases of occupational diseases of healthcare workers. In the Luhansk region, as of 31 December 2020, 869 COVID-19 cases were registered by the National Health Service of Ukraine,⁶⁹ however, the State Labour Service had only been notified of 42 (less than five per cent).
47. Furthermore, completed investigations resulted in a low recognition rate, with only 28 per cent (or 2,558 cases) of COVID-19 infections of healthcare workers recognized as work related.⁷⁰ There were also significant regional discrepancies in the recognition rate of COVID-19 infections of healthcare workers as work-related. For example, four per cent of cases in Poltava region (11 out of 266 cases of COVID-19 infection in which the investigations were completed), seven per cent in Sumy region (16 out of 266 cases), and eight per cent in Luhansk region (one out of 13), compared with 80 per cent in Ivano-Frankivsk region (199 out of 249) and 66 per cent in Kharkiv region (232 out of 351 cases).

NON-RECOGNITION OF COVID-19 INFECTIONS OF HEALTHCARE WORKERS AS WORK-RELATED



Source: Social Insurance Fund, all in 2020

their work, leaving room for corruption and personal influence and/or connections to obtain the desired conclusions by the commission. Кабінет Міністрів України, Постанова №337 «Про затвердження Порядку розслідування та обліку нещасних випадків, професійних захворювань та аварій на виробництві» від 17 квітня 2019 р. [Cabinet of Minister of Ukraine, Resolution No. 337 “On the approval of the Order to investigate and register occupational diseases and accidents at work” from 17 April 2019], available at <https://zakon.rada.gov.ua/laws/show/337-2019-п#Text>. On 5 January 2021, further changes were made to the Cabinet of Minister’s Resolution regulating investigations of healthcare worker deaths. See Кабінет Міністрів України. Постанова №1 "Деякі питання розслідування випадків смерті окремих категорій медичних працівників" від 5 січня 2021 року [Cabinet of Ministers of Ukraine, Resolution No.1 “Some questions regarding the investigation of deaths of some categories of medical workers” from 5 January 2021], available at <https://zakon.rada.gov.ua/laws/show/1-2021-%D0%BF#Text>.

⁶⁷ Information provided by the State Labour Service in response to HRMMU’s letter, 4 February 2021.

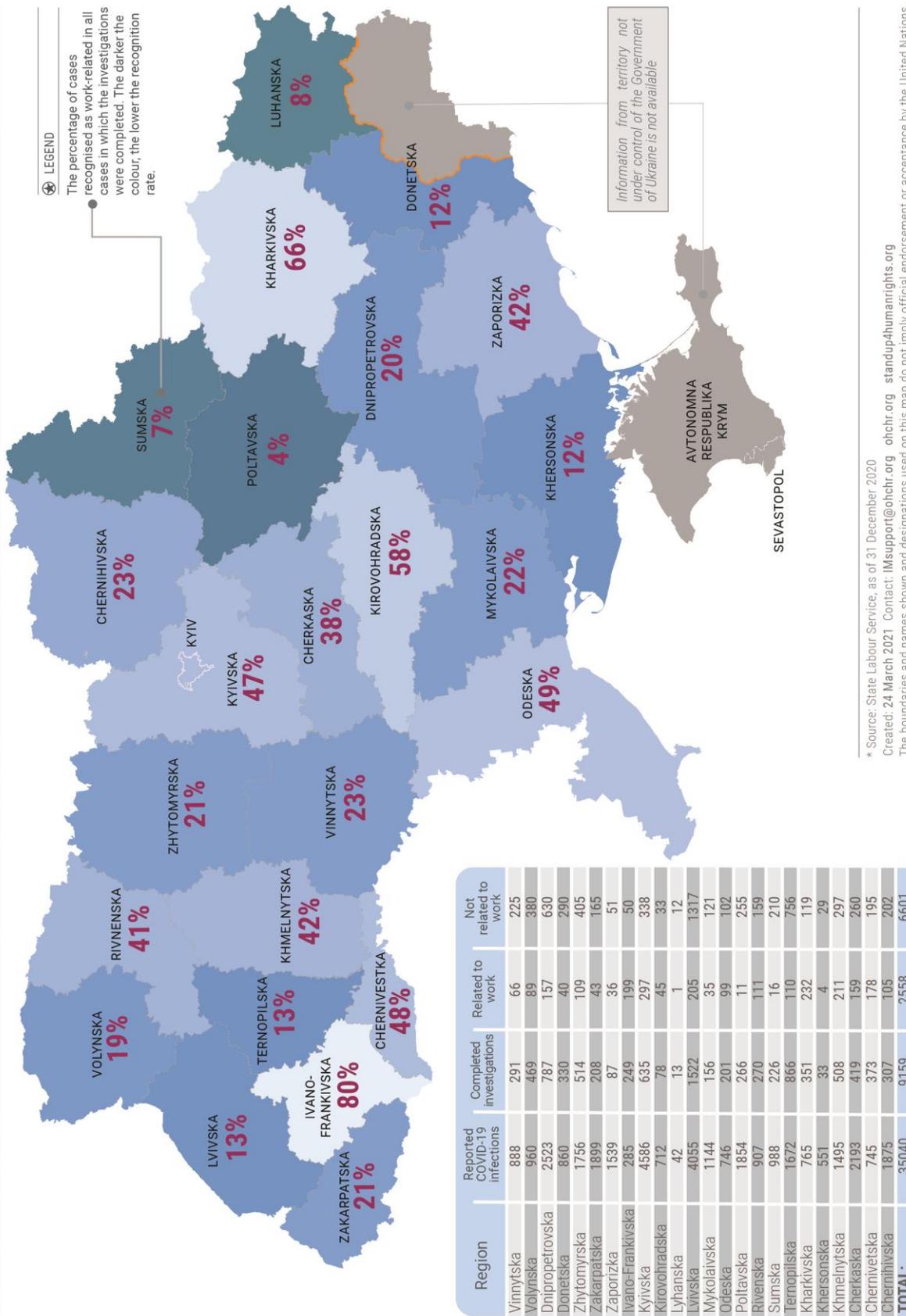
⁶⁸ Фонд Соціального страхування України, “Сергій Таровик: У строк до 1 місяця завершено розслідування 13% випадків інфікування медиків COVID-19” [Social Insurance Fund of Ukraine, “Serhii Tarovuk: The investigations are completed within a month in 13 per cent of cases of COVID-19 infection of medical workers”], 24 December 2020, available at www.fssu.gov.ua/fse/control/main/uk/publish/article/972395.

⁶⁹ See National Health Service of Ukraine, <https://nszu.gov.ua/e-data/dashboard/covid19>.

⁷⁰ Letter from the State Labour Service in response to HRMMU’s letter, 4 February 2021.

Recognition of COVID-19 infections of healthcare workers as work-related*

2020



* Source: State Labour Service, as of 31 December 2020
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48. Trade union representatives confirmed that the specialized commissions responsible for investigations are reluctant to link COVID-19 infections among healthcare staff with their work, and that even convening such commissions was a challenge due to the lack of specialists such as epidemiologists and professional pathologists whose participation is required by law. A number of interviewees also mentioned that it was difficult for healthcare staff who were not officially designated as part of the COVID-19 response (based on the facility where they work) to justify that their COVID-19 infection was work-related, potentially affecting their access to compensation.
49. The director of a primary healthcare facility in Odesa region told HRMMU that cases of COVID-19 among their healthcare workers were not recognized as work-related based on an assumption that workers had disregarded safety protocols for working with patients.⁷¹ Likewise, an interviewee in Kramatorsk said that compensation for work-related cases of COVID-19 was not granted because patient-to-doctor transmission inside healthcare facilities were viewed as a “breach of rules on the appropriate usage of PPE.” HRMMU notes that such practices appear unlawful because according to Ukrainian legislation, violation of work safety rules cannot justify the non-recognition of a case as work-related or affect the right to compensation.⁷²
50. HRMMU also received complaints that sick leave payments from the Social Insurance Fund are often delayed, which contributes to the financial insecurity faced by healthcare staff who earn the minimum wage.
51. Nurses and junior nurses who are nearly always women constitute 54 per cent of all healthcare workers infected with COVID-19, according to the State Labour Service data. They also receive the lowest salaries, which means that they are hit hardest in the absence of compensation for COVID-19 infection. HRMMU interviewed a former junior nurse at an intensive care unit in a Kharkiv hospital designated for COVID-19 patients who was among the first in her unit infected with COVID-19 in spring 2020. She blamed the lack of PPE for her infection. Given that her management tried to conceal her diagnosis, she has never applied for a social insurance compensation as a healthcare worker. Due to health complications caused by COVID-19, she had to quit her job.
52. In addition to the obligatory State social insurance, all healthcare facilities may also contract private insurance for their staff. However, many managers of medical facilities told HRMMU that they either lack the funds to obtain insurance for everyone or that private providers did not want to insure for COVID-19 cases or that providers pay ‘insultingly’ low compensation.⁷³ According to one interlocutor, when she tried to obtain additional insurance for her staff, insurance companies refused to insure healthcare workers aged over 60, while some 35 per cent of her staff were of that age. Hospital workers interviewed by HRMMU reported that due to the scarcity of funds, doctors are prioritised for COVID-19

⁷¹ According to the Social Insurance Fund, the reason for not recognising the case as work-related was the inability of the investigation to establish a connection between the healthcare worker’s infection and his or her work duties. In 2020, there were four cases in which the sum of the one-time payment paid out to healthcare workers who became disabled due to COVID-19 was reduced, based on the decisions of labour safety commissions at their health institutions which ruled that the healthcare workers had not followed labour safety instructions. Letter from the Social Insurance Fund of Ukraine in response to HRMMU’s letter, 2 March 2021.

⁷² “The violation of work safety rules by the insured that led to an accident or an occupational disease does not relieve the insurer of its obligation to execute its duties towards the insured”. Law on the Obligatory State Social Insurance, art. 36(6), available at <https://zakon.rada.gov.ua/laws/show/1105-14#Text>.

⁷³ One doctor with management responsibilities in Dnipro region said that an insurance company offered compensation of 400 UAH (approx. \$14) for treatment and 20,000 UAH (approx. \$806) in case of the death of a healthcare worker.

insurance, leaving mid-level and junior staff behind. Many healthcare workers said that they did not know if they were insured.

53. HRMMU notes that in some regions and cities, authorities decided to provide additional compensation to healthcare workers infected with COVID-19. For example, the Poltava Regional Council adopted plans to pay 10,000 UAH (approx. \$352) to each medical worker in the region who was infected with COVID-19 until the end of 2020 and aims to continue this program in 2021. Similar measures were taken by the Kharkiv Regional Council and Lviv and Odesa City Councils.

5. Effective participation

“After the May protest, the repressions started. My management told me that I should not have signed the petition or talked to journalists, and that I would pay for having done so. Management is used to having staff that act as numb slaves, not saying a word against anything. Those who didn’t want to be silent were either fired or forced to quit.” – A former ambulance crew member from Kharkiv who was forced to leave her job following reprisals for her participation in a public protest about working conditions.

54. According to article 8 of the ICESCR, everyone has the right to form trade unions and join the trade union of their choice, for the promotion and protection of their economic and social interests. ILO Conventions No. 87 on Freedom of Association and Protection of the Right to Organise and No. 98 on Right to Organise and Collective Bargaining, both ratified by Ukraine, also provide guarantees to workers to defend their rights. In addition, article 19 of the ICCPR guarantees the right of freedom of opinion and expression, which includes freedom to seek, receive and impart information and ideas of all kinds. Articles 21 and 22 of the ICCPR also recognize the rights to peaceful assembly and to freedom of association with others, including the right to form and join trade unions for the protection of one’s interests. According to article 25 of the ICCPR every citizen has the right and the opportunity to participate in the conduct of public affairs, directly or through freely chosen representatives. Participation in decision-making processes may take different forms, from providing information on a policy issue, through to consultation, dialogue and to partnership or even co-drafting of regulatory acts.⁷⁴
55. Representatives of healthcare trade unions stated they were not effectively consulted about the Government’s health policy measures to respond to COVID-19 at the national and local levels, nor about the ongoing healthcare reform process. A pre-existing tri-partite council that serves as a platform for social dialogue between policy-makers, employers and employees, had not been used for years.⁷⁵

⁷⁴ For more details see OHCHR, *Guidelines for States on the effective implementation of the right to participate in public affairs*, Geneva 2018, available at www.ohchr.org/Documents/Issues/PublicAffairs/GuidelinesRightParticipatePublicAffairs_web.pdf.

⁷⁵ In March 2020, the CESCR recommended the Government to review the legislative plans that result in the weakening of the powers of trade unions, including the right to strike, resulting in violations of Article 8 of the ICESCR. Committee on Economic, Social and Cultural Rights, Concluding observations on the seventh periodic report of Ukraine, 2 April 2020,

56. Many healthcare workers also reported not trusting trade unions, indicating the unions' lack of political power. Many interviewees said that although they were members of trade unions, they did not see them defending their rights and too often siding with management. As a result, they rarely turned to them to improve working conditions. Some said that they were not members because they did not see trade unions as an effective tool in protecting and promoting their labour rights.
57. HRMMU is alarmed about cases of reprisals against whistle-blowers among healthcare workers who publicly exposed the poor preparedness and response of the healthcare sector to the COVID-19 crisis and the lack of safe and healthy working conditions, by talking to the media or by posting in social media. HRMMU documented cases when individuals who raised their voices about the critical situation in the healthcare system were silenced, including via dismissal and harassment.
58. In Kharkiv, HRMMU interviewed three former emergency healthcare staff – two drivers and a paramedic – who faced reprisals after participating in a public protest against poor working conditions in May 2020.⁷⁶ The paramedic told HRMMU that after the protest she was told by her management that she would “pay for her participation”. She subsequently had to appear before an all-male ethics commission for misconduct. When she appeared before the commission with her lawyer, the proceedings were adjourned. Her management, however, switched her to night shifts and attempted to transfer her to a different sub-station to which she was unable to commute while taking care of her mother who had developed health complications after contracting COVID-19. Unable to cope with the pressure, on 1 December 2020, the paramedic quit her job. She told HRMMU that other protest participants had backtracked on their previous complaints under pressure from their management. An ambulance driver and war veteran who participated in the same protest was not medically cleared for his subsequent shift, under the formal pretext of high blood pressure, with his management publicly claiming he was inebriated. He immediately underwent an independent alcohol test, which showed he did not have any alcohol in his system. In autumn 2020, he resigned ‘due to unbearable working conditions’ and applied to serve in the military again. He also filed a libel case against his management which resulted in the court awarding him 10,000 UAH (approximately \$360) in compensation for the false public claim that he has arrived for work drunk.⁷⁷
59. In Chernivtsi, a doctor was summoned by the National Police after the Regional State Administration accused her of spreading unverified information. This occurred after she had complained about the lack of PPE, equipment and staff available to treat COVID-19 patients in the media and on social media. She considers this was a message from the regional authorities to other healthcare staff not to complain publicly.⁷⁸ In the Zhytomyr

https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fUKR%2fCO%2f7&Lang=en, para. 22 (c) and 27-28.

⁷⁶ On 18 May 2020, members of ambulance crews of the Kharkiv regional Centre for Emergency Medical Care and Medicine of Catastrophes held a press event to express their frustration with their work conditions, and lack of PPE and equal pay in connection with potential COVID-19 cases. They underlined that they would not stop working. See <https://suspilne.media/34341-u-harkovi-mediki-svidkoi-dopomogi-vijsli-na-protest/>.

⁷⁷ The victim asked for 150,000 UAH compensation for moral damages arguing that as a result of defamation, he had to quit his job and that he could not find another job due to the negative attitudes of potential employers. See the court decision available at <https://reyestr.court.gov.ua/Review/94514944>.

⁷⁸ See Телеканал Прямий, “Викликали у поліцію за інформацію про нестачу кисню для хворих: подробиці від лікарки Ольги Кобевко” [TV channel Priamyi, “Police was called for information on lack of oxygen for the sick: details from doctor Olha Kobevko”] (video), 6 November 2020, available at <https://youtu.be/qFsfKvgdP2s>;

region, after staff in rural areas complained to the Ministry of Health about work conditions, they were subjected to additional checks on their activities at work.⁷⁹

60. Local media reported that several medical workers in Odesa suffered reprisals for expressing their frustration with the situation of the healthcare system on social media. Retaliation included being threatened that their bonuses would be cut, or that they would be prosecuted for divulging medical secrets.⁸⁰ Allegedly, the city authorities instructed head doctors to monitor the situation and identify those complaining publicly.
61. Numerous healthcare workers refused to be interviewed by HRMMU or were reluctant to provide detailed accounts of their working conditions, fearing retaliation. One interviewee from Odesa told HRMMU that the personnel at her facility had been summoned for a meeting by their management, at representative of healthcare authorities warned them not to disclose work related information, especially on COVID-19 issues, under threat of dismissal.⁸¹

6. Impact on healthcare

“How could they increase the number of beds in [COVID-19-designated] hospitals? Even if they add new beds, who is going to care for the patients? There aren’t enough healthcare staff for this.” – A doctor from Chernivtsi, November 2020.

“We are always busy [but] the mortality rate [of patients] has gone up as patients are triaged after the ambulances bring them, and only patients with severe complications are hospitalized.” – A nurse from Toretsk, Donetsk region, November 2020.

62. During a pandemic, when the healthcare system is already under pressure, high rates of morbidity and mortality among healthcare workers may seriously affect the availability and quality of healthcare services.⁸² In addition, resignations of healthcare workers due to unfavourable work conditions also has a negative impact on service provision. As a result, the right of everyone to the enjoyment of the highest attainable standard of physical and mental health set out in article 12 ICESCR is at risk.
63. HRMMU is concerned that the poor working conditions for healthcare workers involved in the COVID-19 response described in this Note contributed to staff shortages (due to

Чернівці Live, “Лікарку, що рятує життя, викликали до поліції” [The doctor who saves lives was summoned to police] (video), 6 November 2020, available at <https://youtu.be/QaaXf-apEbk>.

⁷⁹ HRMMU interviews, November 2020.

⁸⁰ “COVID-19: начальство угрожает одесским врачам из-за нелояльных комментариев в соцсетях [COVID-19: Management threatens Odesa doctors for disloyal comments on social media]”, *Dumskaya*, 30 November 2020, available at <https://dumskaya.net/news/bombanulo-v-departamente-zdravoohraneniya-nachal-131778/>. Although HRMMU could not verify this particular case, HRMMU received similar allegations from other interlocutors in Odesa.

⁸¹ HRMMU interview, December 2020.

⁸² During Ebola outbreaks in West Africa, the high rates of infection and deaths among health workers in the most affected countries led to serious negative impacts on the overall functioning of health services. See WHO, *Health worker Ebola infections in Guinea, Liberia and Sierra Leone*, Geneva, 2015, p. 2, available at https://apps.who.int/iris/bitstream/handle/10665/171823/WHO_EVD_SDS_REPORT_2015.1_eng.pdf?sequence=1&isAllowed=y 6.

illnesses and resignations), which further degraded the working conditions for the remaining staff who faced greater workloads. According to the State Statistical Service, the number of healthcare workers decreased by 5.4 per cent in 2020 - from 777,000 in January to 734,900 in December, which may be also attributed to the ongoing healthcare reform process.⁸³ Given that Ukraine already faced a shortage of healthcare workers before the pandemic, the reduction in healthcare staff in 2020 likely had a negative impact on the population's right to health, including access to, and the quality of, essential services.

64. In Kharkiv, the number of ambulance crews decreased in 2020.⁸⁴ This resulted in extended work shifts (up to 15-16 hours), lack of disinfection of vehicles between shifts, inadequate breaks, with crews banned from returning to duty stations between calls, and having to use toilets in patients' houses or relieve themselves on the street. Further, the management established a time limit on how long a crew may spend responding to a call, with crews instructed to leave after approximately 20 minutes. If they remained longer, the crew had to provide a written explanations and risk receiving salary cuts (of up to 20 per cent). If a crew member was diagnosed with COVID-19, others in the team did not self-isolate.⁸⁵
65. The representative of a primary healthcare centre in the Luhansk region told HRMMU that the pandemic had increased the workload for family doctors, from a daily average of 20 patients to 50 patients. Despite working two extra hours per day, doctors were still forced to dedicate less time per patient, affecting the quality of care. Interlocutors also reported that the shortage of medical workers in Odesa was increasing on a daily basis. A doctor from Odesa told HRMMU that she had to oversee about 100 patients located at two stories of a hospital involved in COVID-19 response and at the same time manage the admission of new patients who waited in ambulances near the hospital. Several interviewees also complained about the lack of a sufficient number of nurses to treat patients.⁸⁶
66. Some healthcare workers also mentioned that they were unable to provide quality care, accept new patients with COVID-19 to hospitals or rapidly deploy emergency units due to lack of capacity, including insufficient personnel. Healthcare workers in two Kharkiv hospitals reported that they were aware of cases where medical aid had been denied due to a lack of capacity and excessive workload.

⁸³ See www.ukrstat.gov.ua/operativ/operativ2020/gdn/Sok_ed/Sok_ed2020_ue.xlsx. The State Employment Centre reported that over 68,000 healthcare workers were warned about forthcoming mass dismissals in January-November 2020. Державна служба зайнятості, *Ситуація на ринку праці та діяльності Державної служби зайнятості у січні-листопаді 2020 року* [State Employment Service, *The situation on the labour market and activities of the State Employment Service in January-November 2020*], 30 December 2020, p. 19, available at www.dcz.gov.ua/sites/default/files/infocfiles/sytuaciya_na_rp_ta_diyalnist_dsz_.pdf.

⁸⁴ Kharkiv Oblast State Administration, "Аудит «швидкої» виявив порушення в закупівлях, нецільове використання приміщень та скорочення бригад [The audit of 'the ambulance service' discovered irregularities in public procurement, misuse of premises and reduction of the number of ambulance crews]", 26 October 2020, <https://kharkivoda.gov.ua/news/105602?sv>.

⁸⁵ HRMMU interviews, October -November 2020 and January 2021.

⁸⁶ Before the pandemic, Ukraine had a lower number of nursing personnel per 10,000 population than many other European countries, see WHO, *State of the world's nursing 2020*, 2020, Figure 1.

Conclusions and Recommendations

67. The COVID-19 crisis has exacerbated the human rights concerns faced by healthcare workers in Ukraine, such as the lack of adequate remuneration that provides for a decent living, and created new vulnerabilities related to their working conditions and social protection. Degrading working conditions contribute to the shortage of healthcare staff in Ukraine, which negatively impacts the population's right to health. The Government's response to the COVID-19 health crisis needs to place healthcare workers front and centre, and guarantee, in close consultation with them, their right to just and favourable working conditions. This must encompass fair wages and equal remuneration and occupation safety and health, including mental health and psychosocial support services, and improvement of their social protection.

68. In order to address the negative impact of the pandemic and mitigate related risks, HRMMU recommends that the Government of Ukraine, regional and local authorities:

Increasing public investment in the health sector

- Increase investments in the health sector, including by extending budgetary space and prioritization of healthcare in budgets, improved revenue administration and other measures.⁸⁷ Provide state funding to the healthcare sector at no less than five per cent of GDP as per the national commitment established in the 2017 law 'On State Financial Guarantees of Healthcare Services to the Population' and increase the effectiveness of expenditure in the health sector by continuing the healthcare reform process.
- Increase average salaries to all healthcare staff in Ukraine to provide decent pay and prevent staff leaving the public healthcare sector. This should take the form of an increase in salary (as opposed to the payment of bonuses) that would allow for an adequate standard of living and higher pensions in the future, thus improving the social security of retired healthcare staff.
- Close the gender pay gap and ensure equal pay for work of equal value among different health professionals.
- Promote equal opportunities for women to access decent work, dismantling harmful gender stereotypes that perpetuate the segregation of women into low paid jobs.
- Revise the rules for the payment of bonuses in close consultation with healthcare workers, at all levels and in all types of work, including non-medical staff, to ensure their fairness and transparency.
- Ensure that resources are not diverted from other essential health services, including sexual and reproductive health services.

Ensuring adequate protection at work

- Ensure adequate protection of healthcare workers, at all levels and in all types of work, including non-medical staff, by providing them with sufficient and adequate PPE, safe disposal of used PPE and training. Ensure adequate working conditions, including break and rest time and adequate sanitary facilities. Apply the recommendations made by WHO and ILO in the Guide on Occupational Safety and Health in Public Health Emergencies: a Manual for Protecting Health Workers and Responders (2018).

⁸⁷ See WHO, *Budgetary Space for Health in Ukraine*, July 2020.

- Provide mental health and psychosocial support to healthcare workers, in all levels and in all types of work, including non-medical staff, and include mental health considerations in occupational health and safety management.
- Include mental health conditions in the list of occupational diseases approved by the Cabinet of Ministers.
- Develop measures to ensure the full protection of healthcare staff against physical attacks, including speedy interventions when the panic button is activated by staff.

Improving social protection of healthcare workers and their families

- Provide support to women and men among healthcare workers to discharge family and care responsibilities, by providing care services, limiting daily and weekly working hours and ensuring regular rests and paid leaves, including sick leave benefits⁸⁸ and family-friendly workplace policies. Invest in public care services and public policies to support both women and men to balance their professional life/livelihood activities and their family and all other care responsibilities. These measures should go hand-in-hand with far-reaching awareness-raising campaigns on sharing family responsibilities in the home, including household chores and child-care, to promote equality between women and men.
- Abolish the need to prove the link between COVID-19 infections and work duties for healthcare workers and pay compensation to them and members of their families living with them in case they are infected by them. The compensation should be paid regardless of claims of violations of safety rules. The compensation should at minimum cover the full cost of treatment and rehabilitation.
- Collect gender-disaggregated data on the national healthcare workforce to develop gender sensitive labour and social protection policies in the healthcare sector.

Ensuring effective participation

- Investigate allegations of corruption in the healthcare sector and protect whistle-blowers by condemning and investigating any reprisals against them and developing specific policy measures to ensure their protection.
- Encourage healthcare workers who raise their voices to defend their rights rather than punishing them, by establishing various channels through which they can complain (for example, a dedicated hotline which would respect the anonymity and confidentiality of healthcare workers making complaints).
- Closely consult and actively involve healthcare workers in the design and implementation of measures that affect them, including through effective social dialogue.
- Renew consultations within the Tripartite Socio-Economic Council at the national and regional levels and convene sessions focused on the right to work of healthcare workers.

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Some ideas on how health organizations and public policy institutions may facilitate women healthcare workers in combining caring responsibilities and work duties include measures aimed at decreasing workload, flexible scheduling, teleworking through telemedicine, back-up/emergency childcare and eldercare. See Claudia Crimia and Annalisa Carlucci, "Challenges for the female health-care workers during the COVID-19 pandemic: the need for protection beyond the mask", *Pulmonology* 2021, 27(1), pp. 1-3, available at www.journalpulmonology.org/en-pdf-S2531043720302117.

Annex. Best practices of COVID-19 responses protecting healthcare workers

Remuneration

In Argentina, the federation of associations of healthcare workers and the Government reached an agreement to guarantee that all healthcare workers would continue to earn their full salaries during periods of preventive and mandatory isolation. Healthcare workers would also be eligible for free, government-subsidized transport during the pandemic.⁸⁹

Social protection

In Germany, Austria, France and the Netherlands, during the closure of day care centres and schools, some facilities remained open with minimal personnel to take care of children of essential workers. In Italy, the Government established a “childcare allowance” of up to 1,000 Euros so that healthcare workers can pay for the cost of childcare services at home.⁹⁰

⁸⁹ East, Laurence and López Mourelo, *COVID-19 and the situation of female health workers in Argentina*, p. 24.

⁹⁰ Ibid, p. 28.