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**Building the Evidence on Forced Displacement**

# **Addressing the Human Capital Dimension of the COVID-19 Response in Forced Displacement Settings**

# Addressing the Human Capital Dimension of the COVID-19 Response in Forced Displacement Settings

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<sup>1</sup> This is the fourth in a series of six knowledge briefs which aim to share knowledge and foster exchange of information among different stakeholders working on forced displacement and health in the context of the COVID-19 pandemic.

## SUMMARY

Frontline health care workers (HCWs) bear the heaviest burden of the health system response to the COVID-19 pandemic. HCWs in low- and middle-income countries (LMICs) are at higher risk of COVID-19 related adverse health outcomes, including infection, burnout, depression, and death. As of June 2020, over 4960 HCWs were infected with COVID-19 in sub-Saharan Africa and North Africa, 2084 HCWs in South Africa alone. The challenges facing HCWs are compounded by a lack of personal protective equipment, stigma, and financial insecurity. In fragile and displacement settings, HCWs may experience violence, a high disease burden and limited resources and financial support. HCW shortages have limited the efficiency of the COVID-19 response globally, especially in LMICs. This brief will explore human resource-related challenges and innovations during the COVID-19 pandemic, including leveraging the refugee health workforce and protecting and supporting HCWs in resource-limited settings, based on emerging evidence and lessons learned from past epidemics.

### KEY MESSAGES

1. Protecting the health workforce across all fronts of the response – including formal, community-based, and informal healthcare and social care workers – is essential to prevent health system collapse.
2. Integrating refugee HCWs into the COVID-19 response can rapidly address health workforce gaps and strengthen the pandemic response.
3. Proactive steps need to be taken wherever possible to anticipate and mitigate the hidden burdens borne by HCWs, especially the impact of stigma and the strain on mental health.

# WHY IS THE SAFETY OF THE HEALTH WORKFORCE CRITICAL FOR AN EFFECTIVE PANDEMIC RESPONSE?

Epidemics such as the 2014-2016 Ebola outbreak have shown that the health workforce has a major effect on health system resilience and epidemic outcomes. The ability to recruit and deploy HCWs, including clinical providers, public health and community health workers (CHWs), could improve communicable disease control even in settings with weak health infrastructure. A robust epidemic response requires the health workforce to be adequate, well trained and protected. Lack of attention to these factors in past epidemics such as Ebola and SARS had a detrimental impact on quality of care, service availability and HCWs' health and wellbeing. Infection spread within health facilities can lead to health workforce losses, health service disruption, and erosion of trust in health systems, which may contribute to health service underutilization, treatment delays and stigma against HCWs. All of these factors can exacerbate both the direct and indirect impacts of an epidemic.

**It is important to note that** this knowledge brief examines humanitarian and national health actors in LMICs. It focuses on the frontline health workforce, defined as those who have direct interaction with confirmed and suspected COVID-19 patients such as clinical providers, lay and CHWs, surveillance teams and prehospital emergency care providers. While non-frontline HCWs such as laboratory professionals and the health management workforce also play an important role in the pandemic response, their role is beyond the scope of this knowledge brief.

## What are the roles of the health workforce during epidemics?

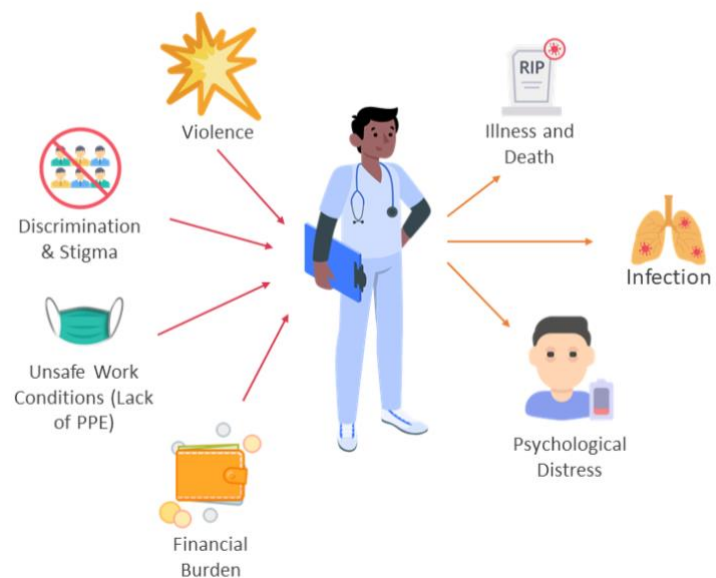
Frontline HCWs responding to the COVID-19 pandemic take on various medical, public health and community level roles. Frontline HCWs contribute to disease prevention, epidemiological surveillance and treatment of patients. Frontline HCWs are a diverse group, including CHWs at the household level, prehospital care and emergency medicine services providers who provide care en route to a facility, nurses who conduct triage, treatment provision, emergency and critical care, home-based care social service provision and mental health.

## What risk factors are experienced by health workers during epidemics?

Epidemics increase demands on the health workforce while increasing the risk of various hazards, including COVID-19 infection and death (Figure 1). The lack of personal protective equipment (PPE), and its inappropriate use, coupled with long working hours in settings with substandard infection control measures increase infection risks among HCWs several times above the risk for the general population. During the 2014 - 2016 Ebola outbreak in Liberia, HCWs had a higher Ebola virus disease (EVD)-related mortality than the general population (8.07% compared to 0.11%). Health facilities can become foci of outbreak emergence and spread into local communities, causing fear and loss of confidence in the health system and stigmatization of HCWs who may be blamed for spreading disease. Discrimination and stigma have led to the exclusion of HCWs from public transportation, social ostracism, and physical attacks. In Egypt, residents of the Dakahlia Governorate protested against the burial of a female doctor who died of COVID-19, fearing contamination if she was buried in the village cemetery. HCWs who speak out against unsafe working conditions or gaps in the state response may risk threats such as termination of employment and arrest.

Epidemics also impact the psychosocial wellbeing of the health workforce. Medical surge and health workforce shortages place additional strains on HCWs, due to excessive working hours, requirements to work outside their expertise to meet urgent needs and unsafe working conditions, including a lack of PPE. Stigma, as noted above, compounds these risk factors.

HCWs may experience social isolation and a lack of social support that can be exacerbated by required separation from families and close friends. Fear for family safety affects HCW resilience, especially when a close family member or colleague becomes infected. HCWs may face increased care responsibilities, causing more stress and fear of transmitting the virus to the family. Financial burdens, for example due to pay cuts or increased childcare costs due to school closures related to the pandemic, may also impact psychosocial wellbeing.

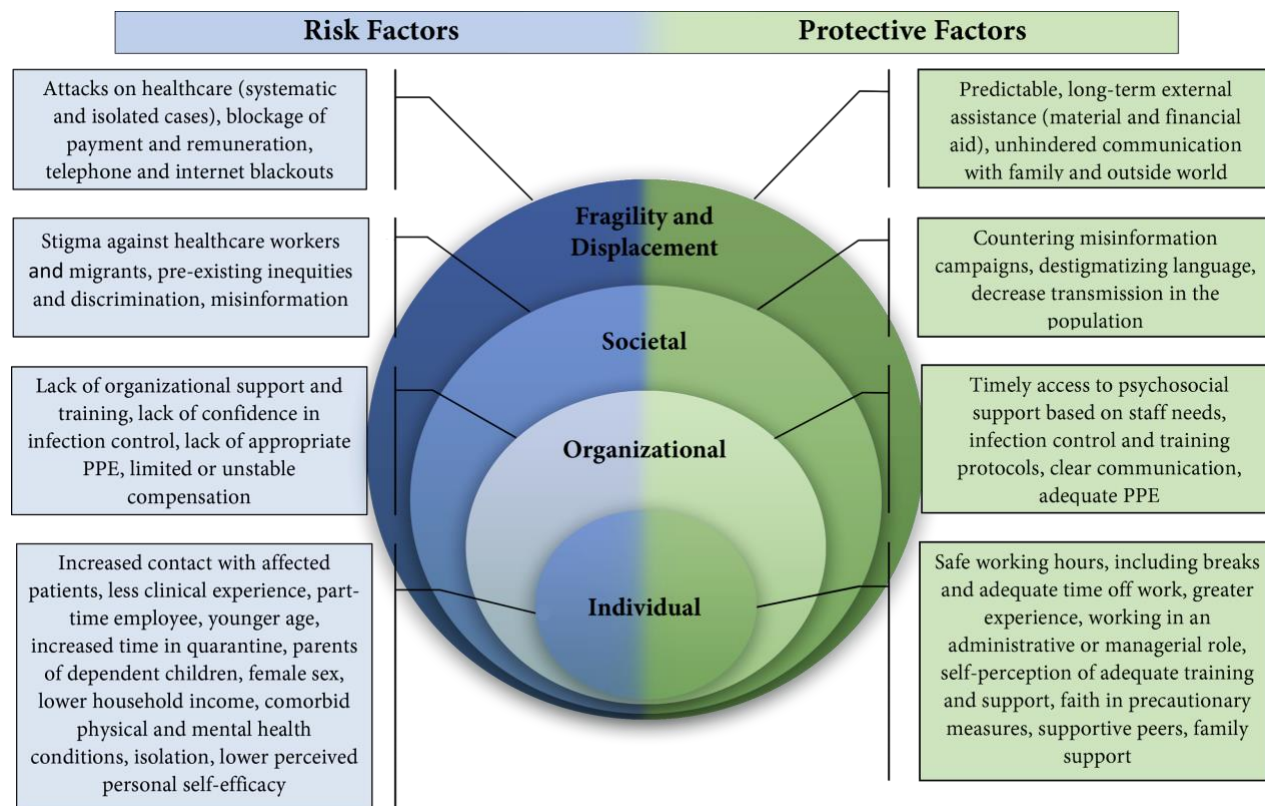


**Figure 1:** Main risk factors and adverse outcomes affected HCWs during the COVID-19 pandemic

Different health workforce subgroups have disproportionate exposure to epidemic-related risks. Risk factors include prolonged exposure to infected patients, performing high-risk medical procedures, inadequate access to PPE, working at night, and part-time employment (possibly related to increased caseloads and lack of support or supervision). UK

doctors from immigrant and ethnic minority backgrounds were twice as likely to report being pressured to work in unsafe environments without access to PPE and to experience PPE shortages. During recent Ebola outbreaks, nursing staff had the highest Ebola exposure frequency.

**Figure 2:** Socio-Ecological model of risk and protective factors affecting psychological wellbeing of HCWs



*Based on Kisely et al. (2020), Witter et al. (2017), Armitage and Nellums (2020), Gold (2020), United Nations (2020), Witter (2020), Castles (2020), Robert et al. (2020), Save the Children (2018)*

## How are vulnerabilities different for the health workforce in contexts of fragility and displacement?

Countries suffering from forced displacement and protracted conflicts often experience pre-existing challenges, including shortages of HCWs, skill-mix imbalances, geographic maldistribution favoring urban centers, a shortage of specialized medical and public health workers, as well as financial instability and weak infrastructure with suboptimal controls for infection in health facilities. These factors heighten the vulnerability of the health workforce responding to COVID-19 in displacement settings.

## **Threats to physical safety and security, including violence and systematic attacks on healthcare.**

HCWs have long been targets of isolated and systematic attacks against healthcare facilities in settings of fragility, conflict and violence. Against this backdrop of the weaponization of healthcare, COVID-19 has led to new forms of violence against HCWs, including death threats, unlawful arrests, and physical violence, triggered in part by fears of infection, public opposition to lockdown orders and other restrictive public health and social measures, and actions taken by HCWs to expose gaps in the state response. Fifteen attacks on healthcare in Afghanistan were recorded during the first two months of the COVID-19 pandemic. In Pakistan, Quetta, Balochistan, approximately 100 HCWs were arrested for staging a protest over a lack of PPE. Such attacks are not unique in fragile and conflict settings as they have been reported in countries including the U.S., Russia, and India. However, in settings where accountability is weak, HCWs' vulnerability is amplified. Beyond the loss of human life and the destruction of health infrastructure, such attacks disrupt every aspect of the COVID-19 response along with routine health services.

## **The challenge of a higher disease burden and fragmented health systems.**

HCWs working in fragile and conflict-affected countries respond to a high population disease burden while facing severe resource constraints and weak health infrastructure. Health facilities may have limited access to water, electricity, essential medications and supplies and be subject to unpredictable and/or deteriorating socio-economic, political and environmental conditions. HCWs operating under these conditions are already strained and have limited reserves to respond effectively to the new demands of the COVID-19 pandemic. For example, in Yemen, providers with very limited access to testing kits and radiography have documented the difficulty of managing patients with COVID-19 symptoms.

Fragility complicates data collection, contact tracing, and the ability to standardize and coordinate the COVID-19 response at state and national levels. Doctors in DRC voiced concerns about the challenges of responding to COVID-19 when the country is dealing with four simultaneous outbreaks (malaria, measles, cholera, and Ebola) and ongoing insecurity. Fragility impacts health actors' ability to distribute the health workforce according to the epidemic burden, train the available health workforce on infection prevention and control and infectious disease management, recruit new HCWs, and coordinate the response across all health stakeholders.

Fragile states also suffer from weak logistical systems, including provision and distribution of PPE and medical supplies such as consumables for basic infection control, medications, ventilators, and supplemental oxygen. A recent analysis of Service Provision Assessment surveys found that less than a third of clinics and health centers in Bangladesh, DRC, Nepal, and Tanzania had any face masks. This shortage in PPE and medical supplies cripples the healthcare system and burdens HCWs with moral dilemmas regarding the allocation of scarce resources and triage of patients, further contributing to psychological distress and burnout. Global competition for medical supplies amid the COVID-19 pandemic has also left behind many fragile states and humanitarian agencies.

## Unstable and unpredictable financial support

Financial instability is prevalent in the context of fragility and forced displacement. While low spending on health systems is a common challenge across LMIC countries, fragile states heavily depend on external donors and non-governmental organizations (NGOs) to fund and sustain basic health services, with funding commitments that range from a few months to several years. HCWs in such settings face high financial insecurity due to low wages and unreliable payment schemes and may be forced to depend on other unregulated funding sources, including user fees. In Kinshasa, HCWs have experienced a four month delay in payments and compensation for families of HCWs who died due to COVID-19. The COVID-19 epidemic has also caused economic contraction worldwide, which limits the ability of fragile states to fund health services.

# WHAT ARE THE LESSONS LEARNED FROM PAST EPIDEMICS WITH REGARD TO HEALTH WORKFORCE PROTECTION?

## Centralize the protection of the health workforce across all fronts of the response, including the formal, community-based, and informal health workforce.

During the 1995 Kikwit Ebola outbreak in the DRC, the spread of infection within hospitals in the early phase of the outbreak caused widespread fear and nearly all patients fled from those hospitals. By the end of the outbreak, HCWs constituted 25% of total deaths in Kikwit. During the 2002 SARS outbreak, 1706 HCWs were infected. Risk factors included performing airway and respiratory-related procedures and insufficient infection control measures including the reuse of N95 respirators. Various strategies to protect the health workforce showed significant impact in past epidemics. The implementation of compulsory protective measures in Hong Kong hospitals decreased the spread of SARS among HCWs and their families. A study of HCWs' experiences in Sierra Leone's Ebola outbreak found that simple strategies such as supportive supervision, workshops to deal with stigma, and risk allowances could have a significant impact on the health workforce's resilience. Risk allowances compensate HCWs for the additional risk assumed during outbreaks, serving to both mitigate negative financial consequences and sustain motivation and morale.



## Support and leverage the refugee and displaced health workforce

HCWs among refugee and internally displaced communities have played significant roles in health programs, including the management and control of infectious diseases. Vaccination campaigns in non-government controlled areas in Syria have been implemented by local NGOs formed by displaced HCWs since the reemergence of polio in 2013. In Lebanon, Syrian refugee physicians provided informal healthcare services in their communities. In Guinea, peer health education programs implemented by refugee CHWs from Sierra Leone had positive impacts on maternal health, family planning, and HIV risk perception. In Tanzania's Lugufu camp, former Congolese HCWs formed health information teams that facilitated disease surveillance and patient referrals. In many camp settings, on-site trained refugee HCWs have enhanced existing health services and facilitated public health awareness. This strategy is discussed in more detail below. Inclusion of displaced HCWs in the provision of various health services, including infectious disease care, has been shown to have a positive impact on population health by increasing service coverage, treatment seeking behavior, and knowledge regarding disease prevention.

## Anticipate and address hidden burdens, especially mental health and the impact of stigma on the health workforce.

Fear and stress have been shown to impede the effectiveness of the response to viral outbreaks. During the 1995 Kikwit Ebola outbreak in the DRC, HCWs suffered from severe stress and psychosomatic symptoms as they had to deal with the loss of their colleagues and the fear of transmitting the infection to their families. Vulnerable HCWs may experience psychological distress including anxiety and depressive symptoms, fatigue, and occupational burnout. Such distress can severely impact HCWs wellbeing and functioning and may lead to increased absenteeism or, in extreme cases, suicide.

In past epidemics, such as HIV/AIDS and Ebola, stigma had a major impact on health workforce functioning and the effectiveness of the epidemic response. Stigma toward HCWs is often attributable to misinformation about affected groups and transmission dynamics, discrimination, and fear. Refugee HCWs experience the double burden of social stigma against HCWs and both social and structural discrimination against migrants.

Public messaging can either counter or exacerbate misinformation and stigma. Regular risk communication and fact checking are recommended strategies to fight misinformation (Box 1). The use of war metaphors could lead to more fear and anxiety among the population and the health workforce and reinforce stigma. Referring to HCWs as "troops" may normalize their loss and reduce pressure on health systems to protect HCWs and provide a safe environment. Governments needs to distinguish between misinformation and inequality-driven mistrust as a source of false beliefs about COVID-19.

## Box 1: Strategies from the field for protecting the psychosocial wellbeing of healthcare workers

Emerging research suggests that the elevated levels of psychological distress and mental health problems observed among HCWs responding to COVID-19 are, at least in part, attributable to the stigma and discrimination faced by HCWs. To mitigate these mental health consequences, efforts to prevent stigma and discrimination, complemented by mental health and psychosocial services are critical to support and protect HCWs responding to COVID-19.

A number of countries have developed innovative strategies for supporting frontline responders (e.g., tele-mental healthcare for HCWs). Several countries, including Afghanistan, Kenya, and Lebanon, have committed to providing mental health, psychosocial support and anti-stigma strategies to frontline HCWs as part of their COVID-19 response plan. Lebanon's mental health and psychosocial support response plan includes specific activities to support HCWs including: 1) training on self-care, including identification and referral of mental disorders; 2) training nurses working in quarantine on self-care using recorded videos and providing a self-care tip sheet; 3) establishing mental health support systems for HCWs in quarantine, including having an on-call mental health professional available for phone support, providing information about available services to HCWs, and ensuring brief, regular check-in meetings to monitor psychosocial wellbeing.

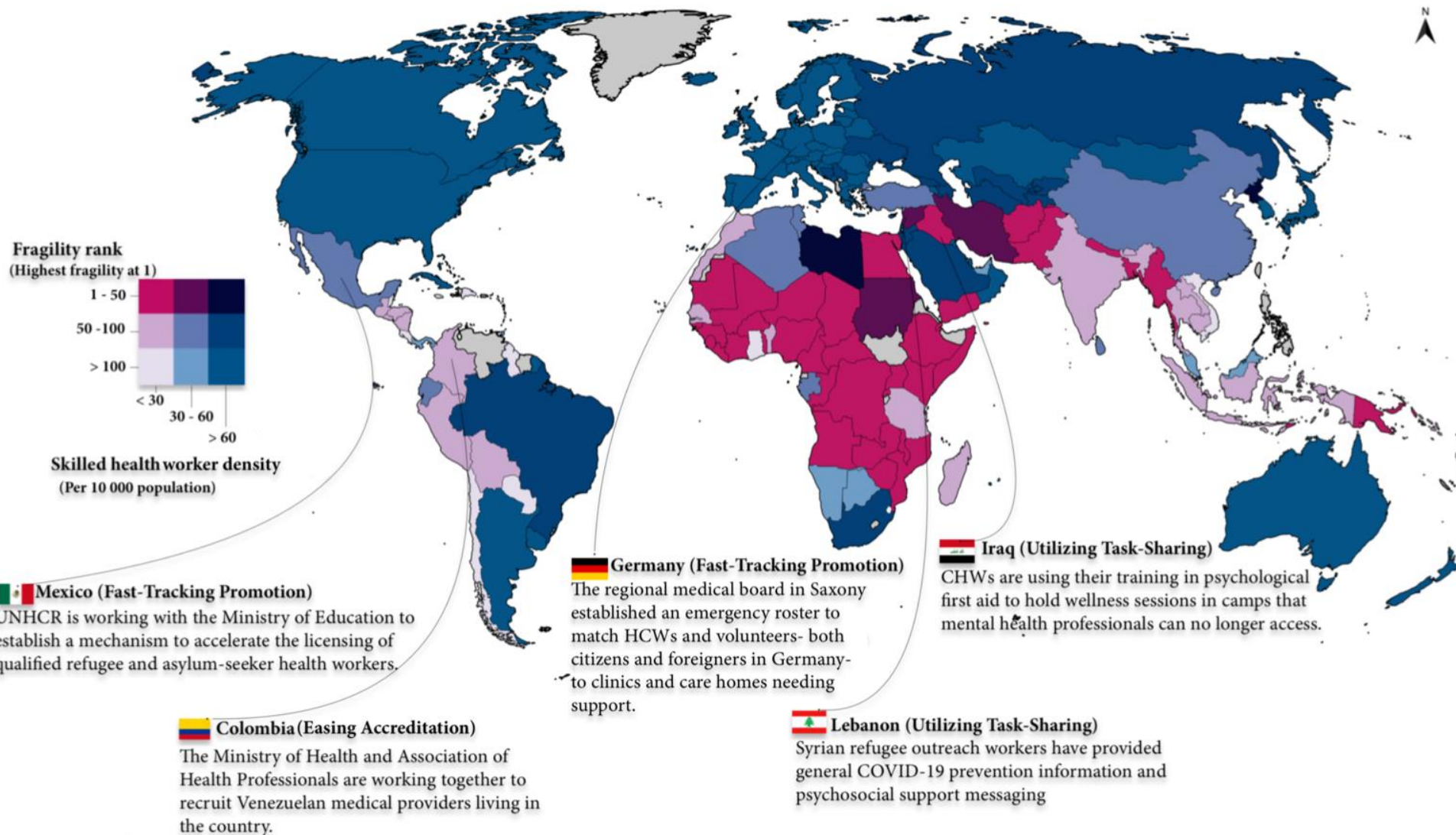
### Leveraging the refugee health workforce as a strategy to address HCW shortages.

Health systems in fragile and low-income countries are easily overwhelmed during epidemics. The shortage of HCWs and their uneven distribution in fragile and conflict-affected countries impedes the delivery of and access to life saving health services. A country's inability to rapidly expand its health workforce hampers its ability to deal effectively with the outbreak. Various strategies have been utilized by states in a bid to expand their health workforce including the deployment of retired HCWs and medical students. Such strategies are of relatively little value in fragile and displacement contexts. In such contexts, as described above, refugee HCWs can play an important role and serve as a vital resource – one that is often underutilized.

### Refugee HCWs are a vital and largely untapped resource in the global efforts to control COVID-19.

More than 79 million people are forcibly displaced worldwide, many of whom have experience working in the health sector, including physicians, nurses and workers with other health credentials. They are often unable to enter the formal health workforce in their current country of residence and are forced to either work informally or outside the health sector. Approximately 85% of forcibly displaced people are in LMICs, which are most severely affected by the global shortage of 4.3 million healthcare professionals. Accessing the underutilized health workforce in

## Global Snapshot of Fragility and Skilled HCW Density and Select Strategies to Leverage the Displaced Health Workforce



Note: Skilled Health Workforce data for 2019 were not available for all countries; in those cases, the most recent available data are shown.

Data sources: Fragile State Rank is based on the work of Fund for Peace (2020), Skilled health professionals data from WHO Global Health Workforce Statistics (2019)

a time of surging demand such as COVID-19 is perhaps the most efficient strategy to fill the existing health human resources gap. Utilizing refugee HCWs in the formal and humanitarian health sectors can also help the host country's health workforce to expand their linguistic and cultural competencies, enable health actors to provide more effective and efficient care to refugee communities, and increase disease surveillance in hard-to-reach communities. Many refugee HCWs have honed skills working in high-intensity, low-resource settings. COVID-19 response efforts could provide an opportunity for refugee HCWs to share their expertise in working in unstable settings.

Refugee HCWs are playing leading roles in the pandemic response in their host countries. A Cuban physician seeking asylum in the U.S. is leading pandemic preparedness at an informal camp in Matamoros, Mexico. In Kenya, Mozambique, and Uganda, refugees have been hired as CHWs to fill service gaps and enhance community outreach in response to COVID-19, a technique successfully used in Liberia during the Ebola outbreak in 2014-2016.

Beyond medical care, refugee-led organizations have responded to meet the needs of their communities by providing food and other essential support at a time when international aid has been severely cut. Refugee outreach workers in Lebanon have provided community-based psychosocial support, while other refugee-led organizations are creating and disseminating culturally appropriate communications regarding COVID-19.

Countries that facilitate the integration of refugee HCWs have found it to be a boon for overwhelmed health programs. With support from WHO and EU, Turkey leveraged Syrian HCWs to address gaps in health services for refugee populations. As a result, the health workforce in Turkey gained over 1300 Syrian HCWs who formally increased health service utilization among Syrian refugees by 28% in just one year. Mobilizing refugee HCWs as CHWs has been beneficial for physical and mental health outcomes in refugee camps and other humanitarian settings. Beyond population health benefits, leveraging the refugee health workforce can support the wellbeing and integration of HCWs and their families.

## **Addressing the legal, financial, and bureaucratic barriers facing the refugee health workforce**

Eight months into the pandemic, states have been experimenting with different approaches to meet their human capital needs and have experienced varying success and logistical and coordination challenges. At the peak of the COVID-19 crisis in New York City, 92% of approximately 89,000 medical volunteers remained untapped despite state officials' ongoing requests for additional aid. In many health settings, onboarding is a months-long process requiring extensive background checks and hospital-specific training; rapidly processing additional staff requires dedicated personnel, program adaptability and resources for training and supervision. Going forward as we plan for the future there will be a need to map and address existing bottlenecks.

Refugee HCWs face numerous barriers to joining the health workforce, which fall into three main categories: policy, professional development and social barriers. Interventions at the public policy and institutional levels have the greatest potential to facilitate the rapid re-integration of refugee HCWs into the formal health workforce.

1. **Policy Barriers** include the legal, financial and bureaucratic hurdles that limit a refugee's ability to participate in their host country's economy, not least limitations on a migrant's right to work. A report by Asylum Access found that 45% of refugees surveyed live in a country where their right to work is completely banned, despite international regulation supporting the right to work for refugees. Refugee HCWs may find their medical licensure, credentials, and training are not acknowledged by their host country, or that additional training – often multiple years' worth – is required in order to obtain certification and licensure. In some cases, refugees may have the necessary credentials but are unable to access their education and credentialing records due to government resistance or university closures in the conflict-affected countries. Refugee HCWs trying to enter the health workforce face unfamiliar and complex bureaucratic systems, especially as visa services are paused or moved online due to COVID-19. Additionally, fees for licensure exams and renewals can be prohibitive.

**Potential policy facilitators** that allow refugee HCWs to respond to crises and rapidly expand the health workforce include emergency exemptions, waiving or fast-tracking licensing, and task sharing (Box 2). When governments lack the capacity to scale up training and credentialing, support from international actors and local researchers can play a key role. Changing regulations that currently exclude refugee health workers can quickly increase health-related human resources, but it must be accompanied by concomitant increases in processing capacity to enable rapid onboarding, as well as outreach to increase awareness of these initiatives within the refugee community. This rapid expansion of the healthcare workforce needs to be balanced with the appropriate safeguards that minimize disruptions to the quality of health services. The ideal policy is one that enable the activation of all available healthcare workforce including refugee HCWs taking into consideration their skills and experiences while paying attention to their limits and gaps in training.

2. **Professional Development Barriers** are individual, interpersonal and organizational challenges that hinder refugees' access to employment through the absence of integration programming. Barriers to professional development include a lack of language, cultural and educational opportunities, which are likely to be especially important for people displaced outside their country of origin. Another professional development barrier is the difficulty of accessing professional networks in the host country, which may be exacerbated by language barriers that increase the challenge of networking. Barriers to professional development also include limited access to physical and mental healthcare; health disparities in turn impact an individual's capacity to work, especially in the high-intensity and physically, mentally, and emotionally demanding positions found in the health field.

Identifying **professional development facilitators** is necessary to ensure sustainable workforce integration for refugees and asylum seekers. Such facilitators may include language education, continuing medical education and training opportunities, and reliable access to high-quality physical and mental healthcare for refugee HCWs. Language education programs must be culturally informed and bilingual assistants may facilitate communication and migrant self-advocacy. Language assessment tools may need to be revisited in cases where they are unnecessarily challenging, and where there is a need to rapidly expand the workforce. Planning for such eventualities is an important part of preparedness.

3. **Social Barriers** are cultural and societal challenges to integrating refugee HCWs into the workforce, stemming from stigma, discrimination, and xenophobia. Resistance to authorizing refugees' credentials from host country professional organizations can delay or obstruct new accreditation policies. Discrimination from employers, coworkers, and patients can affect refugee HCWs' psychosocial wellbeing and their ability to provide appropriate care.

Social barriers are the most resistant to change as these hurdles are often historically ingrained in a country's social fabric. They require societal reframing and must be addressed through social policy, institutional management, and interpersonal relationships.

**Social facilitators** include policies that support refugee HCWs' right to privacy regarding their refugee status, counter misinformation about affected groups, and address and protect workers from racism and discrimination.

The solutions above are not without concurrent challenges. Refugees may not be willing to take high-risk, short-term opportunities in the health sector unless they receive longer-term guarantees; or they may be limited in their ability to do so when their immigration status is tied to existing employment. Similarly, frontline HCWs may hesitate to take positions with a high risk of exposure to COVID-19 if they lack health insurance or access to social support for their families should they become sick. Employers may be resistant to hiring refugees HCWs due to stigma and discrimination among personnel or patients. Other systemic barriers include the processing time, strict criteria for exemptions, and limited awareness of these opportunities in refugee communities.

## Box 2: Strategies to leverage the refugee health workforce during past epidemics and the current COVID-19 response

During the COVID-19 pandemic, many strategies have been proposed to bolster the existing health workforce, including expanding providers' scope of practice, deploying medical students, recruiting retired HCWs, and re-training and re-allocating existing health workers. As discussed previously, integrating refugee HCWs into the response leverages their skills to address health workforce shortages.

### Utilize Task-Sharing

In many humanitarian settings prior to the COVID-19 pandemic, task-sharing with CHWs, including refugee HCWs, was already taking place. For example, task-sharing with less specialized workers has been used previously to provide primary care services to internally displaced people in Myanmar, behavioral health interventions in conflict-affected areas of Pakistan, and family planning services in Afghanistan. In Jordan, Syrian refugee community health volunteers have been providing care for non-communicable diseases to Syrian refugees and uninsured Jordanians. Task-sharing with CHWs has been used during past epidemics, including during the West Africa Ebola outbreak. During the COVID-19 pandemic, returned migrants in Guinea have been trained and equipped to conduct community outreach and COVID-19 health education. In Bangladesh, over 3,000 refugee volunteers in the Cox's Bazar camps shared key COVID-19 public health messages. In Lebanon, refugee outreach workers have provided general COVID-19 prevention information and psychosocial support messaging, and in Iraq, CHWs are using their training in psychological first aid to hold wellness sessions in camps that mental health professionals can no longer access.

### Promote Fast-Tracking

Accelerating the licensing of HCWs has emerged as another key strategy to expand the health workforce. In Mexico, UNHCR is working with the Ministry of Education to establish a mechanism to accelerate the licensing of qualified refugee and asylum-seeker health workers. In the UK, hundreds of refugee HCWs have sought to expedite their accreditation, prompting calls from parliament to investigate ways to fast-track their licensure. However, in countries including Germany and France, fast-tracking has presented bureaucratic and logistic challenges. The Council of Europe and UNHCR have promoted the use of the existing European Qualifications Passport for Refugees (EQPR), which documents and validates overseas accreditations. The EQPR has successfully connected HCWs in Greece. The EQPR has served as a model for the development of a new global UNESCO Qualifications Passport for Refugees and Vulnerable Migrants.

### Ease Accreditation

Many countries have eased accreditation requirements, facilitating the entry of refugee HCWs into the health workforce. Argentina and Chile have authorized the recruitment of HCWs whose credentials are still being validated. In the United States, some states including New York have permitted health workers without licensure who have completed one year of graduate medical education at a foreign medical school to provide patient care in hospitals. In France, providers trained at foreign medical schools have been permitted to practice with supervision. In Ireland, the Irish Medical Council has said that refugee workers could provide "essential support" through roles such as healthcare assistants. Advocates have recommended easing language requirements, allowing HCWs who have passed all requirements except a final exam to practice with supervision, or providing provisional approval for a narrow scope of practice. The cost of licensing exams presents another barrier to accreditation, and some NGOs have stepped in to provide grants or loans to support refugee workers seeking accreditation.

Some governments, such as Colombia and France, have directly appealed to refugee HCWs to join the COVID-19 response. In Colombia, the Ministry of Health and Association of Health Professionals are working together to recruit Venezuelan medical providers living in the country. In Germany, the regional medical board in Saxony issued a Facebook appeal to refugee HCWs to help with COVID-19 care, and 300 volunteers had already responded by March 2020.

## Ensuring protections for refugee and displaced HCWs and supporting their transition into the formal health sector in host communities

Integrating refugee HCWs into host country workforces requires strategies to ensure that refugee health professionals are adequately trained, oriented, supervised, and supported throughout and after the transition. Possible strategies include increased pathways to formal licensure, including relaxing licensing accreditation protocols to include temporary work in the COVID-19 response. For CHWs, this could mean moving away from per diem pay structures which have been previously criticized for failing to provide economic security for workers and frequently falling below the living wage. While such strategies may be introduced to meet short term needs, creating **sustainable pathways to long-term employment** would expand a countries human capital and strengthen the capacity of the health system to deal with future patient surge needs.

Good practice suggests that members of the health workforce would benefit from **adequate health insurance and social support** in the event of contracting COVID-19. Efforts should also be made to ensure that refugee HCWs are not discriminated against in terms of salaries, access to PPE, psychosocial support, working hours, rostering and working conditions; and that they are protected against work-related violence. Protecting the most vulnerable HCWs groups from discrimination would ensure the protection of all HCWs.

Globally, refugees and other forcibly displaced people are more likely to work in the informal sector than their native-born counterparts. This results in lower wages, less protection standards, and less economic stability. In the health sector, this also creates additional risks for both patients and workers; transitioning refugee HCWs from the **informal to the formal health sector** through accreditation can help to address these risks, while strengthening the health system.

## HOW CAN WE SUPPORT AND PROTECT THE HEALTH WORKFORCE DURING COVID-19, IN FORCED DISPLACEMENT SETTINGS?

### Strengthen the health system with a health workforce centered approach.

1. **Facilitate a safe, supportive environment for HCWs where they can provide high-quality care to patients.**
  - a. **Assess existing capacity and rapidly adapt health facilities to maintain essential services, prevent healthcare-associated infections, and provide COVID-19 case management**, including expanding intensive care surge capacity.



National and humanitarian actors should ensure that non-COVID care can be sustained safely. By analyzing existing health infrastructure and supplies in conjunction with local COVID-19 burden, stakeholders can identify and adapt health facilities to support non-COVID-19 essential services, mild and moderate COVID-19 patient care, or acute COVID-19 care. Designating the appropriate use of health facilities is critical to ensure the safety of HCWs, the provision of high-quality care, and patient trust. These decisions must be made with ongoing HCW input. Infection control measures within health facilities need to be adapted locally, including social distancing within outpatient clinics, pharmacies, and waiting rooms, establishing triage sections before emergency departments, and constructing isolation centers. Health facilities must be adapted and equipped to ensure that HCWs can enact appropriate IPC measures to protect themselves and their patients. Likewise, medical waste management practices and safe procedures for the handling of the deceased must be assessed and adapted at health facilities.

- b. **Build and sustain robust supply chains throughout the response.** Functional supply chains are essential to ensure HCWs have appropriate supplies, including PPE, to protect themselves and provide high-quality care to their patients. Robust supply chains have three core elements: they should be continuous, sustainable, and deliver high-quality products. The increased demand for PPE, ventilators and other medical supplies have driven fierce global competition led by hard-hit countries in the global north. Many LMICs are implementing innovative policies and solutions to procure medical supplies and strengthen existing supply chains. Colombia has adopted policies to accelerate imports and encourage domestic production, such as simplifying bureaucratic processes and using digital registration forms. Some countries are taking other steps to protect HCWs, including establishing agencies to evaluate the quality of locally made PPE.
- c. **Encourage the use of telehealth services, where appropriate, to reduce the risk of COVID-19 transmission and maintain essential services.** The transition of some services to digital platforms will be essential in settings in which health facilities encounter challenges in adapting to maintain essential services while providing COVID-19 case management. Telemedicine can be used to screen and triage for COVID-19, monitor COVID-19 symptoms and recovery, and maintain essential services. By reducing the number of people in health facilities and triaging suspected COVID-19 patients before they arrive, telemedicine can reduce the risk of exposure for HCWs and patients. Likewise, shifting some services to telehealth will reduce the use of PPE, preserving PPE to protect HCWs and patients. Any implementation of telehealth services should address potential harms (including loss of privacy and confidentiality), barriers to access, and contextual considerations; for example, in displacement settings digital technology is often shared among members of a household, or women and girls may have their access controlled by male family members. HCWs providing telehealth services should be equipped with the required supplies and should not be expected to use their own resources to provide services.

## 2. Augment the health workforce and ensure HCWs have the skills required to protect themselves and provide high-quality care.

- a. **Assess skill and knowledge gaps across the entire health workforce and adapt training modules to local contexts.** Strengthening training and educational systems will build the capacities of domestic health workers. Digital, hybrid, and synchronous approaches with supportive supervision structures allow for capacity building for triage and infection prevention and control.
- b. **Mobilize community and lay HCWs.** CHWs contribute significantly to the COVID-19 response through community education and mobilization, disease surveillance and filling service delivery gaps. CHWs may also conduct COVID-19 testing, contact-tracing, and supervise isolation. CHWs should be included in PPE projections. In the absence of PPE and diagnostic tests, CHWs should focus on information provision rather than testing. Workflows should be modified to allow for the provision of patient care in a safe manner via phone or from a safe distance. CHWs should be designated as essential workers to limit disruptions to services and, where feasible, integrated into national health systems as was done in Kenya. Appropriate training, stable financial compensation and dedicated supervision are key for occupational safety and an efficient pandemic response.
- c. **Leverage telehealth services to augment the health workforce in settings with shortages of HCWs.** Asynchronous interprofessional teleconsultations via “store and forward” technology have been adopted prior to COVID-19 in humanitarian settings, for example, to support the provision of mental health services. In addition to maintaining essential health services, teleconsultations can be utilized to provide expert guidance for COVID-19 patients, for example, by allowing a member of the in-person care team to communicate in real-time with specialists in other regions or countries. Tele-intensive care unit platforms allow providers to conduct real-time monitoring of critically ill patients. Telehealth and interprofessional teleconsultations can serve as an important tool to augment the health workforce, essentially shifting HCWs to where they are needed most, such as virus hotspots or areas with personnel shortages.

## 3. Ensure sound communication, coordination and information-sharing between HCWs, supervisors, and decision-makers.

- a. **Build agile data and information management systems to monitor HCW indicators and outcomes.** Beyond population surveillance, it is important to systematically collect data on health workforce outcomes, including mortality, infection, and incidents of violence. Data collection should encompass all HCWs involved in the response, including community and lay HCWs. Data should be disaggregated (for example, by HCW demographics, location, HCW cadre, and any potential risk factor) to allow decision-makers to identify trends that can be used to promote the protection of HCWs and support vulnerable HCWs (Figure 1). Existing digital platforms to monitor HCW performance should be adapted, where feasible,

to collect and monitor this data. Digital platforms utilized by HCWs are already being adapted to COVID-19; for example, the Malaria Consortium has adapted its upSCALE platform for CHWs in Mozambique to remotely track stock-outs including PPE. These adaptations provide opportunities to increase real-time monitoring of health workforce indicators.

- b. **Adapt supportive supervision structures, foster communication, and address HCWs concerns in a timely fashion.** Maintaining and enhancing supportive supervision, including information-sharing, is essential during rapidly changing situations. Supportive supervision should be provided remotely, where possible, and may involve different strategies, including individual, group and peer sessions, communication via digital platforms such as WhatsApp, and real-time monitoring, for example, through an app. While information should be shared in a timely manner, supervisors and supervisees should agree upon boundaries, including, working hours and protocols for contacting supervisors outside those hours. Avenues to solicit feedback from HCWs should be developed and strengthened; listening sessions with HCWs are one such mechanism. Supervisors and decision-makers should focus on providing specific responses to HCW concerns, escalating concerns when needed, and providing honest and clear communication about follow-up actions to close feedback loops. At the facility level, decision-makers may adopt various strategies to centralize the HCWs concerns in the response plan, such as holding regular meetings with frontline HCWs and organizing simultaneous group psychological support and feedback. HCWs should be provided with resources needed for remote supervision, such as cell phones or cell phone minutes.
- c. **Promote collective coordination that incorporates all public, humanitarian and private stakeholders throughout the response.** In settings with multiple health actors, strong coordination and collaboration is necessary for an effective response. The establishment of a task force involving relevant stakeholders, including national and international NGOs, national health systems, and local health actors, can facilitate coordination efforts. Effective coordination can optimize deployment of HCWs and supplies to regions with the greatest need. In settings where restrictions on movement, including movement of international staff, has impacted health system capacity, coordination mechanisms can facilitate re-deployment of HCWs where required. In northwest Syria, a grassroots governance system among health actors, including local and international NGOs, has enabled a flexible response. The inclusive governance structure was important to promote legitimacy and trust among affected communities.

**4. Support HCWs by providing financial incentives such as risk allowances and compensation for COVID-19 and other work-related hazards.** Previous epidemics, such as the West Africa Ebola outbreak, show us that beyond the financial impact on the whole population, stigma and discrimination can exacerbate an epidemic's negative financial impact on HCWs. Risk allowances and other compensations, especially death benefits, should involve minimal

bureaucratic processes and should be paid on-time. Mobile payments should be considered in settings in which they are feasible and acceptable.

## Develop rapid health workforce deployment strategies prioritizing refugee HCWs.

1. **Encourage task-sharing.** Task sharing utilizes tiered staffing models in which highly-trained HCWs and HCWs with fewer qualifications share clinical responsibility through extensive communication and limited expansions to scope of practice through rapid training. This allows all staff members to work at the full scope of their training, thereby increasing system-wide efficiency. When applying task-sharing strategies, staff skills should be closely considered in order to ensure they are placed in the position where they can be most effective.
2. **Ease accreditation, especially for stringent language requirements.** As seen in Saxony, Germany, waiving language exams for refugee HCWs with functional fluency, especially while exams are cancelled due to the pandemic, can rapidly increase human resource capacity while ensuring patients are protected.
3. **Utilize Emergency Exemptions for HCWs with foreign credentials.** Some governments, such as those in New York and New Jersey, in the U.S., have authorized medical staff who are licensed in another country to work in that role as part of the COVID-19 response.
  - a. **Allow HCWs with foreign credentials to work in supervised or limited support roles.** In circumstances where providing emergency licensure with a full scope-of-practice is not possible, authorizing personnel to work under a limited scope or with direct supervision can function as a middle ground. Off-site supervision should be considered to increase capacity and decrease risk of infection.
  - b. **Allow HCWs with foreign credentials to work in non-licensed healthcare roles.** In the United States, refugee HCWs are working as COVID-19 testers and contact tracers. In Iran, a refugee physician provides telephone symptom screening. Leveraging refugee HCWs in non-licensed healthcare positions allows governments and organizations to dramatically increase testing and public health capacity. Utilizing trained HCWs enables accelerated training due to familiarity with infection control and prevention measures, PPE, and other public health concepts.
  - c. **Remove fees associated with credentialing and licensure.** USAID partner Union Venezolana has helped dozens of Venezuelan doctors to validate their professional qualifications in Peru, in part by providing support for the \$700 registration fee.
4. **Increase uptake of emergency credentialing opportunities:**

- a. **Promote online pathways for obtaining emergency credentials.** At a time when travel and waiting in long lines creates additional risk, creating methods for online recruitment and processing that can be done online is key.
- b. **Promote awareness of emergency credentialing opportunities through targeted advertisements and community outreach.** Refugee HCWs can only be included in new policies if they are aware of available opportunities. Examples of awareness raising initiatives include Facebook announcements and targeted advertisements.
- c. **Offer pathways to long-term employment where possible.** Refugee HCWs prioritize long-term opportunities, even if they are outside their original specialization. They may be hesitant to take on temporary opportunities during the response if it means risking their long-term job security.
- d. **Increase administrative capacity to process applications.** In New York City, hospitals struggled to process the nearly 90,000 medical volunteers, and volunteers that completed the vetting process and faced long waits before receiving badges, computer and medication access, and authorization to start seeing patients. Expanding administrative capacity is essential for expedited hiring.

## **Protect HCWs from extreme stress and stigma and address violence against health facilities and HCWs.**

1. **Prevent and mitigate social stigma and discrimination against HCWs.** Stigma-reduction strategies should be integrated in government response plans to protect HCWs and other populations vulnerable to stigma. Communication about COVID-19 should use inclusive language and less stigmatizing terminology (e.g., first person language, “person with COVID-19”). Correcting misconceptions, amplifying the voices of HCWs and displaced persons, and promoting messages of solidarity and cooperation, as opposed to fear, can help to protect healthcare workers against stigma.
2. **Promote a climate of self-care and support for HCWs.** Providing HCWs with self-care strategies and a supportive environment is essential to promote mental health and prevent the exacerbation of psychological distress during the COVID-19 pandemic. Basic self-care strategies for HCWs, self-help interventions, and resources for peers to provide support to other HCWs must be actively integrated into standard operating procedures to support HCWs during crises, when they are at high risk of developing psychological distress and mental health issues.
3. **Promote a culture of supportive supervision within the structure of the health workforce.** In the context of mental health and psychosocial support, supportive supervision encourages joint problem solving and open communication between the supervisor and supervisee in order to collaboratively improve care and address challenges

including staff stress and burnout. Supervisors should be trained to identify signs of distress among employees and to facilitate referrals and linkages to appropriate mental health and psychosocial resources when needed. Preventive psychosocial support and mental health services should be made readily available to all HCWs. Supervisors can play a role in facilitating the use of these services as appropriate.

- 4. Implement measures addressing violence against HCWs through national and international legal systems and multi-sectoral efforts.** All of the strategies aimed at protecting the health workforce hinge on the assumption of political and legal protection of the entire health workforce, including informal and refugee HCWs. Protections for HCWs, including whistleblowers and those working with marginalized communities, must be enforced, and any violations should be investigated thoroughly.

In fragile contexts, state and non-state actors must cease any activity that threatens the life and wellbeing of HCWs in times of epidemics. Respect for health care is enshrined in both international humanitarian law and international human rights law. HCWs' ability to work and respond effectively to COVID-19 is contingent on feeling protected in the health system, humanitarian organizations, and wider socio-political institutions. Any targeted attack, arrest or other forms of aggression against HCWs or their families' needs to be documented and reported to national and international legal institutions.

## Box 3: Useful resources/tools for health workforce strengthening and protection during epidemics

### Health Worker Protection, including Personal Protective Equipment:

- [COVID-19 Guidance on use of personal protective equipment for different clinical settings and activities](#) (Africa Centers for Disease Control and Prevention) [French version](#)
- [Rational use of PPE for COVID-19 and considerations during severe shortages](#), Interim guidance (WHO)
- [Care for health workers exposed to the new coronavirus \(COVID-19\) in health facilities](#), Interim guidance (WHO)

### Infection Prevention and Control:

- [COVID-19 Infection prevention and control during health care for COVID-19 cases](#), Interim guidance (WHO)
- [Standard Operating Procedure for Triage of Suspected COVID-19 Patients in non-US Healthcare Settings](#), (US Centers for Disease Control and Prevention (CDC))
- [ECDC's Infection Prevention and Control Guidelines for Healthcare Settings](#) (ECDC)
- [Infection prevention and control during health care when coronavirus disease \(COVID-19\) is suspected or confirmed](#), Interim guidance (WHO)
- [Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts](#), Interim guidance (WHO)

#### IPC Trainings:

- [Infection Prevention and Control \(IPC\) for COVID-19 Virus](#), Online course (WHO)
- [COVID-19 Training for Health Workers: Preparedness and Response](#) (DisasterReady.org)
- [Library of COVID-19 focused online courses for frontline HCWs including community health workers](#). (covid-19digitalclassroom.org)
- [Infection Prevention & Control & PPE for low resource settings](#), Preparation checklist (Doctors Worldwide)

### Telehealth

- [Telehealth Models for Promoting Workforce Education and Training](#) (Rural Health Hub)
- [Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic](#) (CDC)9 (CDC)
- [Global Preparedness Against COVID-19: We Must Leverage the Power of Digital Health](#) (JMIR Viewpoint)
- [Uses of Telehealth during COVID-19 in Low Resource Non-U.S. Settings](#) (CDC)
- [Virtually Perfect? Telemedicine for Covid-19](#) (New England Journal of Medicine)

### Building Surge Capacity

- [Essential Resource Planning technical guidance](#), including a health workforce estimator (WHO)
- [COVID-19 Surge tool](#) (CDC)
- [Use of Alternative Medical Care Facilities in the COVID-19 Pandemic](#) (JHU - Center for Health Security)
- [Task Shifting: Rational redistribution of tasks among health workforce teams](#)(WHO)
- [Community-based health care and outreach and campaigns, in the context of the COVID-19 pandemic](#), interim guidance (WHO)
- [Responding to COVID-19: Guidance for humanitarian agencies](#) (ALNAP)

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