Strengthening health workforce resilience across fragile and shock-prone settings

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ReBUILD FOR RESILIENCE

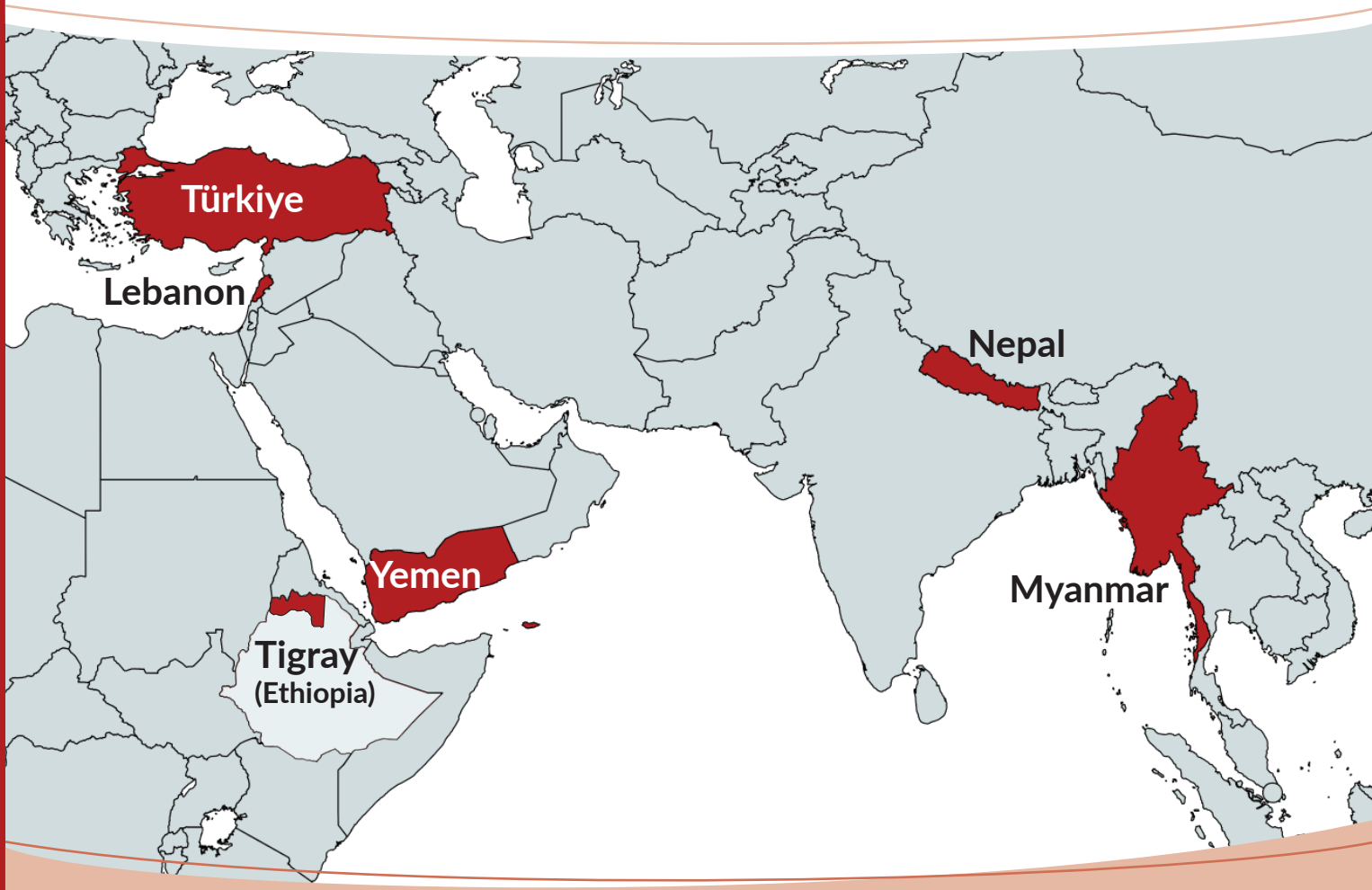
Background

The resilience of a health system depends primarily on the health workforce. This is especially the case in fragile and shock-prone settings,(1,2) where distinct challenges are faced that are often more acute than in stable environments.(3) A recent review of 36 studies in conflict-affected settings shows how conflict intensifies workforce pressures, disrupting service delivery, training systems, governance, and staff wellbeing, while adding risks such as violence and displacement.(4)

Our ReBUILD for Resilience (ReBUILD) research spans multiple countries and regions and provides grounded evidence-based insights from a wide range of health staff, from community health workers to local managers and policy makers, working across public, private, and informal sectors, including in contested, transitional, or non-state spaces.

In today's era of polycrises and permacrisis - with overlapping, persistent shocks driven by the climate crisis, protracted wars, epidemics and other stressors - understanding workforce roles and how they are managed and supported is critical to resilience and long-term strengthening of the health system.(5)

This brief sets out context-specific actions for policy and practice. We highlight the need for strong management capabilities and coordinated, plural provision of health services, public, private, faith-based and humanitarian, to refugees and other marginalised populations.(6) The brief concludes with concrete steps to strengthen resilience.



Overview

ReBUILD examined health workforce challenges, lived experiences of health workers, and management across diverse settings using a wide range of methods, covering 2020 to 2025. By reviewing findings across these studies, we identified key themes in health workforce management, highlighting both commonalities and differences across crises. These themes are presented here as practical recommendations for action.

Studies informing findings

	Where? Country/ setting	Shock? Type of shock	What? Study design	How? Methods used	Who? Participants/ stakeholders
The gendered experience of close-to-community providers in fragile and shock-prone settings	Multi-country	COVID-19	Qualitative	Qualitative interviews, focus group discussions	Close-to-community providers, supervisors, policymakers
Close-to-community providers addressing gender norms and power dynamics	Lebanon	Economic crisis	Participatory action research	Participatory workshops, focus group discussions	Close-to-community providers, communities, programme managers
Mapping resilience capacities of health workers in Sana'a	Yemen	Protracted conflict	Qualitative	Qualitative interviews, document review	Health workers, hospital managers
Understanding health system resilience to respond to COVID-19 in Nepal	Nepal	COVID-19	Case study	Policy analysis, qualitative interviews	Provincial & municipal officials, health workers
Exploring health workforce preparedness for shocks	Türkiye	Earthquakes	Qualitative	Qualitative interviews, focus group discussions	Policy makers, health workers, facility managers
Health system resilience in Tigray region	Ethiopia (Tigray)	War, blockade	Case study	Qualitative interviews, secondary data review	Health workers, elected representatives, government staff, private and non-state actors
Assessing the role of non-state actor in health service delivery and health system resilience in Myanmar	Myanmar	Military coup, conflict	Qualitative	Document review, secondary data analysis, qualitative interviews	Donors, international and local NGOs, civil society organisations and Ethnic Health Organisations
A liminal health system: exploring the resilience strategies of healthcare providers and communities along the Thailand-Myanmar border	Myanmar and Thailand	Military coup, conflict	Qualitative	Workshops, qualitative interviews	Community members, health workers

Expansion and adaptation of the health workforce

Surge capacity saves lives: flexibility, integration, and protection of the health workforce are key

Experiences from Lebanon, Türkiye, Nepal, Yemen, and Myanmar showed both the ingenuity and the gaps in current approaches.

Mobilising non-traditional cadres. In Lebanon, qualified but unregistered Syrian refugee health workers were drawn into service delivery, while along Myanmar's border areas, community health workers and health workers in the Civil Disobedience Movement provided essential maternal, infectious disease and emergency care as formal staff fled. These examples highlight how informal or displaced professionals can sustain care, while also raising concerns over regulation, supervision and potential exploitation.

Emergency teams and volunteers. Türkiye's earthquake response activated national emergency response teams (UMKE), WHO-supported international Emergency Medical Teams, and large-scale volunteer mobilisation through the Turkish Red Crescent. These brought rapid reinforcement, but integration and coordination proved challenging.

Flexible policies and redeployment. During COVID-19 in Nepal, the Ministry of Health issued guidelines to reassign staff, extend working hours, recruit new graduates and draw on the skills of private and NGO health workers. These measures helped spread the load but the local systems, which were already facing shortages, were strained.

Limits of resilience. In Yemen, the absence of structured surge mechanisms meant existing staff absorbed overwhelming workloads during cholera and COVID-19 outbreaks, often working for days without rest. Reliance on individual resilience, without relief or emergency recruitment, left both providers and patients at greater risk.

Key message: Informal, flexible, and volunteer solutions are indispensable for surge capacity, but with a lack of structured planning and protection, they risk becoming exploitative. Effective surge capacity requires advance mechanisms to integrate diverse health worker groups, safeguard quality, and protect workforce wellbeing.

Leadership, governance, communication and coordination

Crisis response needs two-way communication that reaches health workers providing services

During crises, the ability of authorities to provide clear direction, manage work systems, and maintain effective communication with health workers is essential. Evidence from Türkiye, Nepal, Myanmar, and other contexts illustrates both strengths and persistent gaps.

Central coordination vs. local implementation. In Türkiye, national leadership by the Disaster and Emergency Management Authority (AFAD), the Ministry of Health, and WHO was relatively strong, yet gaps appeared in translating national strategies into sub-national and facility-level action. Delays in deploying staff and medical supplies, overlapping responsibilities, and unclear guidance created bottlenecks. The integration of large numbers of volunteers further complicated coordination and clarity around their roles was slow to emerge.

Communication channels and clarity. Nepal used a wide range of channels during COVID-19; press briefings, reports, websites, social media, radio, and television. Nevertheless, communication remained largely one-way and top-down. Messages were not tailored to different audiences, leaving provincial governments, local authorities, and health workers somewhat unclear about their roles. Weak orientation and training meant many staff initially struggled to implement case investigation, contact tracing and maintain routine services such as immunisation.

Community and trust-based approaches. In Myanmar's conflict-affected border regions, communication and coordination relied less on formal structures and more on trust between health workers, communities, and parallel systems. In these fragile contexts, these relationships enabled service continuity but also reflected the absence of institutionalised governance mechanisms.

Key message: Effective crisis response requires more than strong central coordination: timely, two-way communication that reaches health workers is essential, as too is clarity on roles and responsibilities, and meaningful involvement of community-based providers, particularly women. Without such elements, policies risk breaking down in implementation, undermining both the speed and equity of service delivery.

Resources, safety and support for health workers

Health workers cannot deliver care without safety, protection, and the right resources

For health workers to function effectively, adequate resources and a safe working environment are essential. Experiences from Yemen, Ethiopia, Nepal, Myanmar, and across community settings during COVID-19 show how fragile these foundations can be in times of crisis.

Supply chain weaknesses. In Yemen, the absence of a centralised mechanism for tracking medical goods led to oversupply in some locations and shortages in others. Inefficiency in resource management and logistical confusion undermined the ability of health workers to provide consistent care. In Tigray, siege and blockade conditions cut off electricity, communications, banking, and supplies, including life-saving items, often meaning staff had to improvise with what little remained.

Protective equipment and confidence. Across settings, shortages of personal protective equipment (PPE) and screening tools undermined the safety and confidence of providers. Community-based providers in multiple countries reported being overlooked in PPE and vaccination distribution, despite their critical role in the COVID-19 response. Ensuring adequate protection is not only important for reducing infection risk but also helps build and maintain trust with families and communities.

Policy response. In Nepal, global PPE shortages at the start of COVID-19 forced health workers to operate at personal risk. National and local authorities responded by issuing guidelines and directives to prioritise PPE and safety supplies for health workers, volunteers, and support staff, though implementation of this was uneven.

Fragile and conflict-affected contexts. When working in conflict areas such as Myanmar, safety and security remain paramount challenges for health workers. In Yemen, health workers operated under continuous threat from airstrikes. Despite the trauma, workers continued their duties, motivated by a strong sense of responsibility and professional ethics.

Key message: Reliable supplies, adequate protection, and workforce security can't be considered optional. They are the foundation of effective crisis response. Without these, health workers are forced into unsafe, improvised practices that compromise both their wellbeing and the quality of care they are able to provide.

Task shifting

Task shifting can expand access if structured and supported

The reallocation of responsibilities across health worker cadres, or "task shifting", emerges repeatedly as a survival strategy in crises. Experiences from Lebanon, Türkiye, Yemen, Tigray, and Myanmar highlight both its potential and its risks.

Expanding roles under pressure. In Lebanon, refugee health workers operating informally would often accept expanded responsibilities, heavier workloads and lower pay, but this came without recognition or protection. Similar dynamics were seen in Yemen, where nurses and mid-level staff routinely took on emergency and infectious disease duties that were beyond their training, adding to their already unmanageable workloads.

Rapid reallocation in emergencies. In Türkiye, the earthquake response required both medical and non-medical staff to take on unfamiliar tasks: mental health providers shifted to staff support, administrative personnel managed care coordination, and volunteers filled logistical and patient support roles. While often necessary, these shifts lacked clear protocols and recognition, leading to inconsistencies and accountability challenges.

Structured but under-resourced approaches. In Tigray, shifting surgical tasks to non-physician clinicians expanded access to emergency surgery and earned community acceptance. Yet the model faced systemic barriers: inadequate supplies, professional tensions and overwork. Similarly, in Myanmar's border areas, community health workers have long delivered essential maternal and child health care, malaria and TB services, and basic treatments as part of a deliberate task-shifting model. However, during the recent political crisis, abrupt and forced task expansion saw them pushed into roles for which they were not prepared.

Key message: Task shifting can extend access to care, especially in fragile and resource-constrained settings, and may be welcomed by communities. But when it occurs without training, recognition, or support, it risks overburdening workers, lowering quality, and undermining accountability. Effective task shifting requires structured planning, adequate resourcing, and safeguards for both health workers and patients.

Recognition, remuneration and rights

Fair pay and recognition are essential to sustain the health workforce

Health workers are the backbone of health systems, yet in fragile and shock-prone settings they often work without adequate protection, recognition, or reward. Experiences from Lebanon, Yemen, Nepal, and Myanmar highlight how rights and entitlements are frequently undermined, and how workers and communities are left to create their own coping mechanisms.

Lack of protection and benefits. In Lebanon, informal health workers, many of whom are refugees, are excluded from basic health and social benefits, denied union membership, and lack avenues to claim entitlements. Women close-to-community providers have responded by establishing their own Working Women Support Group to share childcare, build leadership skills, and prepare collective advocacy campaigns.

Erosion of livelihoods. In Yemen, years of unpaid or heavily reduced salaries have left health workers dependent on borrowing, selling belongings, or family support. With no legal or institutional mechanisms to protect them, many report feeling abandoned by both state and international actors. Their vital contributions to crisis response remain unrecognised, without compensation, career progression, or safety guarantees.

Training and capacity gaps. In Nepal, policies during COVID-19 emphasised capacity building but failed to reach the local level. Most health workers received no formal training or orientation on PPE use or critical care, relying instead on self-learning through online videos, posters, and social media. This left health workers vulnerable and ill-equipped during the pandemic, and their motivation was further affected by delays and inconsistencies in incentive payments across municipalities.

Identity and legal recognition. In Myanmar, recognition of health workers' skills and roles is complicated by conflict, displacement, and legal status, particularly in border areas. Workers frequently operate without formal remuneration or acknowledgement of their professional identity.

Key message: Health workers' rights to protection, pay, and recognition are not optional. Where states cannot safeguard them, non-state actors and communities often step in, but these are no substitute for systemic guarantees.

Psychosocial support

Psychosocial support is a core component of health workforce protection

In fragile and shock-prone settings, health workers face profound psychological stress in addition to unpaid wages, unsafe conditions and lack of recognition. Evidence from Türkiye, Yemen, Ethiopia's Tigray region, Nepal, and Myanmar shows that psychosocial needs are often neglected, leaving workers to cope with trauma largely unsupported.

Severe psychological toll. In Türkiye, many first responders to the earthquake endured trauma, grief, and exhaustion while continuing to work under extreme conditions. Structured support such as peer groups and counselling was introduced, but implementation was late and uneven, with little anticipatory planning. In Yemen, health workers reported constant fear of bombings, disease, and patient deaths due to medicine and equipment shortages. With no formal mental health services, coping depended on faith, family, and informal peer networks.

Conflict-driven trauma. In Tigray, health workers experienced killings, torture, starvation, and displacement. Despite immense suffering and the absence of salaries, many continued to serve their communities, drawing resilience from pride, community solidarity, and limited NGO support. Survival often required selling possessions and relying on family networks. In Myanmar, community health workers faced stress not only from COVID-19 exposure without recognition or vaccination, but also from operating between parallel and conflicting health systems in border areas.

Policy gaps. In Nepal, health workers responding to COVID-19 reported fear and anxiety due to poor information and inadequate protection. Although guidelines placed responsibility for counselling on hospitals, no monitoring or support was in place to ensure implementation, and services were rarely provided. They also faced stigma and discrimination in the early days of the pandemic, which added further physical and mental risks.

Key message: Health workers' resilience is remarkable, but relying on individual strength or informal coping mechanisms is unsustainable. Psychosocial support must be integrated into crisis preparedness and response, with structured, accessible, and monitored services to safeguard the mental health of health workers and their families.

Health worker agency

When formal systems falter, health workers' agency sustains care and reconfigures power

Emergencies often loosen the boundaries of formal regulation, enabling health workers to exercise greater agency and reshape established practices. Evidence from Lebanon, Türkiye, Yemen, and Nepal illustrates how health workers adapt, innovate, and at times challenge traditional hierarchies to keep services running.

Operating beyond formal systems. In Lebanon, the Ministry of Public Health tacitly permitted informal clinics run by Syrian doctors and staffed by Syrian health workers, despite regulations requiring registration at primary health care centres. This adaptation, driven by urgent shortages and community needs, empowered refugee health workers to provide essential care and reconfigured traditional power relations between formal authorities and frontline actors.

Adapting bureaucracy to speed response. In Türkiye, the earthquake response saw traditional hiring procedures suspended in favour of simplified recruitment and flexible shifts. Many of these adjustments were initiated at facility level, reflecting how local managers and staff exercised agency in adapting rigid bureaucracies to meet urgent needs.

Decision-making under collapse. In Yemen, where formal structures were weak or absent, health workers themselves adapted care practices under extreme resource constraints. Redeployments across departments and assumption of new responsibilities occurred informally, with workers relying on necessity and moral obligation rather than official guidance.

Expanding community roles. In Nepal, federalisation compounded human resource gaps, but during COVID-19 flexibility was demonstrated at multiple levels. Health workers took on new roles, including deployment to quarantine centres; local governments reallocated staff across facilities; and federal guidelines were adapted to emerging contexts. Female Community Health Volunteers reinforced preventive practices and community monitoring, while supervision and motivation were critical in sustaining this flexibility.

Key message: Crisis contexts open space for health workers to act beyond formal rules, often reshaping authority, norms, and practices in the process. Harnessing this agency through flexible policies and supportive systems can turn necessity-driven improvisation into a recognised strength for health systems.

Gender, equity and justice

Crisis response must address gendered barriers in the health workforce

Health workforce roles and decisions are inherently gendered. Crises amplify these dynamics, often reinforcing inequities unless deliberate attention is given to gender equity and justice. Evidence from Yemen, Nepal, Lebanon, and Myanmar shows how gender norms shape both the conditions of health work and the recognition of women's contributions.

Gendered deployment and protection. In Yemen, women were exempted from night shifts and given priority for hospital transportation, reflecting attempts to accommodate caregiving responsibilities and countering risks from unsafe commutes. In Nepal, some facilities adjusted deployment during COVID-19 based on pregnancy status, age, or gender, while others were unable to apply such measures due to acute shortages. Only after incidents of sexual violence and lack of separate facilities in quarantine centres did provincial governments begin integrating gender and equity considerations into policies.

Undervaluation of women's roles. Women close-to-community and refugee providers in Lebanon and Nepal often faced work overload and restricted mobility, with their labour viewed as an extension of domestic roles rather than professional contributions. Participatory action research gave these women a platform to voice concerns and co-develop solutions, such as informal childcare networks in Lebanon and community films in Nepal that helped shift recognition within families and communities.

Heightened risks in fragile settings. In Myanmar, women community health workers faced disproportionate risks during COVID-19, juggling domestic duties alongside case monitoring and disease prevention without the protection afforded to formal health workers.

Key message: Gender inequities within the health workforce are structural and intensified by crises. Addressing them requires gender-transformative policies that go beyond inclusion, recognising women's roles as professionals, providing protection and fair deployment, and challenging the patriarchal norms that underpin health systems.

From evidence to implementation

1 View workforce management through a rights lens — guaranteeing fair pay, legal protections, and safe conditions, and supporting unionisation or informal collectives.

2 Build resilience without exploiting health workers — systems cannot rely on unpaid labour, family coping, or sacrifice; minimum protections and guarantees are essential.

3 Plan and sustain surge capacity — with mechanisms for flexible recruitment, redeployment, and integration of volunteers and informal cadres, backed by accountability.

4 Treat coordination as a core health-system function — mapping actors, clarifying roles, and activating mechanisms early to avoid duplication, gaps, or confusion.

5 Balance national and local preparedness — central planning should empower provincial and facility-level systems to adapt with resources and autonomy.

6 Recognise and support health worker agency — flexible policies and decision-space should enable health worker innovation while safeguarding quality and accountability.

7 Structure and support task shifting — with proper training, recognition, and fair compensation to avoid exploitation and ensure safe care.

8 Integrate psychosocial support from the outset — providing tailored, structured services for health workers and their families rather than relying on informal coping.

9 Embed transformative gender equity — policies address undervaluation of women's labour, unequal domestic burdens, and unsafe or discriminatory practices.

10 Guarantee protection and essential supplies for all — ensuring PPE, medicines, and safety equipment reach every provider, including informal and community health workers.

Syrian close-to-community health workers in Majdal Anjar, Lebanon

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Post-earthquake emergency care in Türkiye. ©Prof. Dr. İsmail TAYFUR ismailtayfur@yahoo.com

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