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Psychological resilience, fragility and the health workforce: lessons on pandemic preparedness from Liberia and Sierra Leone

Laura Dean [iD],[1] Janice Cooper,[2] Haja Wurie,[3] Karsor Kollie,[4] Joanna Raven,[1] Rachel Tolhurst,[1] Hayley MacGregor,[5] Kate Hawkins,[6] Sally Theobald [iD],[1] Bintu Mansaray[3]

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[1]Centre for Health Systems Strengthening, Liverpool School of Tropical Medicine, Liverpool, UK
[2]Carter Center, Monrovia, Liberia
[3]University of Sierra Leone College of Medicine and Allied Health Sciences, Freetown, Western Area, Sierra Leone
[4]Neglected Tropical Disease Programme, Ministry of Health, Monrovia, Liberia
[5]Institute of Development Studies, Brighton, UK
[6]Pamoja Communications, Brighton, UK

Correspondence to
Laura Dean;
Laura.Dean@lstmed.ac.uk

INTRODUCTION

COVID-19 presents a time to redefine vulnerability; however, in discussions of vulnerability, the health workforce, particularly in regard to their psychosocial well-being, is often forgotten.[1]

Healthcare workers (HCWs) in fragile settings are constantly exposed to health system shocks, including; conflict, disease outbreaks and natural disasters, which compound the everyday challenges of working in an under-resourced health system. Based on a commitment to serve their communities, they often cope with repeated shocks and protracted crises through innovation and creative thinking.[2] However, they also experience repeated acute and chronic stressors that can lead to psychological distress. For some, prolonged exposure to risk of psychological distress can lead to personal growth, for others, continuous exposure to chronic stress and uncertainty can lead to psychological injury.[3]

Psychological impact cannot be reduced to personal resilience, rather it becomes linked to dynamic interactions between an individual and the structural and social circumstance within which they live and work; as well as the level and type of support they receive. HCWs are central to health systems responses to shock, becoming the medium through which policies and programmes become adopted or adapted.[2] Yet the long-term psychological well-being of health-workers is seldom considered in planning for health systems resilience. HCW well-being is ultimately determined by structural factors and change that requires political will. Nonetheless, psychological support and attention to ways of alleviating

Summary box

► Health workers in fragile settings are constantly exposed to stressors that become exacerbated in times of crisis; the scarcity within which they operate is now increasingly globally acknowledged.
► Many providers—whether based in facilities or communities—may still carry unresolved trauma from earlier shocks.
► Health systems resilience may require fundamental changes in resources and other structural factors, but also key to this is facilitating health workers access to long-term psychological support to enable them to navigate psychological distress.
► Psychological support during shocks should be available for all health workers early, consider needs across cadres (including close to community providers) and respond to cumulative and historic trauma as well as associated stigma.
► Health system planners need to design context-specific responses that are informed by close to real-time data and systematic research focused on improving understanding of healthcare workers stresses and mental health needs.

distress throughout all phases of systems shocks is central to mitigating longer-term impacts on HCW mental health.[3]

Sierra Leone and Liberia both experienced decades of conflict and fragility that have rendered fragile health systems and have undoubtably influenced the psychological well-being of their health workforce. They have few HCWs. Their communities are resilient yet vulnerable, and trusting relationships between governments, health systems and communities are precarious. Ebola is the latest in a series of historical traumas and health systems shocks. Now, global and local responses to COVID-19 may trigger anxieties

and in some cases post-traumatic stress disorder among HCWs across Sierra Leone and Liberia. Such experiences may result from limited action to understand HCWs psychological trauma and a lack of aftercare to manage underlying psychological injury as a result of ongoing chronic stressors or stressors experienced during previous shocks.[3]

RESILIENT SYSTEMS AND RESILIENT PEOPLE

Health systems resilience relies on the ability of systems to be able to adapt their functioning to absorb a shock and transform where necessary to recover from disaster while maintaining essential services.[4] Discussions of resilience are frequently framed in relation to larger shocks (eg, Ebola) that affect health systems functioning, but are less well documented in relation to chronic historical stressors (eg, inability to provide medicines to avoid life-altering morbidity). A systems ability to respond to chronic stressors has been described as 'everyday resilience',[5] and the argument has been made that this type of resilience can support health systems to respond when less predictable changes arise and health workers are key to this.[5] However, current framings of resilience are arguably limited as they do not reflect the combined extreme pressure that acute shocks and ongoing stressors place on individual HCWs.

Large shocks and chronic stressors both negatively impact the psychosocial well-being of HCWs to create a unique context of risk. In this commentary, we draw together reflections from people who were first responders during the Ebola epidemic and researchers focused on health systems strengthening in Liberia and Sierra Leone to reflect on this unique context of risk. We outline some key stressors that could be influencing HCWs' psychological response to the current pandemic to draw learnings for pandemic preparedness, health systems resilience and its relation to the psychosocial well-being of HCWs, who are central to the health systems response to COVID-19.

Learning 1: provide psychological support for health workers early

During the 2013–2016 West African Ebola epidemic, little attention was given to the psychological support needs of the health workforce, particularly in the early phases.[6] This included HCWs stationed in Ebola specific treatment areas, as well as those in non-Ebola-specific centres across the public, private and Non-Governmental Organisation (NGO) sector.[7] Latterly, efforts were made to provide mental health and psychological support services (MHPSS) for HCWs and communities. For example, during the outbreak in Sierra Leone, HCW peer-support 'WhatsApp groups' were established and found to be safe spaces for sharing feelings and in-seeking guidance.[8] In both contexts, immediately following Ebola, psychological first aid and mental wellness and self-care workshops were offered to some HCWs. During workshops, many HCWs reflected on their own experiences of trauma during previous conflict; emphasising how acute shocks can trigger underlying and potentially unaddressed trauma.

Since the Ebola period, through the implementation of WHO's Mental Health Gap Action Programme (mhGAP), MHPSS have been strengthened across both Sierra Leone and Liberia. mhGAP supports the scale-up of evidence based mental health services by equipping non-specialised HCWs with training and decision making tools.[6] HCWs can access integrated mental health services associated with mhGAP, although a specific focus on HCWs support needs is limited and the provision of wide-scale longer-term psychological interventions for HCWs is an ongoing challenge.

Learning from this initial neglect, building on stronger MHPSS platforms, and galvanising interventions that prioritise psychological well-being from the outset is essential in supporting HCWs within the COVID-19 response. This learning is reflected in Liberia and Sierra Leone with both countries having a MHPSS pillar within their current emergency response. In Liberia, the 'MHPSS Pillar Action Plan for the COVID-19 Response', recognises a need to: 'ensure duty of care through the protection of all responders from chronic stress, poor mental health and psychological distress during the response'. This plan encourages HCWs to access mental health and psychosocial care regularly and calls for the provision of appropriate personal protective equipment and training on its use. In Sierra Leone, it is suggested that mental health nurses, trained through mhGAP, could also provide ongoing support services to HCWss (see box 1). In both settings, ongoing research is also being conducted to document the interlinkages between structural and individual factors that contribute to distress experienced during crisis. This will ensure understandings of their support needs informs practice and also creates a space to hear what kind of support HCWs want and value. Ensuring mandatory rest periods, establishing designated critical incident teams that include mental health professionals, and the creation of 'de-stressing zones' have been beneficial in other settings during the COVID-19 pandemic.[7] These examples of rapid psychosocial support interventions, summarised in box 1, could be adapted in Sierra Leone and Liberia to facilitate HCWs to access MHPSS.

Learning 2: scarcity in health systems is Psychologically distressing for health workers

HCWs in the Global South are no strangers to challenging conditions, moral dilemmas and difficult decision making in times of scarcity. Epidemics intensify everyday resource deficiencies and their associated practical and ethical dilemmas. This is particularly true within health systems that have experienced multiple shocks.[4 7] However, these decisions and their impact on psychological well-being is now visible in global health narratives related to COVID-19. A focus on 'moral injury'[1 6] as a

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Box 1 Mental health and psychological support services support strategies for health workers in fragile settings

Learning 1: Intervention opportunities for rapid support

► Establish peer-support 'whatsapp' platforms as well as confidential helplines.

► Instigate mandatory rest-periods and shift rotations.

► Establish critical incident teams that include mental health trained clinicians specifically for the health workforce.

► Create destressing zones (a space where health workers can go at the end of a shift before returning home) and support health workers to identify their own mental health support needs through the use of Schwarz rounds and/or self-assessment tools.

► Use trained mental health nurses to offer mental health support to health workers, for example, through bimonthly catch up conversations.

Learning 2: Strategies to promote systemic change and support systems strengthening

► Support ongoing implementation of interventions such as Mental Health Gap Action Programme postcrisis to ensure prioritisation of mental health services within systems strengthening. Consider establishing specific components for health worker support.

► Ensure that health workers from across multiple and diverse settings are able to contribute towards shaping global health narratives.

Learning 3: Stigma reduction and promoting community cohesion

► Ensure appropriate provision of personal protective equipment for all cadres.

► Facilitate community healing dialogues to promote stigma reduction postcrisis.

► Establish Peer-Support Groups for communities and health workers in affected areas. Support groups should focus on mental wellness and self-care.

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result of HCWs having to make decisions that challenge their moral conscience and values and the anticipated psychological distress associated with emotional guilt and shame has, understandably, become dominant. This has presented a moment of critical reflection for some clinicians working within a landscape of resource limitation:

'My hospital has two oxygen tanks…I am always having to make decisions about who gets access to it…this is our norm. I didn't know we had to feel anxious about it…and now the [global] framing changes' (Medical Doctor, Sierra Leone).

Undoubtedly, many clinicians across the globe are facing unprecedented dilemmas about how to allocate scarce resources. However, there has been minimal reflection on the psychological impact such debates may have on the well-being of practitioners living and working within the Global South. For example, what is the mental health impact of having their routine experience discussed as unique and unprecedented in the Global North? How does the anticipated escalation of their own every day dilemmas challenge their mental well-being?

The Global Health community can learn from the psychological resilience and vulnerability of HCWs in

Liberia and Sierra Leone, but we also have an ethical and moral imperative to recognise these experiences in our discussions of 'unprecedented' psychological impacts among the health workforce. Ensuring that HCWs from across multiple and diverse settings are able to contribute towards shaping global health narratives is essential.

Learning 3: stigma and discrimination threaten health system and community cohesion and the psychological well-being of all cadres of the health workforce

Stigmatisation is often associated with infectious disease, including othering and discrimination toward those affected.[9] This is less commonly experienced by HCWs working with those affected; HCWs are normally embraced by their communities.[7] However, in the latter phases of the Ebola outbreak, HCWs in both contexts were frequently stigmatised by their communities and families.[10] In some instances, stigma was attributed to fear of disease transmission, while in others it was thought to be rooted in resentment towards HCWs who were perceived as financially benefitting from the influx of aid associated with the Ebola response.[10]

'Internalised stigmatisation' was also common among HCWs and the risk of passing infection to loved ones was a key stressor, particularly where they knew access to adequate care was limited.[2 10] Forms of stigma related to COVID-19 are still emerging with fear of transmission shaping responses. Community support and strong social connection is often a key source of mental resilience for HCWs,[11] and when this is compromised distress and demotivation can occur. Experiences of stigma and discrimination are also commonly associated with mental distress. Thus, understanding possible forms of stigma (enacted/internalised) experienced by HCWs at different time points during health systems shocks is essential in shaping provision of psychological support as well as stigma-reduction strategies.[7] Following the Ebola epidemic, 'community healing dialogues' facilitated by trained community HCWs across Sierra Leone and Liberia resulted in stigma reduction, greater community cohesion, and reduced psychosocial implications of trauma (see box 1). Understanding similar shifting community dynamics amid COVID-19 is critical to support HCWs.

Close-to-community (CTC) health providers are essential cadres in supporting routine community healthcare and in providing epidemic responses. CTC providers were central to controlling the Ebola outbreak and in stigma reduction processes as they maintained trusting relationships with their communities. In responding to COVID-19, self-quarantine, home based and in some cases palliative care is likely to be necessary. As before, CTC providers will play a critical role in providing home-based and or palliative care and in supporting communities to navigate this pandemic. However, despite the critical importance of CTC providers across Sierra Leone and Liberia, most are underpaid and under-recognised.[12] CTC providers are also exposed to job-related chronic stressors, which are also shaped by other factors such

as gender and age, and that may lead to psychological distress. For example, female CTC providers are often at greater risk of sexual and gender-based violence than their male counterparts. These vulnerabilities, experiences of stigma and their intersection with characteristics that shape individual identities (eg, age and gender) should be considered in psychological responses to this pandemic and in providing longer-term support.[8] Providing CTC providers with PPE, supporting them economically and attending to their psychosocial needs during this shock is essential to ensure their safety.

CONCLUDING THOUGHTS: AN OPPORTUNITY TO CATALYSE CHANGE

A critical step in developing psychological support systems and interventions is to work with HCWs to understand the areas of distress that they are experiencing and what kind of support they require[13] (box 1). Understanding domains of distress within the backdrop of existing traumatic experiences will be particularly critical in ensuring health systems resilience in fragile settings.[11] Examples of best practice from previous shocks, and evidence from other COVID-19-affected settings, would suggest that simple early interventions during the shock period will be impactful for HCWs. However, these interventions could be seen as a 'stop-gap' that can leave the long-term effects of trauma unsolved.

The vulnerability of HCWs is shaped by chronic health systems weaknesses, but also by the way in which mental health and well-being are often undervalued within global health approaches. Sustainable infrastructure is needed to address the historical marginalisation of psychological support for HCWs. This is likely to require innovation and investment and multidisciplinary approaches.[14] Presenting HCWs with opportunities to access MHPSS services will support HCWs to create meaningful narratives from traumatic events[3] that will continue to support the ongoing and remarkable 'everyday resilience'[5] of Liberia and Sierra Leone's health systems.

Twitter Laura Dean @Laura_Deano and Bintu Mansaray @BintuMansaray9

ORCID iDs
Laura Dean http://orcid.org/0000-0002-4910-9707
Sally Theobald http://orcid.org/0000-0002-9053-211X

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