World Health Organization
REGIONAL OFFICE FOR Africa

WHO REGIONAL OFFICE FOR AFRICA COVID-19 RAPID POLICY BRIEF SERIES

SERIES 11: COVID-19 RESPONSE CAPACITY WITH THE HEALTH SYSTEM

NUMBER 011-03: Health workforce recruitment and retention for COVID-19 emergency management

Based on information as of 31 December 2020

Rapid Policy Brief Number: 011-03 - COVID-19 response capacity with the health system: Health workforce recruitment and retention

WHO/AF/ARD/DAK/32/2021

Designed and printed in the WHO Regional Office for Africa, Brazzaville, Congo

1	**RAPID POLICY BRIEF NUMBER: 011-03**
2	**RESEARCH DOMAIN: COVID-19 RESPONSE CAPACITY WITH THE HEALTH SYSTEM**
3	**TITLE:** Health workforce recruitment and retention for COVID-19 emergency management
4	**DATE OF PUBLICATION:**
5	**BACKGROUND** Sustaining or scaling up the health workforce, the linchpin of the health system, has been a constant challenge for many national governments in both low- and middle-income countries (LMICs) and high-income nations since at the least the last three decades [1,2]. In many countries there are not just enough health workers to meet the ever-growing health needs of their aging or exploding populations [1-3]. By and large, health workers are a scarce resource globally, and the growing competition for their labor exacerbates maldistribution of available human resources for health between and within countries [4]. During national and global health crises like the ongoing COVID-19 pandemic, adequate support is essential for mitigating health workforce attrition and for incentivizing emergency recruitment. Through a technical working guidance published in April 2020, the World Health Organization (WHO) made 16 recommendations for strengthening health systems for COVID-19 response [5]. Policy recommendation #8, the most relevant to this brief, suggests multiple strategies for retaining or scaling up workforce capacity during the COVID-19 pandemic namely, to repurpose and mobilize the existing workforce, change working patterns, recall inactive or retired health professionals back to the workforce, call on volunteers, and mobilize military, nongovernmental and private sector workforce capacity [5]. This policy brief provides a rapid and succinct review of countries that have used any of the above strategies to increase the surge capacity of their health workforces in response to COVID-19.
6	**SEARCH STRATEGY / RESEARCH METHODS** Our search for supporting evidence involved the following databases: Coronavirus Research Database, Cochrane Library, Embase, Global Index Medicus, Medline, and PubMed. We searched these databases from December 2019 to December 31, 2020 using the following combinations of terms and phrases: (COVID-19 OR coronavirus disease 2019 OR SARS-CoV-2) AND (health workforce OR health personnel OR health worker OR health care professional OR human resources for health OR doctor OR physician OR dentist OR nurse OR midwife OR pharmacist) AND (recruitment OR hiring OR employment OR unemployment OR underemployment OR deployment OR retirement OR retention OR migration). In addition to the above databases, we also searched Google Scholar, while using the less restrictive search engine Google to identify relevant articles from the gray literature. From an initial yield of 308 results, 18 articles directly germane of the themes of interest were retained and reviewed for this brief. These included five articles focusing in whole or part on the African health workforce that were summarized separately.
7	**SUMMARY OF GLOBALLY PUBLISHED LITERATURE RELATED TO THE SUBJECT** In response to COVID-19, the WHO Regional Office for Europe set up the Health System Response Monitor to collect and organize up-to-date information on how countries in the region are responding to

the pandemic [6]. Thanks to this system, the best global evidence of health workforce retention and recruitment strategies for COVID-19 emergency management we currently have comes from Europe, more specifically from the work of Gemma Williams and colleagues who have observed how 44 European countries and Canada have used the strategies recommended by WHO to expand health workforce capacity and incentivize health workers during the first wave of the plague [7,8]. This rapid policy brief has drawn heavily from the above authors' research.

In many countries in Europe and in Canada, the implementation of recruitment and retention strategies to expand the capacity of the respective health workforces required the enactment of emergency legislation. Finland enacted a decree mandating all 18 to 68 years old staff working in both private and public healthcare to work as needed in order to tackle the plague. Greece rescinded leave of absences for public service personnel and Israel barred health workers from leaving the country. The Canadian provinces of Ontario and Quebec enacted regional legislation to reassign on a need basis health and social care professionals to different facilities, and to cancel annual holidays and change work schedules. In Germany, instructions on minimum nurse staffing levels in hospitals and nursing homes as well as ambulatory nursing practices were suspended, while Italy enacted several decrees to boost health workers' availability. England redeployed private sector staff into its National Health Service through an agreement brokered for the government to take over private hospitals and their staff for the duration of the crisis. As a result, tens of thousands of clinical staff moved to the public health sector [7].

In 21 countries including Germany, Ireland, Italy, Spain and Sweden, the existing workforce was fully stretched by asking health workers to work extra hours, allow extra overtime, or move from part-time to full-time positions. Work schedules was modified in Canada and Croatia while ongoing or scheduled external rotations for residents in training were suspended in Spain and Romania. Exemptions after night shifts or on-call activities were also suspended in Poland, Spain, and Switzerland while leaves of absence or foreign-travel were cancelled in Spain, Greece, Canada, Czech Republic, Luxemburg, Norway, and Israel. The United Kingdom (UK), the Netherlands, Hungary, and Austria temporarily changed or postponed re-registration and revalidation requirements for their physicians [7].

COVID-19 recruitment campaigns targeted nationally or locally and often buttressed by emergency legislation were launched to bring back inactive and retired health professionals into to the workforces of Canada (Ontario and Quebec provinces), Belgium, Bosnia and Herzegovina, Denmark, Germany, Iceland, Ireland, Italy, Malta, the Netherlands, Norway, Poland, and the UK [7]. "Be on call for Ireland," a national recruitment drive urging former Irish healthcare staff at home and abroad to get involved in the fight against COVID-19 in their homeland, registered 73 000 volunteers, some of whom travelled from as far as Australia to lend support [7, 9,10]. By mid-April, 63 Irish physicians and 260 Irish nurses were hired [7]. Recent reports suggest the latter numbers have not changed since then, and nearly one-half of the applicants did not have the adequate skills for the positions with the most need, namely doctors, nurses, healthcare assistants, domestic cleaners, porters, dentists, dieticians, radiographers, physiotherapists, occupational therapists, pharmacists, pharmaceutical technicians, mortuary attendants, medical scientists and laboratory aides [9,10]. Short-term training courses for returnees were offered by hospitals in several countries including Germany, the Netherlands, and Bosnia and Herzegovina [7].

Between early and mid-March 2020, the Italian government adopted two decrees which allowed for the permanent hiring of 20 000 additional healthcare personnel and allocated 250 million euros for staff overtime, while authorizing the retention of eligible staff above the retirement age, offering retired physicians and nurses the opportunity to volunteer to practice, and requesting temporary enrolment for doctors and nurses in the army. In Greece, the Ministry of Health created a digital platform through which more than 8000 volunteers applied to support the COVID-19 response. Germany sought to tap into the estimated 14 000 of unlicensed foreign-trained physicians living there, mostly as refugees. By the end of March 2020, roughly 300 of these foreign physicians had signed up to volunteers as medical assistants in the German State of Saxony in response to a Facebook appeal from that state's medical association [7].

In Europe's most COVID-19 burdened country, the UK, an excess of 10 000 health workers volunteered to return to work with nearly 5000 re-enlisted and redeployed by mid-April [7, 11]. In England, NHS 111—a helpline service dedicated to giving the public quick medical advice—was capacitated for COVID-19 response through an initial extra 1.7 million British pounds to hire 500 more call handlers that could answer 20 000 additional calls per day [12]. Likewise, in the UK, Canada, and 34 other European countries, arrangements for early graduation of medical and nursing students were made so that they could join the workforce [7]. This amounted to a potential of 5500 final-year medical students being offered a position of "F1 locum appointment for training" in the UK [13].

Several of the above countries also have adopted a combination of special measures to support the wellbeing of their health workforces during the COVID-19. These include mental health assistance through remote counseling and helplines, childcare facilities, free transportation, accommodation, continuing education credits, and one-time bonuses [8]. In the United States (USA), the Health Resources and Services Administration (HRSA) waived interest and extended the opportunity for forbearance on health professions student loans through December 31, 2020 [14].

8 SUMMARY OF AFRICA-SPECIFIC LITERATURE ON THE SUBJECT

The limited number of publications directly focusing on Africa were mostly comments on international recruitment of health personnel [15-17]. As the pandemic overwhelmed the health systems of many high-income nations, triggering a growing demand for health labor in the global North, this raised concerns of potential acceleration of health personnel outward migration from the African continent and LMICs [16, 17]. An article from the African edition of Academic World News suggests 8,600 Egyptians were accepted into the USA by May 2020 following a call for applicants issued in late March 2020 by the U.S. Department of State's Bureau of Consular Affairs [16]. Multiple stakeholders have been critical of the U.S. actively advertising special facilitating guidance for foreign medical professionals seeking to get to this high-income country during the COVID-19 surge [17, 18]. Through a correspondence in the South African Medical Journal (SAMJ), the University of Cape Town Global Surgery Division expressed its deep concern for the asphyxiating effect large-scale international recruitment of skilled health professionals by the UK and the USA could have on health systems in Africa [17]. As regards local emergency hiring plans for COVID-19 management within Africa, the only direct evidence we identified came from South Africa where the provincial government in Western Cape has organized ongoing temporary recruitment

	targeting physicians and nurses in private practice to assist with healthcare delivery in the public sector throughout the COVID-19 crisis [19]. Likely as a way to motivate prospective recruits, salaries for various positions and ranks are published. These range from R821 250 (US$55 000) for entry-level general practitioners to R1 834 890 (US$122 889) for senior-level medical specialists. [19]
9	**POLICY FINDINGS** • The COVID-19 Health Systems and Response Monitor appears to be an efficient and valuable tool for capturing and monitoring national health workforce data during pandemics. • The adoption of emergency legislation during the COVID-19 crisis has provided much needed flexibility to planners, commissioners, and providers of healthcare services. • Additional financial rewards and psychosocial support are important determinants of health workers' motivation during the COVID-19 pandemic. However, the effect of each of these determinants need to be evaluated.
10	**ONGOING RESEARCH IN THE AFRICAN REGION** None found.
11	**AFRO RECOMMENDATIONS FOR FURTHER RESEARCH** • Routine and systematic data collection and data monitoring on health personnel recruitment and retention in countries of the WHO African Region is essential, as dearth of reliable and up-to-date information on workforce capacitation in the continent impedes knowledge generation and effective policymaking. • It is interesting to note that Africa produces a good number of highly qualified health care workers who go to serve in Europe, USA, Canada and Australia. Many of them come from poorly resourced countries. The issue driving brain drain from Africa is health worker demotivation (poor remuneration, lack of benefits such as health insurance, risk allowance etc.), poorly conducive environment to execute their skills as in majority of countries in Africa, the budget allocation for the public health sector is insufficient, hence private health sector is thriving, and inaccessible to most. How do we then reconcile this fact? Going forward, seeing the insufficiencies in health care systems in Africa being highlighted as a result of the COVID-19 pandemic. How can WHO mitigate this fact? High level advocacy? What innovative measures can WHO as an organization come up with to mitigate these glaring issues that face the health care systems in Africa? • Research on health worker unemployment and underemployment in Africa should be conducted during and after COVID-19 to shed light on the paradox of health worker unemployment in countries with critical shortage.

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BRIEF PRODUCED BY: Information Management Cell, of the WHO Regional Office IMST and the Cochrane Africa Network