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A Scoping Review on Health Care Employees Experience with Covid-19: Insights from Human Resources Perspective

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Abstract

The objective of this review was to present evidence gathered from research studies across African countries on Health Care Employees experiences with COVID-19 pandemic focusing mainly from Human Resource perspective. A scoping review method was used to search materials from Google Scholar, PubMed, Thematic scholar, Web of Science, Cochrane Library, and ScienceDirect. Data on HCEs was collected from 12 countries from Africa. Findings indicate that there were poor leadership on COVID-19 management in many health care facilities across Africa, shortage of HCEs in various COVID-19 treatment centers, increased workload, lack of training on COVID-19 management, poor staff welfare such as food and resting space, and majority of them were poorly paid. It was also reported that HCEs experienced disconnection from family members and others were exposed to physical and psychological work place violence. The current review provided evidence that human resource practices as experienced by HCEs during the outbreak of COVID-19 pandemic in Africa had negative effect on their physical and mental well-being. Governments in Africa should ensure that there is proper leadership in managements of health facilities that will oversee adoption and implementation of human resource practices that enables HCE to properly fight against outbreaks of pandemics like COVID-19.

Keywords: COVID-19, Health Care Employees, Human Resource Practices, Employees Experience, Africa.

Introduction

The significance of Health-Care Employees (HCEs) to the health of larger population of any country cannot be overemphasized. Economic growth and development of any country depend heavily on the healthy working individuals whose health entirely rely on the work of Health-Care Employees (HCEs). Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2) popularly known as COVID-19 broke-up in December, 2019, in Wuhan-China. The virus brought-up unprecedented changes in the healthcare system particularly on Health Care

Employees (HCEs) who found themselves with the task of fighting the pandemic. The WHO (2006) define HCEs as all people engaged in actions whose primary intent is to enhance health including nurses, doctors, midwifery, pharmacists, laboratory technician, paramedic staff, psychologists, morgue attendants and hospital administrators. Indeed, HCEs are important human resources who have played a key role in the response to COVID-19 outbreak. However, managing their health and safety has been a key Human Resource Management challenge in many health facilities. The WHO estimates that a total of 180,000 Health Care Employees have died from COVID-19 as of May 2021. Unlike employees in other sectors who were forced to comply with hygiene protocols such as social distancing and working from home to avoid contracting the virus (Gigauri, 2020; Mwita, 2020; Kabir et al., 2020), HCEs had to continue working and thus exposing themselves to risks such as contracting the virus, illness, and even death (Chorwe-Sungani, et al., 2020; Elkholy et al., 2021; Limbani et al., 2022; Afulani et al., 2021).

The impact of COVID-19 on HCEs has been reported worldwide. Recent studies from countries of developed economies have established that HCEs experienced stress (Vindrola-Padros et al., 2020); mental health Shechtera et al (2020); burnout Felice et al (2020); and anxiety (Wei et al., 2020). For instance, Duarte et al. (2020) conducted a study on the impact of COVID-19 among Portuguese healthcare workers and found that 52.5% had high burnout, 66.9% anxiety, and 70.6% depression. Vindrola-Padros et al (2020) employed Rapid Appraisal Combining method to investigate experiences of HCEs during the COVID-19 pandemic in the United Kingdom. They suggested that lack of personal protective equipment (PPE) and routine testing created anxiety and distress among HCEs. Felice et al (2020) investigated the impact of COVID-19 on HCEs in Italy. The result showed that 95% experienced high risk and 77% had access to PPE. These findings are strongly supported by studies on the experience of the HCEs with the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003. For instance, Ives et al. (2009) through qualitative study found that HCEs experienced illness, transport difficulties and risks during an influenza pandemic in United Kingdom. Raven, et al (2018) study on coping strategies with the Ebola epidemic in Sierra Leone found that HCEs experienced community and peer and family support, and a sense of serving their country as coping mechanism during the epidemic. Although studies have examined different factors experienced by HCEs during COVID-19 outbreak, there is no review examining HR practices experienced by HCEs in the course of COVID-19 intervention.

This study contributes to COVID-19 management literature in several ways. First, the review provides empirical evidence on HR practices as experienced by HCEs during COVID-19 pandemic. Much of the existing research has mainly focused on socio-psychological factors leaving other factors unexplored. For example, meta-analysis studies of Spoorthya, et al (2020); Shaukat et al (2020); El-Qushayri et al (2021); Robertson et al (2020) assessed only articles focusing on aspects of HCEs mental health problems such as anxiety, depression, and burnout. Factors associated with human resource management such as training and remuneration have not been systematically explored. Human resource practices such as good pay, training on management of the virus, and recruitment of more staff to reduce workload would help HCEs get physical and psychological well-being resulting to good work performance. Therefore, understanding of these variables particularly during COVID-19 pandemic is crucial.

Secondly, majority of the existing review studies covers the period of January to December, 2020 (Spoorthya, et al., 2020; Shaukat et al., 2020; Robertson et al., 2020). This coverage leaves a lot of evidences as experienced by HCEs unreported and therefore not known to the general public. It is almost two years since COVID-19 outbreak was reported for the first time. In this period, there has been major development in the literature and increase in publications including discovery of various COVID-19 mutated strains and commencement of vaccination program for HCEs (see El-Qushayri et al., 2021). Lack of inclusion of issues published within this period creates academic lacuna that this study intends to fill. Thirdly, the current study contributes to the research on HCEs experiences with COVID-19 by covering all literature published from all countries in Africa. The few existing meta-analysis studies (Robertson et al., 2020; El-Qushayri et al., 2021) covers HCEs experiences with COVID-19 at the individual country level. Such coverage limits holistic understanding of HCEs experiences as many African governments adopted different approach in response to COVID-19 pandemic. For instance, Tanzania adopted COVID-19-denial approach Buguzi (2021) by prohibiting release of official COVID-19 statistics and declared the country free from COVID. The impact of such measures on HCEs who were in the front line battling the disease is not known. Therefore, this study tried to answer the following research question: *What were HR practices experienced by HCEs during COVID-19 pandemic?* The main objective of this study was to provide a comprehensive analysis of HCEs experiences from COVID-19 pandemic as reported by research studies across Africa.

Methods

Research Design

As the objective of the study was to summarize and disseminate research findings, this study adopted a scoping review research approach as suggested by a Arksey and O'Malle (2005). Arksey and O'Malle outlined five stages of scoping review namely, identifying the research question, identifying relevant studies, study selection, charting the data and collating, summarizing and reporting the results. Guided by these stages, the study thought to answer the following research question: *What are HCEs experiences from COVID-19 pandemic in Africa*?

Database Search Strategies

In a bid to tap all the materials as possible the following data bases were used to retrieve articles: Google Scholar, PubMed, Thematic scholar, Web of Science, Cochrane Library, and ScienceDirect. This was supplemented by hand-picked materials from reference lists. The collection of data was done in February, 2022. All articles published between December, 2019 to January, 2022 which addresses COVID-19 and HCEs in African context were downloaded. This period was deemed proper as it covered the whole period of the existence of the pandemic. To ensure reliability, before embarking on a full search, piloting of the search strategy was done to enable for refinement. Cognizant of the shortage of skills for data search on the part of the authors, three librarians, one from Institute of Accountancy Arusha, University of Dar es salaam and University of Nairobi were requested to assist the authors to identify potential data base and materials. Hand-search for key journals to identify articles was also done. Key words used for search include; "Corona virus -19" "health care workers" "health care employees" "COVI -19 effects" on "health care workers" "human resource challenges" during "COVID-19". "Corona virus" and "workplace Challenges". Also individual

country's name was added to the search key. For example, "COVID-19" and "health care workers" in "Kenya" in "Tanzania" in "Rwanda" in

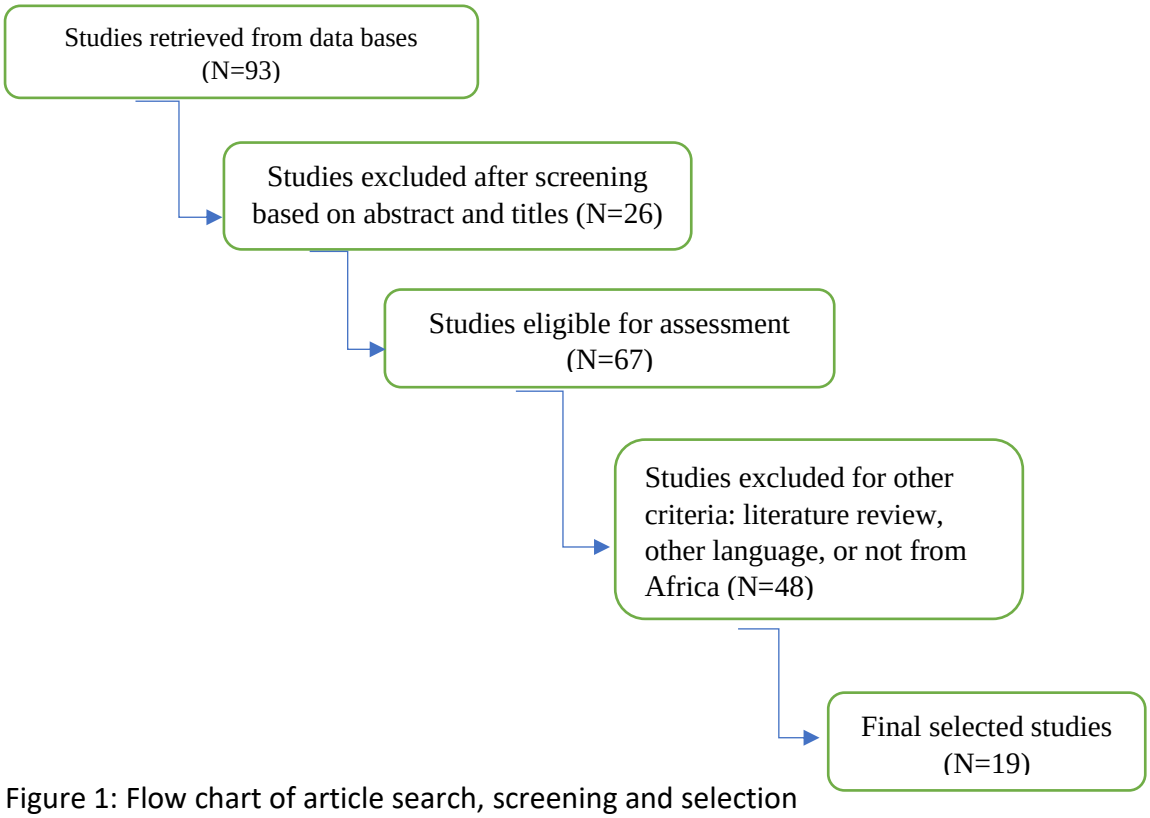

Figure 1: Flow chart of article search, screening and selection

"Cameroon" in "Egypt" in "Africa" The downloading of articles continued until saturation point was reached.

The Selection of Studies and Inclusion Criteria

This study used all materials published in a peer-reviewed academic journals examining HCEs and COVID-19 from an African context. Additionally, guided by the guidelines of Arksey and O'Malley, reviewers, after reading the full article, and satisfied that the materials answered our research question, the decision was made to be included in the study. Original research article, commentaries, and letters to the editor were included. Abstracts, editorials, and literature reviews studies were excluded as they did not capture full scope of the written articles. Finally, due to time limit, all articles not published in English language were excluded. To avoid duplication of data, studies that were conducted in more than one country especially when the other country is not in Africa were also excluded (see figure 1).

Data Extraction and Thematic Construction

Information on HCEs and COVID-19 from selected studies were sorted based on guidelines provided by (Arksey and O'Malley, 2005). The organization and presentation of charted data from studies were presented in two ways. First, a summary of information outlining processes that were used on each study was done. Microsoft-word table was used as a data charting form whereby each information was entered into. The collection of information was based on name of the author(s), year of publication, geographical study location, study objective, research design, number of target population, data collection instruments, and study findings. Additionally, because of diversity and overlapping of methods and study findings a summary

of results in the table was presented according to the alphabetical order of the authors Secondly, as Arksey and O'Malley (2005) suggest that since scoping study does not seek to synthesize evidence or to aggregate findings from different studies some analytic framework or thematic construction can be used to present results. Guided by this thinking, information from study findings were reorganized around main themes arising from the study's findings and presented in a narrative way. Two reviewers were involved in the data extraction process and a consensus was reached whenever a contraction happened.

Results

Research Study Characteristics

As indicated in figure 1 and table 1 respectively, a total of 93 articles were retrieved from search data bases. Scientific screening based on abstract and titles found 26 as duplicates hence excluded. The screening on the remaining 67 based on factors such as being a literature review, not written in English, and not from African context left 19 articles which were included in the final analysis.

Two studies were from Uganda, one from Zimbabwe, five from Nigeria, one from Ethiopia, two from South Africa, one from Ghana, one from Egypt, three from Malawi, one from Cameroon, one from Sudan and one study covered 13 African countries. Additionally, five studies adopted qualitative approach, nine used quantitative approach, two used secondary data, similarly, nine studies were cross-sectional, one was a longitudinal design. As all studies addressed HCEs with the composition of medical doctors, pharmacists, assistant medical officers, clinical officers, clinical assistants, nurses, midwifery, laboratory technicians, paramedic staff, and hospital administrators

Table 1
Summary of Studies, Methods and Findings

Author(s), Publication Year	**Study Location**	**Study Objective**	**Methods**	**Main Findings**
Afulani et al. (2021	Ghana	Preparedness for response to COVID-19 associated with stress and burnout among HCWs	Cross-sectional online survey N- 414 for stress N-409- for burnout	-Appreciation from management and family decreases stress and burnout - stress and burnout negatively affected HCEs job satisfaction, productivity, quality of care, and workforce turnover
Chorwe-Sungani (2020).	Malawi	Assessing COVID-19 related anxiety among nurses	A cross-sectional study, online survey, N-102.	- 48% of nurses suffered from functional impairment due to COVID-19.
Debes, et al. (2021)	13 countrie	Risk of Healthcare Worker Burnout in	Online Survey, N- 489	- 49% of HCEs reported a decrease in income, 25% experienced

	s in Africa	Africa during the COVID-19		salary reduction, 66% had access to PPE, 20% had no access to PPE, 31% reported increase in daily depression
Ebuka (2020)	Nigeria	Doctor's Strike: Nigerian govt threatens 'No Work no Pay' rule.	Secondary sources	-HCEs downed their tools over unpaid salaries and non-payment of hazard allowance
Elkholy et al. (2021)	Egypt	Mental health of frontline healthcare workers during COVID-19	A cross-sectional survey, Questionnaire N- 502	- HCEs had symptoms of anxiety, insomnia, depression, and stress. - Fever hospital workers were at higher risk of severe depression (95%)
Gebreselassie , et al. (2021).	Ethiopia	knowledge, attitude and perception on workplace readiness regarding COVID-19 among HC providers	Online survey, N- 400	- 96% of workers enjoyed support from their families
Ilesanmi et al. (2021).	Nigeria	Infection prevention and control among HCWs during COVID-19 pandemic	Qualitative study N- 16	- HCEs had poor knowledge of infection prevention and control, lack of sufficient IPC training, Poor financial motivation - lack of break periods during duty hours increased workload
Kwaghe et al. (2021)	Nigeria	Stigmatization, psychological and emotional trauma among HCWs treated for COVID-19 in Lagos	A qualitative study, N-12	-HCEs continued while positive with COVID-19 -colleagues, family and friends provided encouragement and few colleagues and families had negative reactions when tested positive for COVID19
Limbani et al.(2022)	Malawi	A qualitative description of HCWs experiences during	Qualitative, N- 39	- HCEs underwent COVID-19 training though delayed and rushed,

		the first wave of COVID-19		there were inadequate working sp ace -There was resentment around the provision of additional monetary allowances, poor transport
Mbaba et al. (2021)	Nigeria	Willingness of HCEs to Respond to Covid-19 in Nigeria	A cross-sectional survey, n=113	-97.53% of HCEs preferred cars or car loans for militating against absenteeism from work - there was high absenteeism among HCEs (93.42%).
Migisha et al., 2021	Uganda	Risk perception among HCW during early phase of the COVID-19	Cross-sectional survey, N- 335	-HCE experienced lack of workplace support (63%), increased workload (59%) and inadequate staffing (58%).
Moyo et al. (2022)	South Africa	Experiences of nurse managers during the outbreak of COVID-19	Descriptive phenomenologi cal research design, N- 10	- Nurse managers experienced Human resource challenges, freezing of vacant posts, shortage of staff, Increased workload -HCEs tested positive for COVID-19 continued working due to shortage of staff
Munyenyemb ea et al. (2021).	Malawi	COVID-19 anxiety-coping strategies among HCWs	Longitudinal, qualitative study, N-68	- There was human-capital deficits -No training for HCEs on COVID-19 handling, increased workload - HCEs deliberately stayed away from work to minimize exposure to COVID-19
Nicholas et al. (2021)	Camero on	Psychological Impact of Covid-19 among Healthcare Workers	online survey, questionnaire, N- 271	- 74.9% of HCWs felt unsafe working during the pandemic, 21% felt abandoning their

				job,74.2% felt motivated performing their duty, 29.5%) felt saving lives as reason for motivation-
Okediran et al. (2020)	Nigeria	The experiences of HCWs during the COVID-19 crisis in Lagos	Qualitative, N-10 medical officers N-4 nurses	- HCEs experienced shortage of staff, difficulties working in a new environment, limited working space - IPC experts trained HCEs, poor staff welfare such as food and resting space, delayed allowances -HCEs denied visits to their homes
Seruwagi, et al. (2021)	Uganda	HCWs preparedness for COVID-19 management and implementation experiences	A cross sectional, mixed-method, questionnaire and interviews, N- 485	- HCEs did not receive trainings causing knowledge and skill gaps in most facilities, increased workloads demands
Truscott, (2020).	Zimbabwe	Zimbabwe's response to Covid-19	Secondary sources	-HCEs struck over low salaries
Zungu et al. (2021)	South Africa	Organizational factors associated with HCEs protection during the COVID-19 pandemic	Cross-sectional, quantitative and qualitative N- 170,686, N-45	-Health facilities had no enough HC professionals -34,192 HCE from 45 health facilities were trained in the qualitative observational HealthWISE
Mahgoub et al. (2021)	Sudan	Psychological effects of the COVID-19 pandemic: Perceived stress, anxiety, work-family imbalance, among healthcare professionals	Cross-sectional self-administered questionnaire, N-344	- Majority of HCEs had poor work-family balance (60.2%)

Source: Authors

Presenteeism and Absenteeism from Work

Four Studies presented evidence on HCEs absenteeism and presenteeism during COVID-19 pandem. On the issue of presenteeism, the COVID-19 pandemic led to majority of HCEs being infected with the virus hence falling sick. However, due to shortage of staff majority were required to continued working while ill. A study by Moyo et al (2022) from South Africa reported that nurses who had tested positive for COVID-19 and those waiting for their COVID-19 results were requested to continue working as there were no any other option of getting replacement. Similarly, Kwage et al (2021) from Nigeria reported that majority of frontline health workers were working while positive with COVID-19. On the other hand, one study by Mbaba et al (2021) from Nigeria found that there was high absenteeism among HCEs (93.42%). Respondents narrated that that they had to change their working pattern by not going to work on some days for fear of contacting the virus. Similarly, a study by Munyenyembe & Chen (2022) from Malawi reported that HCEs opted for a deliberate tardiness and stayed away from work to minimize exposure to COVID-19 patients.

Employees Recruitment

Recruitment of HCEs was assessed by five studies (Zungu et al., 2021; Munyenyembea et al., 2021; Moyo et al., 2022; Okediran et al., 2020; Migisha et al., 2021). These studies found that there was shortage of HCEs in various COVID-19 treatment centers. A study by Munyenyembea et al (2021) from Malawi, demonstrated hospitals' lacked sufficient staff, something that increased the workload of the existing employees. A descriptive phenomenological study from South Africa by Moyo et al (2022) reported that the government froze vacant posts due to financial constraints, a move that created staff shortages in different hospital wards "*We were told all vacant positions had been frozen, meaning that they could not advertise or employ anyone because the government does not have the money*" narrated one respondents. There was a shortage of nurses and drivers. Insufficient workforce at isolation centers was also reported by Okediran et al (2020) from Nigeria whereby deployment of non-critical care staff was done to man the centers. In some instances, HCEs were told to stop taking COVID-19 test for fear of being short-staffed. Using four Referral Hospital in Uganda with Migisha et al (2021) study shows that many HCEs reported increased workload (59%) and inadequate staffing (58%). These outcome of human resource shortage affected health facilities management and treatment of the sick. Zungu et al (2021) from South Africa found that whereas Province A and B had a medical practitioner, and health nurse, Province C lacked the environmental health practitioner and health and wellness professionals.

Employees Training

In relation to HCEs training, a contrasting results were found among six studies. Four studies Nicholas (2021); Okediran et al (2020); Limbani et al (2022); Zungu et al (2021) confirmed that HCEs received proper training on management of COVID-19. A study by Okediran et al (2020) found that Nigerian Centre for Disease Control and IPC experts in the COVID-19 response team provided training sessions to HCEs during COVID-19 period. Similarly, a study by Zungu et al. (2021) from South Africa found that 34,192 from forty-five health facilities were trained in the qualitative observational HealthWISE risk assessment for SARS-CoV-2. Limbani et al (2022) narrated that on the job training and posters were the only methods used to receive the knowledge. On the other hand, four studies Seruwagi et al (2021); Okediran et al (2020); Munyenyembea et al (2021); Ilesanmi et al (2021) reported that majority of HCEs did not

receive any training related to COVID-19. A study by Seruwagi et al (2021) from Uganda documented that HCEs received certain information regarding the virus to increase their awareness. The study found that constraints was mainly on training materials and content. A study from Malawi by Munyenyembea et al (2021) pointed out that HCEs did not receive any training on how to handle COVID-19 patients nor proper orientation on how use equipment such as testing kits.

Employees Compensation

One study by Truscott (2020) from Zimbabwe found that despite working for long hours HCEs experienced poor pay as they fought COVID-19. Poor financial allowances were also identified by Ilesanmi et al (2021) from Nigeria and Limbani et al (2022) from Malawi. Ilesanmi et al (2021) found that there were poor Incentives and/or hazard allowance provided to HCEs involved in the COVID-19 response. According to the Limbani et al., HCEs expressed their dissatisfaction with the provision of additional monetary allowances, whereby senior managers and officials were given allowances with no provision for lower cadres. A study by Okediran et al (2020) from Nigeria found that there was poor staff welfare such as food and resting space for HCEs and delayed payment of allowances. As noted by Truscott (2020) from Zimbabwe that lack of monetary motivation led some HCEs to go on strike. Other countries resorted to other kind of motivation. A study by Limbani et al. (2022) that HCEs were offered with transport to and from work and a quarantine centre after completion of their block of shifts. Nicholas et al (2021) from Cameroon found that 23.6% HCEs attributed their motivation to continue working because of financial motivation they got. Mbaba et al (2021) from Nigeria reported that majority of the HCEs 97.53% (n=237) perceived the provision of cars or car loans was the best options of militating against healthcare worker's absenteeism from work. Debes et al (2021) established that 49% of HCEs in Africa reported a decrease in income and majority experienced 25% salary reduction. Ebuka (2020) from Nigeria reported that doctors downed their tools over unpaid salaries and non-payment of hazard allowance during COVID-19 pandemic.

Employee Workload/workflow

Six studies showed that COVID-19 management introduced many additional administrative work such as screening and contact tracing of ill patients. These activities increased workload of both HCEs and health care administrators. A study by Moyo (2022) from South Africa pointed out that there were increased work such as screening of workers, visitors, documenting everything for a follow-ups and extra patients care. One study from Malawi Chorwe-Sungani et al (2020) reposted that half of the respondents (48%) experienced functional impairment due to COVID-19. The prevalence of functional impairment was significantly higher among female respondents (56.2%, n=41) compared to their male counterparts (27.6%, n=8). Munyenyembea et al (2021) from Malawi alluded that HCEs experienced too much workload increase due to insufficient staff. One study by Okediran (2020) from Nigeria found that majority of HCEs perceived COVID-19 working period as tiresome and boring due to repetitive tasks. Ilesami et al (2021) from Nigeria explained lack of break periods during duty hours increased workload among HCEs resulting to stress and improper decision-making. A study by Seruwagi et al (2021) from Uganda established that 81% of HCEs explained that due to increased demand their job required them to work fast with a lot of effort and 66% had no adequate time to accomplish work.

Employee Work-Family Balance

In relation to Work-Family Balance and support, five studies highlighted that HCEs experienced high support from their families. A study by Gebreselassie et al (2021) from Ethiopia and Afulani et al (2021) from Ghana found that majority of the respondents enjoyed support from their families. However, different results were noted by Okediran et al (2020) from Nigeria that HCEs were deprived the opportunity for regular visits to their homes and hence experience a disconnection among family members. One study by Mahgoub et al (2021) from Sudan established 60.2% HCEs experienced poor work-family balance during Covid-19 pandemic. Majority of them were unable to cope between work and family issues resulting into high stress and anxiety. Kwaghe et al. (2021) from Nigeria found that HCEs received encouragement from colleagues, family and friends as they fought COVID-19 pandemic.

Discussion of Findings

The current study adopted a scoping review method to examine HCEs experience with the COVID-19 in Africa. The rationale for study emanated from the fact that despite statistics (WHO, 2021) showing low rate of covid-19 prevalence across the continent, however, Africa was equally hit with covid-19 pandemic. As such, HCEs found themselves in the frontline battling the disease amid weak healthcare systems. It is from this backdrop that understanding what HCEs went through from multiple countries was significant. The findings from the current study suggest that Human resources (HR) shortages in health care facilities was a common defining characteristic in many African countries. Results from majority countries in Africa indicates that there was lack of sufficient and qualified HCEs which in turn increased the workload of the existing staff. Shortages were frequently noted in intensive care units and isolation centers due to absence of professional HCEs. The outcome was poor service performance. Staff with low experience were deployed to man these units. Freezing of recruitment due to financial constraints was one of the main reason for non-recruitment. This finding was not unique to Africa. Studies by Shechtera (2020) reported similar findings

The proper management of COVID-19 was contingent on many aspects including training. Given that Africa is faced with poor health care facilities, training for HCEs was meant to disseminate accurate and timely knowledge about COVID-19 including infection, use of PPE, and handling of dead bodies. The current review found mixed empirical findings. Respondents from Several countries including Nigeria, South Africa and Cameroon acknowledged receiving COVID-19 training. However, majority opine that the method used for training i.e on the job training and posters which were argued to be of little impact. This finding support the findings of Ali et al (20220) from Ireland who suggested that training received by HCEs were insufficient and 50% of sampled HCWs suggested the need for more education and training using multidisciplinary approach. In the same vein, studies from countries like Uganda, Nigeria and Malawi reported that majority of HCEs did not receive any training related to COVID-19. Previous studies such as that of Vindrola-Padros et al (2020) from United Kingdom reported similar findings. It is suggested that during the outbreak of pandemic like COVID-19 multiple approach should be adopted to disseminate knowledge. In other countries like Nigeria, e-Learning was adopted to provide day-to-day update on COVID-19 management to the HCEs. All healthcare workers in either undesignated or designated health centers for COVID-19 treatment should be trained in handling COVID-19 cases. Proper education and training on

the appropriate use, removal, and disposal of all necessary PPE are vital to prevent reinfection.

Since the working environment was riskier higher wages and extra allowances were needed for boost HCEs motivation. This study has found that despite working beyond their call of duty during COVID-19, majority of African countries provided low compensation to HCEs. It is well known that earnings of /basic salary for HCEs in many African countries is low. Poor financial allowances were reported in Zimbabwe, Nigeria and Malawi. In other countries like Zimbabwe HCEs had to take industrial action to push for better pay. This finding is in line with the results of Ogunleye et al (2020) study on response to COVID-19 Across Africa. It was suggested that dependency of African countries on financial support from developed countries limited its ability to motivate its HCEs during the outbreak of COVID-19. Lack of better compensation was likely to compromise better health care delivery. On the contrary, lack of incentives did not deter HCEs from continue working as majority believed that they continued working because it was their duty and they wanted to save live.

Presenteeism and absenteeism were common feature among HCEs in Africa During COVID-19 pandemic. The result presented above indicates that majority of HCE continued working while ill. This finding support the Hunter et al (2021) who reported that HCEs with medical conditions continued working during COVID-19. Additionally, lack of willingness to work was rampant among HCEs during COVID-19 pandemic. This situation led to majority being absent from work presenting false reasons such as being tired or sick. This finding support the finding by Challener et al. (2021) who found that both hourly and salaried workers have more unscheduled absences influenza-like illness. This study suggests that during pandemics HCEs should be introduced to shorter working periods, regular breaks and rotating shifts to avoid absenteeism from work. Absence of HCEs from their workplace due to illnesses increased workloads leading to poor service delivery.

Limitations of the Study

The following aspects were identified as limitations to the current study. First, lack of empirical data from other countries such as Angola, Ivory Coast, Namibia and from war torn countries such as Mali, South Sudan and Libya limit the generalizability of the findings across the continent. Secondly, methods of respond to the COVID-19 pandemic taken by some countries in Africa such as Tanzania and Burundi limits availability of detailed data on HCEs experience with COVID-19. For example, secrecy stance around covid-19 adopted by Tanzania government affected research on COVID-19. Much of the information available from Tanzania are the work of journalists which are too narrow and lacks detailed information. No specific empirical study available on HCEs experience with COVID-19 pandemic. We are therefore admitting that the current study used low-level evidence materials. Thirdly, majority of studies adopted a cross-sectional, online survey method, which was likely to limit response rate and biased sample.

Conclusion

This scoping review focused on presenting evidence on HCEs experience with COVID-19 pandemic across Africa from human resource management perspective. The reviewed data shows that while some studies found that majority of HCEs who were infected with the virus continued working while ill, other studies established that there was high absenteeism among

HCEs. On the issue of recruitment, studies established that there were shortage of staff in hospitals and treatment centers hence increased workload, which in turn affected treatment of the sick. Furthermore, whereas some studies reported that HCEs received training on COVID-19, other studies found that HCEs did not receive any training related to COVID-19. The study also found that HCEs were poorly compensated including delay in payment of allowances and poor staff welfare. On the other hand, while some studies reported that HCEs experienced high support from their families, other studies found that majority were unable to cope between work and family issues resulting into high stress and anxiety

A valuable lesson can be drawn from these findings. African governments should adopt strategies that protect HCEs from challenges arriving from pandemic outbreaks. Adoption of HR practices in the work places that safeguard HCEs, and strong collaborative management for policy and programs implementation is likely to reduce infection and mortality among HCEs across Africa.

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