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Qualitative Analysis of Quality of Life of Frontline Health Care Workers During Covid-19 Pandemic in Lagos State

Gbenga-Epebinu, Mary Ayodeji
Department of Nursing, Faculty of Basic Medical Sciences, Ekiti State University, Nigeria

Ayorinde, Adebola Margaret
Nephrology Unit, ABUAD Multi-System Hospital, Ado – Ekiti, Ekiti State

Olaitan, Oluwakemi Tinuke
Renal Care Center, Nursing Department, University of Ilorin Teaching Hospital, Ilorin, Kwara State

Osagie, John T.
Winston Churchhill School, Gainsborough Road Potomac MD, USA

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ABSTRACT: *Frontline health care workers seem to be the most affected category of people during any pandemic. Therefore, the study assessed quality of life of frontline health care workers during COVID-19 pandemic outbreak in Lagos State. This study adopted descriptive phenomenology research design. An interview guide was used to determine quality of life of frontline healthcare workers. The sample consisted of 14 interviewees while qualitative data collected were subjected to thematic analysis. The result of findings revealed that frontline health workers experienced fatigue, discomfort, helplessness, fear and concern for COVID-19 patients, and traumatic experiences. Findings further revealed that there was too much workload at a time because of the increased COVID-19 patient compared to the available volunteers, fear of contracting the virus, the joy of seeing their patients getting well and reuniting back with their families. It was recommended among others that the welfare of health care workers should be put as priority in Lagos State and Nigeria in general as this may discourage brain drain causing limited number of frontline healthcare workers available during outbreak of infectious disease.*

KEYWORDS: quality of life, front line, health care workers, Covid-19

INTRODUCTION

The novelty of Coronavirus infection makes it a scourge that is sweeping across continent increasing frequency of zoonotic spillovers leading to human infections and transmission. Bhagavathula and Shehab (2020) submitted that COVID-19 is among the deadliest infectious diseases to have emerged in recent history, like other pandemics, the mechanism of its emergence remains unknown. Official names have been announced for the virus responsible for COVID-19 (previously known as 2019 novel Corona virus) and the disease it causes (WHO, 2020a). The official names are COVID-19 caused by SARS-Cov 2. The reason for the name of the virus is that the virus is genetically related to the corona virus responsible for the SARS

outbreak in 2003, though related the two viruses are different. Coronavirus is a respiratory virus known to cause illness such as common cold, headache, breathing problem and severe acute respiratory syndrome. Coronavirus can be transmitted from animal-to-human and human-to-human. The coronavirus is spread from human to human through feco-oral, droplets and direct contact with an incubation period of 2-14 days (Baud, et al., 2020).

The high prevalence of COVID-19 in the general population of many countries, its novelty and highly infectious nature, and the associated morbidity and mortality rates are placing an unprecedented demand on health and social care services worldwide. In addition to the admission to hospital of high numbers of critically ill patients, care demands on nurses and care assistants have also increased.

Volunteers played a major role in the early days of the palliative care movement. They continue to be involved in the provision of palliative care, both in the community and in institutional settings. Although family and professional healthcare workers provide the majority of end-of-life care, volunteers take up several roles, for example, assisting with recreational and social programmes, visiting patients, taking them out and providing companionship and support. These tasks are considered as core to providing quality palliative care. Previous studies show that volunteers can positively influence the quality of care for both the person who is dying and those close to them by reducing stress, offering practical and emotional support and providing a link to the community (Quill & Abernethy, 2013).

Nurses, as a major population of healthcare professionals serving in the COVID-19 pandemic, continue to serve in diagnosing, treating and caring for patients for weeks with limited resources (Newby, et al., 2020). In collaboration with other healthcare professionals, nurses' skill, competence, compassionate care can help prevent the patient's functional decline, eliminate knowledge deficits for the patient and family, and promote their engagement in health care thus leading to care satisfaction (Melissa, 2015). Nurses are the frontline healthcare professional that patient meet up with, spend the highest amount of time with and rely upon for recovery during hospitalization, they play a prominent role in determining the overall satisfaction of patient's hospitalization experience (Vincent & Creteur, 2020).

The nature of care itself and new ways of working are potentially highly stressful for staff. Caregivers are not only experiencing an increase in the volume and intensity of their work, but are to accommodate new protocols and a very "new normal." For instance, many mental health services have transformed almost overnight from providing face-to-face care and treatment to a predominately virtual service of telephone or video consultations. In many other areas, caregivers are adjusting to providing end-of-life care more frequently and often in the face of more rapid deterioration than they are used to.

During outbreaks, any individual may be affected emotionally as is happening during the COVID-19 crisis. Everyone reacts or responds differently to stressful situations. How a person responds to the outbreaks is influenced by individual background, the differences compared to others, and the community they live in. It is common for individuals to feel stressed, worried and anxious. Fear and anxiety about COVID-19 can be overwhelming and cause strong emotions in an individual.

Caregivers are likely to experience moral and ethical conflict with the potential for stress and moral distress or moral injury (Bridges, 2013; Greenberg, et al., 2020; Morley, et al., 2019). These stressors are present across settings in health and social care, and relevant to all members of the nursing team, including care

assistants and temporary members of the team drafted in from their studies or from retirement. There is also an emerging narrative of guilt and some of potential shaming among caregivers and students who are unable to contribute to direct patient care due to their own high risk and vulnerability to coronavirus.
Infection control interventions, full or partial quarantines, social distancing regulations and restrictions on meetings are among these measures. However, while they have reduced the pandemic's levels of mortality and morbidity, they have caused social isolation and stigma (Xiang, et al., 2020). Studies conducted by Kim (2018) and Xiang, et al. (2020) have found that such situations caused healthcare workers to prefer social isolation, to feel guilty and to prefer living in a dormitory that limits their contact with the outside world (Kim, 2018; Xiang, et al., 2020).

Loneliness experience by caregivers together with poor quality social relationships have been associated with self-reported poor sleep quality and day time dysfunction (Jacob, et al., 2016). Other stressors evident from research to date include concerns about shortages of staff and of personal protective equipment (PPE), navigating an unfamiliar setting or system of care and lack of organisational support (Kim, 2018). Additionally psychological conflicts between healthcare workers' responsibility to care for the ill and their right to protect themselves from a potentially lethal virus were reported (Chen, et al., 2015).

Quality of life is subjective, it includes both positive and negative facets of life and is multidimensional in nature. Quality Of Life (QOL) is defined as how individuals perceived themselves in life in the context of the way they live and value the life they are living in relation with how they meet up with their goals, expectations, standards and concerns"(Nazarpour, et al., 2018). Health care workers especially volunteer caregivers are at high risk of infection and are also fearful. Meanwhile, they have great burdens in clinical treatment and public prevention. High expectations, lack of time, skills and social support may cause occupational stress, and stresses and challenges can lead to anxiety, post-traumatic stress disorder, great distress, and burnout or physical illness. As a result, they may not be able to provide high-quality medical services and may even quit the job. COVID-19 is highly infectious, which make caregivers even more worried about their family members, subsequently making them more anxious, stressed and more inclined to adopt negative coping methods. Inadequate training in infection control, lack of knowledge and unclear specific tasks increased perceived personal risk and reduced willingness to work. Protection training can help to understand the nature of infectious diseases, standardize protection measures, enhance confidence, and improve caregivers' compliance with infection control measures, thus reducing the risk of disease transmission. Protection training is necessary, especially for the highly infectious COVID-19 (Jiang, 2020; Khalid, et. al., 2016).

Thus, the degree of burden experienced by the caregiver is an important concern. It has been shown that the more time the caregiver spends doing tasks for the patient, the more the caregiver's schedule is altered and the more the caregiver experiences emotional distress and suffering. It also has been shown that providing emotional support for the patient and others is perceived to be among one of the more difficult tasks for the caregiver (Adams & Walls, 2020; Liu et al., 2020).

Sun, et al., (2020) reported that caregivers' normal working hours and workloads have increased by approximately 1.5–2 times due to the COVID-19 outbreak (Sun et al., 2020). Caregivers caring for COVID-19 patients have been reported to be at risk for various mental problems later in the pandemic (World Health Organization, 2020; Xiang, et al., 2020). Thus, monitoring caregivers' mental problems and implementing early intervention methods, such as professional psychological counselling and strengthened crisis support

systems, are recommended (Chevance, et al., 2020; Liu, et al., 2020). The main aim of this study was to conduct a qualitative study on quality of life of frontline health care workers during covid-19 pandemic in Lagos State.

METHODOLOGY

This study adopted descriptive phenomenology design. The population of the study consisted of volunteered frontline healthcare workers during covid-19 pandemic in Lagos state. There were several facilities earlier but presently because of the earlier flattened curve of the COVID-19 cases in Lagos-state, few were still functioning. Volunteered frontline healthcare workers who made themselves available for the face-to-face interview and consented were included in the study.

Purposive sampling technique was used for the selection of volunteered frontline healthcare workers for face-to-face interview. A purposive sampling in a qualitative study is a method of sampling in which typical cases are sought and selected for the study. According to Frels and Onwuegbuzie (2013), the sample usually composed of elements that contain the most characteristics, that are representative, and that demonstrate attributes of the population that serve the purpose of the study best. The researchers had some challenges with the required number of volunteered frontline healthcare workers. 14 volunteered frontline healthcare workers were used due to poor staffing, and had to use only the available number of volunteered frontline healthcare workers on the ground that were willing to participate in the study.

This study utilized self-structured interview guide to elicit information about their experiences while working on the frontline of the COVID-19. To ensure the integrity in which the study was conducted and the credibility of findings in relation to qualitative research, responses validation and reflexivity was applied during interview and analysis. Audio-taped interview was transcribed and typed field notes was compared to identify omissions and to ensure that the data on the audio tape are captured accurately in the text. The text was put into a two column table format (first column for text and second column for making notes).

The qualitative data analysis was done using thematic content analysis and by carrying out immediate debriefing after each interview discussion with the observer and a debriefing note was taken. The debriefing note includes comments about the process of the interview and the significance of data. All Non-verbal communication, gestures and behavior were noted Also audio recordings was listened to and the content was transcribed verbatim according to themes and footnotes were compared with audio transcription. The transcript was coded by going through the transcript line by line and paragraph by paragraph, to find significant statements and codes.

Qualitative Analysis of Data Collected (14 interviewees)

They were all single, between the ages of 23 and 30, 12 were Christians and 2 were Muslims.

A 24year old hygienist said ‘I came out to be a volunteer because of my interest in infectious control and my desire to give back to the nation’.

The 30 year old medical Dr said ‘I desire to join the team so as to stem the tide of the ravaging pandemic’.

The 30 year old nurse said “this is not her first time volunteering, that helping and volunteering is her passion’.

The 28 year old male nurse said’ I volunteered so as to gain more knowledge and experience on COVID-19.

On adequacy of PPE, oxygen, drugs; only two hygienists complained of inadequate PPE in their center, other participants reported enough PPE, oxygen, drugs, N95 facemasks among others in their centers.

Welfare of volunteers

Accommodation and meals were provided in each facility as reported by all the volunteers, though remuneration is good, it can be improved upon.

Experience; On their experiences, it had been good, bad and ugly. It has been overwhelming and stressful. There was too much workload at a time because of the increased COVID-19 patient compared to the available volunteers, fear of contracting the virus, the joy of seeing their patients getting well and reuniting back with their families.

People see me as super Hero says an hygienist and Dr, "especially when I feed them with right information on COVID-19. There were many rumors and misconceptions flying round, the limited time I spend on break time was to answer questions on my social media wall about COVID-19, they believe my responses because I am right there in the battlefront".

I ensure strict safety precautions till I was nicknamed "Madam Safety" says a nurse. "I disinfect my environment, I have my sanitizer with me always to clean and always with my face mask when in crowded place". "The challenges I encountered were staying in isolation, missing my loved ones, my mental health was affected because of my disruption of normal life".
A medical Doctor said exhaustion while wearing the PPE, loneliness and been cut off from the world were really killing.

On quality of life

A single nurse said her mother was scared when resuming as a volunteer. In her words "special prayers from family members as support, little minutes spent on social media is for bonding via video calls with relatives and friends and even humorous COVID-19 front-liner team".

All the health care workers submitted that they experienced reduced energy and mostly drenched while sweating under PPE. They also submitted that high rate of death was a toll and drained their mental health seriously as verbalized by all the interviewee.

Some of the health care workers accepted that there was mixture of fear and adrenalin rush in their system at first when they started as a volunteer but later coped with the situation.

All the caregivers submitted that they experienced increased symptoms of depression, anxiety, psychosomatic symptoms, restrictions of roles and activities, strain in marital relationships, and diminished physical health

None of the interviewee contracted the virus, they boosted their immunity with fruits, vegetables and bed rest. One of the female nurse particularly said that "there was decrease in my energy but as soon as I rest, I regained it back says a female nurse".

DISCUSSION OF FINDINGS

Findings from qualitative analysis revealed that there was too much workload at a time because of the increased COVID-19 patients compared to the available volunteers, fear of contracting the virus, the joy of seeing their patients getting well and reuniting back with their families. In line with the findings of Hiu et al (2019), the caregivers caring for COVID-19 patients felt extreme physical fatigue and discomfort caused by the outbreak, intense work, large number of patients, and lack of protective materials. The physical exhaustion, psychological helplessness, health threat, lack of knowledge, and interpersonal unfamiliarity under the threat of epidemic disease led to a large number of negative emotions such as fear, anxiety, and helplessness, which have been reported by several studies (Liu, et al., 2019, Kang, et. al., 2020; Xiang, et. al., 2020).

Findings from the qualitative analysis also revealed that most of the frontline health workers had reduced energy and mostly drenched while sweating under PPE. Also, high rate of death was a toll which really drained their mental health seriously as verbalized by all the interviewee. Studies conducted by Kim (2018) and Xiang, et al. (2020) affirmed the position of this finding as they found that the quality of life of frontline health workers is always affected by pandemic outbreak. They found out that such situations caused healthcare workers to prefer social isolation, to feel guilty and to prefer living in a dormitory that limits their contact with the outside world (Kim, 2018; Xiang, et al., 2020).

CONCLUSION

Sequel to the findings of this study, it is concluded that most of the respondents' frontline health workers experienced fatigue, discomfort, helplessness, fear and concern for COVID-19 patients, traumatic experiences too much workload, fear of contracting the virus, the joy of seeing their patients getting well and reuniting back with their families.

Recommendations

Based on the findings of this study, the following recommendations were made;

1. There should be continuous training of health care workers on how to manage and curtail infectious disease outbreak
2. The welfare of health care workers should be put as priority in Lagos State and Nigeria in general as this may discourage brain drain causing limited number of frontline healthcare workers available during outbreak of infectious disease

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