



Caring on the Frontline during COVID-19

Contributions from Rapid
Qualitative Research

Edited by
Cecilia Vindrola-Padros
Ginger A. Johnson

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Caring on the Frontline: An Introduction

Cecilia Vindrola-Padros and Ginger A. Johnson

In December 2019, the first COVID-19 case was confirmed in Wuhan, China. This would be followed by weeks of uncertainty and reports that the virus had spread to other countries. As cases started to rise around the world, we all became witnesses to the palpable strain the increase in hospital admissions created on healthcare systems around the world. Photos of exhausted healthcare workers (HCWs), with bruises produced by masks and visors, flooded the media. In many countries, the general public made an effort to recognise the work of hospital workers by clapping and posting thank you messages.

As the virus spread to more countries and the pandemic evolved to include multiple epidemiological waves, frontline staff continued to bear the brunt of the uncontrolled spread of the disease. Not all healthcare workers were valued and cheered and many reported difficult encounters

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with the general public (e.g. heated arguments and physical aggression) due to fears that they would be ‘carriers of the virus.’ Many were physically removed from public areas and even evicted from their homes. As personal protective equipment (PPE) shortages were denounced around the globe, HCWs feared they had become disposable and many called on their governments to change the course of action, improving preventive measures and investing in healthcare systems’ most precious resource—its workforce.

In many ways, the COVID-19 pandemic illuminated fractures of healthcare systems around the world, perhaps especially those located in the global North once considered to be among the best examples of functioning healthcare. As governments scrambled to contain and deal with the impact of this rapidly spreading virus, the effects of decades of budget cuts, understaffing, fragmentation and inequalities in access to care could no longer be denied.

This book is a testament to the experiences of frontline healthcare workers delivering care during the COVID-19 pandemic. It paints a global picture of the uncertainty, struggle, fears and hopes of the millions of doctors, nurses, community health workers, therapists, cleaners, porters and managers who worked tirelessly to respond to the demands created by the virus. These experiences are understood and analysed in relation to global trends, epidemiological ‘waves’ and local contextual factors. The book maps these experiences across different stages of the pandemic, including the anticipation and preparation for the impact of the virus while looking afar at the damage it had produced in other countries, to planning for the long-term consequences the pandemic had on populations and healthcare systems—and the stark realisation that COVID-19 ‘is not going away.’

The book is an unusual edited volume in the sense that the content was created by a global network of research teams composed mainly of social scientists who worked collaboratively since the early stages of the pandemic to share study protocols, materials, problems and solutions. The network was developed by the Rapid Research Evaluation and Appraisal Lab (RREAL), with headquarters in University College London in the United Kingdom (UK). The UK team was the first team to design and implement a rapid appraisal on the experiences of healthcare workers delivering care during the COVID-19 pandemic in March 2020. This team then began to contact research teams in other areas of the world, asking them if they wanted to ‘replicate’ the study (with modifications required for the local context) and join a global network of teams carrying

out a series of ‘mirror studies.’ The network grew rapidly and, at one point, teams from 22 countries were replicating at least one aspect of the study. The network met regularly to discuss emerging findings from the study and paint a global picture of the experiences of healthcare workers. This book is an attempt to bring this extensive knowledge base together, reflecting on the similarities and differences of the experiences of healthcare workers at a global scale.

The authors represented within this book felt that the challenges posed by a pandemic which affected HCWs and systems of care in every country in the world, demanded a cross-cultural representation of shared vulnerability and responsibilities. The book can be seen as a journey into the lives of healthcare workers that were shaped by their governments’ response to the pandemic through the development of public policies and guidelines, changes in their clinical roles and care delivery practices, and the emotional and psychological impact of working long hours and encountering death on a daily basis. The journey is shaped by the exacerbation of pre-existing inequalities in access to care in the case of patients, but also in relation to the working conditions of staff, where gender, social class and ethnicity interlaced to increase the risk of infection and death in HCW populations of lower socio-economic status and from minority ethnic groups.

The book is also a journey into the lives of the research teams that made this global network possible, as it reflects on the challenges of carrying out qualitative research in the context of a pandemic. These research teams adopted approaches from the field of rapid qualitative research that allowed them to quickly set up studies, analyse data during successive waves of data collection and share emerging findings with relevant stakeholders (so that findings could be used to inform response efforts). These journeys were shaped by delays generated by ethics review committees, restrictions that prevented access to medical facilities and staff, limited budgets for research and the pressures researchers were facing in their own lives (uncertainty, fears, childcare issues, illness and bereavement).

In the following pages, this introductory chapter sets the scene that framed the development of this book. It provides a close look at the global context of care delivery during the COVID-19 pandemic, drawing lessons from previous epidemics. It then describes how our research sought to document these experiences, teasing out the key messages for public health authorities, UN and non-governmental organisations, think tanks and other research teams we collaborated with to make sure the research

findings were actively used. The chapter ends with an overview of the book by describing the content of chapters that cover public policy, mental health and wellbeing, feeling protected and protecting others, resource scarcity, end of life, clinical uncertainty, inequalities, religious interpretations of illness and care, the knock-on effects on other conditions and areas of healthcare systems, and the long-term consequences of the pandemic.

WORKING DURING AN INFECTIOUS EPIDEMIC: A GLOBAL LOOK

The current global pandemic may feel like an unprecedented series of events for which HCWs and the systems they work for could not have predicted nor prevented. However, we do have many examples, both historic (e.g. influenza pandemic in 1918) and more contemporary (e.g. SARS-CoV in 2002–2003, H1N1 in 2009, MERS-CoV in 2012, Ebola in 2014, Zika in 2016) of sudden outbreaks of infectious disease and their impact on local health systems and human resources.

In this way, HCWs have a history of being at risk, and oftentimes the ‘canary in the coalmine,’ for infectious diseases. Surveilling infections among HCWs is in fact a key component of event-based surveillance (EBS) during the ‘alert’ phase of a pandemic. Data from two global viral infectious disease outbreaks on the spectrum of Coronaviruses which have occurred within the last two decades—SARS and MERS—is telling. For the SARS outbreak which began in November 2002 in Southern China, the number of HCW infections globally was over 21%. The largest numbers of SARS-infected HCWs were in China, with a significant minority of infections reported in health staff in Canada, France, Germany, the Philippines, Singapore, Thailand and Vietnam (Xiao et al. 2020). For the MERS outbreak which began in June 2012 in Western Saudi Arabia (and in which new cases have arisen periodically since), the number of HCW infections reported from 2013 to 2020 has fluctuated depending on season, but with the highest reported peak comprising 32% of total infections (peaking in 2014 and again in 2015). The largest numbers of MERS-infected HCWs have been from Saudi Arabia and, to a lesser extent, South Korea (WHO 2020a; Xiao et al. 2020).

A meta-analysis of HCW occupational acquired infections from the novel influenza A outbreak (H1N1) of 2009, as first reported in Mexico