






# Preparedness and Responses of Healthcare Providers to Combat the Spread of COVID-19 Among North Shewa Zone Hospitals, Amhara, Ethiopia, 2020

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**Background:** Coronavirus disease 2019 (COVID-19) is an emerging respiratory disease that is caused by a novel coronavirus and was first detected in December 2019 in Wuhan, China. The disease is highly infectious, and its main clinical symptoms include fever, dry cough, fatigue, myalgia, and dyspnea. Healthcare providers are in front in fighting the coronavirus spread by making themselves the risk of contracting the disease.

**Objective:** To assess the preparedness and responses of healthcare providers to combat the spread of COVID-19 among North Shewa Zone Hospitals, Amhara, Ethiopia.

**Methods:** Facility-based cross-sectional study was conducted from April to May 2020 among 422 healthcare providers in the North Shewa Zone, Amhara, Ethiopia using a self-administered questionnaire. Study subjects were selected through systematic random sampling based on their proportional distribution of sample size to each hospital. A structured questionnaire was used to collect the data. The data were coded and entered into the Epi data 4.2.1 version and the analysis was carried out in Statistical Package for Social Science 25 versions.

**Results:** Four hundred four participants involved in the study have been given a response rate of 95.7%. The self-satisfaction of healthcare providers revealed 301 (74.5%) of study participants feel unsafe in their workplace. Two-third, 260 (64.4%), of them responded that they feel anxious while working with febrile patients. Nearly one-third (31%), 27.4%, 15.9%, 14.5%, 14.2% of HCPs had access to gloves, facemask, goggle, shoe, and apron respectively in hospitals.

**Conclusion:** Protecting healthcare workers is a public health priority. Access to essential personal protective equipment during the COVID-19 pandemic was limited. The poor perception of healthcare professionals about not having enough support from medical institutions and public health authorities raises the need to urgently implement strategies to protect healthcare workers in the time of the COVID-19 pandemic.

**Keywords:** coronavirus, preparedness, responses, healthcare provider, North Shewa

## Introduction

In human history in 1918 Spanish flu was the reason for 50 million or more deaths. It has been the benchmark for other pandemics and emerging diseases. Another growing epidemic of novel coronavirus infectious disease (Covid-19), which is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Coronaviruses comprise a

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large family of viruses that cause respiratory and intestinal infections in animals and humans, including the Middle East respiratory syndrome (MERS) and SARS. SARS first emerged in the Guangdong province, China, causing the 2002–2003 epidemic. Since mid-December 2019, several cases of a pneumonia-like disease (with symptoms including fever, difficulty in breathing, cough, and invasive lesions on both lungs) of unknown cause have emerged in the central Chinese city of Wuhan.<sup>1,2</sup>

During this pandemic period mental health services with other countries affected by the COVID-19 pandemic, in a different population, vulnerable groups of the communities like elderly individuals, survivors of COVID-19 infections as re-infection is high, and frontline healthcare providers need proper psychological support. And sufficient guidance and counseling are essential, especially in the developing world. With a timely and close collaboration with different nations and institutions, the mental health challenges caused by the COVID-19 pandemic can be adequately addressed.<sup>3</sup>

Globally, there have been more than nearly 6 million confirmed cases, and more than 357,000 registered deaths. On March 3, 2020, the first patient with COVID-19 was detected in Addis Ababa, Ethiopia. From then until May 28, 2020, another 831 COVID-19 cases were identified in Ethiopia.<sup>4</sup>

Healthcare providers are in front in fighting the coronavirus spread by making themselves the risk of contracting the disease. Keeping the well-being in the working environment for a healthcare provider and an effective plan is essential in each phase of a pandemic.<sup>5</sup>

As the coronavirus pandemic rises, trained health providers are a key resource to combat the infection. They are the main priority in many countries, but those healthcare providers have many concerns during this period like availability of necessary equipment's in addition to this they have great concerns for their safety as well as their families because they are worried about transmitting the infection to their family members.<sup>6</sup>

In Africa, the COVID-19 pandemic is rampantly is rising today, even though, there are key constraints to avert the progression of the pandemic, especially in human resources and shortage of personal protective equipment (PPE). In the area of limited or shortage of protective equipment, the risk of COVID-19 infection and dying will be high among frontline healthcare providers this will be a huge blow for countries and healthcare providers as a whole for all communities. Africa is known

with limited resources, weak health system which will be made double burdened. As a result, the government is expected to full fill the necessary equipment and keep the safety of healthcare providers.<sup>7</sup>

Personal protective equipment is the main protection for healthcare providers specifically if the virus spreads to the community, as the numbers of patients with unknown contact history. In addition to this Safety of workplace and fulfillment of Standards for protection, furthermore training how to use and remove personal protective equipment is needed to increase preparedness.<sup>8</sup>

Healthcare providers are in the front line to face COVID-19 outbreak and as a result, they are at greater risk of exposure to bio-hazards that put them at risk of infection with an outbreak pathogen (COVID-19). Hazards include pathogen exposure, long working hours, psychological distress, fatigue, occupational burnout, stigma, and physical and psychological violence.<sup>9</sup>

As the world is being hit hard by coronavirus disease 2019 pandemic, healthcare systems of countries in the world became stunned with a high demand for infectious patients' needs testing and care. Averting coronavirus pandemic infection is on the hands of healthcare workers (HCWs) and patients rely on the effective use of personal protective equipment (PPE). A serious shortage of all of this equipment is expected to develop or has already developed in areas of high demand. So, an increased demand for PPE relies on continuous and reliable supply as the hospitals are overwhelmed by a rapid increase in ill COVID-19 patients.<sup>10</sup>

The findings of this study will help in many aspects such as, better planning for awareness campaigns, guide different health authorities accordingly to modulate their policies as needed and to correct some untoward behaviors to stop the spread of the virus which may result in rapid control and containment of the ongoing pandemic. Therefore, this study aimed to assess the preparedness and responses oh Healthcare providers in tackling the spread of COVID-19 among healthcare workers at North Shewa zone hospitals.

## Methods

### Study Design, Setting, Area and Population

The institution-based cross-sectional study design was conducted in North Shewa zone hospitals, Amhara Regional State, Ethiopia from April to May 2020. North

Shewa is one of the zones in the Amhara regional state. North Shewa has 11 primary Hospitals (of which the two are private Hospitals) and one comprehensive specialized hospital. According to zonal health Department data, more than 2000 healthcare worker provider serves around 3 million people in North Shoa Zone.

All healthcare providers who were working in hospitals at the North Shewa zone were source population whereas, all healthcare providers who are working in selected hospitals of North Shewa Zone during the study period were the study population. Selected healthcare providers in selected hospitals working in the Hospitals of North Shewa Zone were study units.

### Eligibility Criteria

All health professionals working in the selected hospitals were included in the study whereas healthcare providers who were seriously ill and annual leave excluded from the study.

### Sample Size Determination

The sample size was calculated using a single population proportion formula with an assumption of 95% confidence level, marginal of error 5%, and 50% proportion

$$n = Z(\alpha/2)^2 p(1 - p)/d^2$$

where n = minimum sample size:

Z ( $\alpha/2$ )<sup>2</sup>= 95% Confidence level:

P = proportion of healthcare provider preparedness and responses in tackling spread of COVID-19 P = 50% since there is no previous study

D =5% margin of error

In which n= [(1.96)<sup>2</sup> (0.5) (1-0.5)]/(0.05)<sup>2</sup>

=384 adding 10% non-response rate; n=422.

### Sampling Technique and Procedure

North Shewa Zone has 12 Hospitals, among these 5 Hospitals (Ataye District Hospital, Debre Berhan Referral Hospital, Deneba District Hospital, Yifat General Hospital, Arerti Primary Hospital) were selected by lottery methods. In 5 selected hospitals the total number of Healthcare providers was 860. Then, the possible number of respondents in each of the Hospitals of the study area were allocated proportionally based on the number of Health workers. Four hundred twenty-two study participants who fulfill the inclusion criteria were selected by systematic random sampling every two intervals (860/422 = 2) using the list of the workers from each hospital by using the monthly payroll as a sampling frame.

### Data Collection Tools and Procedures

The data were collected through a self-administered questionnaire and observation for the practice of standard precaution in fighting against COVID-19 pandemic using checklists. The questionnaire was distributed to the participants by the principal investigators responsible for data collection. The principal investigators also responsible for the respondents with explanations when requested by the respondents. The data collection tool was designed from risk communication and community Engagement action plan guidance of WHO COVID-19 preparedness and response and related literature.<sup>11,12</sup> Participants from all healthcare professions were selected for the study. The questionnaire was divided into 2 parts. The first part comprised of demographic information of the respondents. The second part assessed the preparedness of healthcare care providers with 26 items of question. Their response was evaluated with four domains: strongly agree, agree, disagree, strongly disagree response. The 3rd part determined the personal protective equipment availability towards COVID-19 with 5 items of the question with a yes-no response.

### Data Quality Assurance

The data collection tool was pretested three days before the actual data collection on 5% of the calculated sample size of 21 healthcare providers on Debre Sina primary hospital and necessary adjustment was made. The collected data were checked for completeness, accuracy consistency, and clarity. Consistency has been examined through a random selection of questionnaire. Codes were given to the questionnaire and participant during data collection so that any identified errors were get traced back using the codes.

### Data Analysis

Before analysis, data were cleaned and coded. Identified errors during this time were adjusted after a review of the original data using the code numbers. Data were entered using Epi-Data version 4.2.1 and analyzed using SPSS 25 statistical software. The descriptive analysis runs first with proportion and summary statistics to describe the study population concerning relevant variables by considering statistical assumptions. Socio-demographic profiles of variables frequency distribution, summary measures such as mean and standard deviation was calculated for outcome variables. When frequencies become smaller than

expected, variables were re-categorized or merge of the levels was done. Finally, results were presented in the form of tables and graphs.

## Result

From a total of 422 samples, 404 healthcare workers completed the questionnaire with a response rate of 95.7%. Of them, Nurses 166 (41.1%), physicians 77 (19.1%), midwives 60 (14.9%), laboratory technicians 39 (9.7%), pharmacists 29 (7.2%), and other professionals 33 (8.2%). Nearly half of the 207 (51.2%) were in the age group between 25 and 29 years with a mean age of 29.1  $\pm$  5.2 years and more likely to be males (63.1%). Above half of them had work experience of fewer than five years (64.1%). Nearly half of them were single 213 (52.7) and more likely to be orthodox 360 (89.1%). More than two-thirds of HCPs was a first degree in level of education (Table 1).

## Preparedness of HCPs

Assessment of self-satisfaction of healthcare providers revealed that nearly three-fourth 301 (74.5%) of study participants feel unsafe working in their working place. Two-third of 260 (64.4%) of them responded that they feel anxious while working with febrile patients (Table 2).

## Personal Protective Equipment

Nearly one-third 111/358 (31%) and more than one-fourth 98/358 (27.4%) of HCPs had access to gloves and face-masks in hospitals, respectively (Figure 1).

## Discussion

This study assessed preparedness and responses of the healthcare provider in tackling the spread of COVID-19 among healthcare providers working in hospitals of the North Shewa zone. Nowadays, humankind in the world is facing devastating COVID pandemic which needs all institutions, communities, organizations both governmental and non-governmental organizations need to collaborate to avert the progression of the diseases. As a result, research to find a new way to combat it, and we are urged to conduct research.

## Preparedness and Emotions of Healthcare Providers

During a catastrophic global pandemic such as the COVID-19, it is common for every person to experience

**Table 1** Shows Socio-Demographic Characteristics of Healthcare Providers Among North Shewa Zone Hospitals, Amhara, Ethiopia, 2020 (N= 404)

Character		Freq.	Percent
Age	20–24	50	12.4
	25–29	207	51.2
	30–34	99	24.5
	>34	48	11.9
Sex	Male	255	63.1
	Female	149	36.9
Work experience	≤5	259	64.1
	>5	145	35.9
Level of education	Diploma	98	24.3
	Degree	285	70.5
	Masters and Specialist	21	5.2
Marital status	Married	187	46.3
	Single	213	52.7
	Others*	4	1
Religion	Orthodox	360	89.1
	Muslim	26	6.4
	Others	18	4.4
Profession	Physician's	77	19.1
	Nurses	166	41.1
	Midwives	60	14.9
	Pharmacy	29	7.2
	Laboratory	39	9.7
	Others**	33	8.2

**Notes:** Others\*= widowed and separated. Others\*\*=Psychiatrist, Anesthesia, Ophthalmic nurse.

intense suffering from anxiety depression, predominantly as a result of social isolation. Physicians, nurses, and other frontline healthcare professionals are particularly exposed to negative mental health effects during caring for patients. The ongoing COVID-19 pandemic is also taking a massive toll on the mental and emotional well-being of front-line healthcare workers around the world. Healthcare providers will suffer longer duration shifts, work-life balance disturbances and worries about taking the disease relatives will be led to intense stress and anxiety, physical and mental fatigue, and burnout for this group of individuals. Besides, healthcare providers concerned about their well-being and their families and friends. As a result of the COVID-19 pandemic, many healthcare providers are facing physical separation and increased in care demands, equipment shortages, and the higher risk of COVID-19 infection. These factors can all lead to decreased mental stability and will increase the chance of stress and anxiety.

**Table 2** Preparedness of Healthcare Providers in Combating Spread of COVID-19 in the North Shewa Zone Hospitals, Amhara Ethiopia, 2020 (N= 404)

Variable		N	%
I feel unsafe in working at my workplace	Agree	301	74.5
	Disagree	103	25.5
I feel anxious while working with febrile patients	Agree	260	64.4
	Disagree	144	35.6
I feel at risk to contract COVID-19 infection at work	Agree	345	85.4
	Disagree	59	14.6
I feel obliged to care for COVID-19 infected patients	Agree	289	71.5
	Disagree	115	28.5
I felt hopeless I might eventually get COVID-19 at work	Agree	191	47.3
	Disagree	213	52.7
I feel threatened if one of my colleagues contracted COVID-19	Agree	262	64.9
	Disagree	142	35.1
If I get COVID-19, I do not feel confident employees care for me	Agree	187	46.3
	Disagree	217	53.7
I feel that I should limit my social activities due to COVID-19	Agree	339	83.9
	Disagree	65	16.1
I feel I will transmit COVID-19 to my family members	Agree	319	79.0
	Disagree	85	21.0
I feel that my family will avoid me since I work in a hospital	Agree	179	44.3
	Disagree	225	55.7
I feel I should avoid leaving my home due to COVID-19	Agree	177	43.8
	Disagree	227	56.2
I feel my family will not look after me if I will be infected	Agree	177	43.8
	Disagree	227	56.2
I do not feel confident in telling my family and friends if I am infected.	Agree	161	39.9
	Disagree	243	60.1
I feel that my institution did not support me the COVID-19 crisis	Agree	228	56.4
	Disagree	176	43.6
I feel my institution losing control of the COVID-19 crisis	Agree	240	59.4
	Disagree	164	40.6
I feel overwhelmed with the new COVID-19 regulations	Agree	260	64.4
	Disagree	144	35.6
I feel COVID-19 crisis increased my workload	Agree	274	67.8
	Disagree	130	32.2
I feel that the increased workload nor met with proper staffing	Agree	238	58.9
	Disagree	166	41.1
I feel absence from work reduce the chance of getting COVID-19	Agree	218	54.0
	Disagree	186	46.0

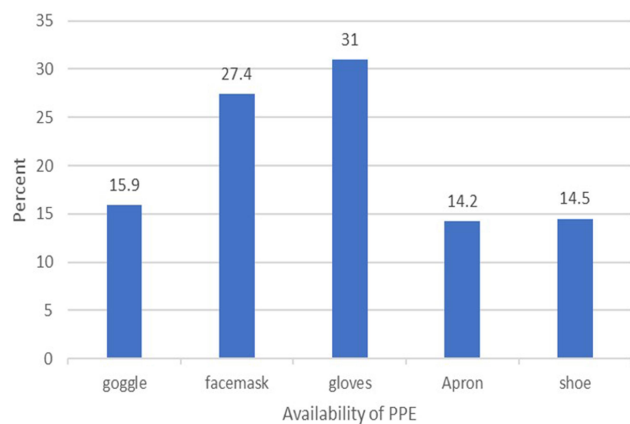
(Continued)

**Table 2** (Continued).

Variable		N	%
In case I have COVID-19, I feel ashamed of telling my manager/colleagues	Agree	141	34.9
	Disagree	263	65.1
I feel I should change my current job due to COVID-19 crisis	Agree	142	35.1
	Disagree	262	64.9
I am not confident with the current infection control measures	Agree	248	61.4
	Disagree	156	38.6
I do not feel proper infection control training has been offered to me	Agree	246	60.9
	Disagree	158	39.1
I do not feel an infection specialist is accessible to respond to my concerns	Agree	248	61.4
	Disagree	156	38.6
I do not feel there is COVID-19 outbreak plan set at my area	Agree	217	53.7
	Disagree	187	46.3
I do not feel safe at work when I use the standard precautions	Agree	219	54.2
	Disagree	185	45.8

Preparedness of healthcare provider assessed by 26-items of question. The self-satisfaction of healthcare providers revealed that nearly three-fourth 301 (74.5%) of study participants feel unsafe working in their working place. Two-third of 260 (64.4%) of them responded that they feel anxious while working with febrile patients. Nearly half 191 (47.3%) of the HCPs agreed that they are feeling hopeless they might eventually get COVID-19 at work. Two-third of HCPs 262 (64.9%) agreed that they feel threatened if one of their colleagues contracted COVID-19.

The majority of the HCPs 339 (83.9%) responded that they feel that they should limit their social activities due to COVID-19. Above three-fourth of HCPs, 319 (79%) agreed that they feel they will transmit COVID-19 to their family members. Below half of the 179 (44.3%) feel that their families will avoid them since they are working in hospitals. Above half 227 (56.2%) of the HCPs feel that their family will not look after them if they will be infected with COVID-19 and 177 (43.8%) agreed that if they are infected with COVID-19 their family will not look after them. Nearly two-thirds of 243 (60.1%) of the respondents did not feel confident in telling their family and friends if they are infected with COVID-19. More than half of the participants, 228 (56.4%) and 240 (59.4%) of HCPs agree that their institution did not support them and loses control in the



**Figure 1** Showing the availability of personal protective equipment's among health-care providers in the North Shewa Zone Hospitals, Amhara, Ethiopia, 2020. **Abbreviation:** PPE, personal protective equipment.

COVID-19 crisis, respectively. This finding is greater than from a study conducted in European Pediatric CoVID-19 Emergency Departments 39% agreed that the hospital was ready and prepared to handle COVID-19 at the time the outbreak (13). This might be due to differences in study time and ward. Our study was conducted lately and in all wards of the hospitals.

For HCPs in North Shoe Zone, safety from infection was the main concern. From this study 196 (76.9%) males, and 105 (70.5%) females feel unsafe in working place. In profession, majority of HCPs: midwife 50 (83.3%), 64 (83.1%) physician, 121 (72.9%) Nurses, 26 (66.7%) Laboratory, 11 (61.1%) pharmacy, and 29 (87.8%) reported they feel unsafe in working place.

## Availability of Personal Protective Equipment

The PPEs recommended by the World Health Organization for healthcare professionals performing aerosol-generating procedures are gown, respirator (N95) standard or equivalent, gloves, eye protection (goggles or face shield) and apron, while those providing direct care to COVID-19 patients should wear a gown, surgical mask, gloves and eye protection.<sup>13</sup>

As the coronavirus disease 2019 (COVID-19) pandemic risen, the world healthcare systems have become stunned with a potential shortage of personal protective equipment (PPE). Averting spread of infection to and from healthcare providers and patients depends on the effective use of PPE: gloves, facemasks, goggles, face shields, respirators, and gowns. A serious scarcity of these is expected to develop or has already developed in places of high demand. PPE, previously universal and throw

away in the hospital environment, is now a scarce and expensive resource in several regions when it is important the most care for highly infectious patients like COVID-19. In this facility-based cross-sectional study the availability of personal protective equipment in North Shewa Zone hospitals was 119 (29.5%). This finding is consistent with a study done in the USA.<sup>14</sup> Gloves 111 (31%), facemasks 98 (27.4%), goggles 57 (15.9%), gowns/apron 51 (14.2%), and shoe 41 (11.5%) PPE were available. The availability of PPE in north Shewa zone hospitals was much lower than a study conducted in Latin America which revealed that gloves (91.1%), gowns (67.3%), face masks (83.9%), and N95 masks (56.1%).<sup>15</sup> This might be due study time which was done early that healthcare providers could be conscious to use PPE and socioeconomic difference.

## Limitations

It was limited by a lack of published literature. Participants were asked to answer the preparedness of healthcare professionals. Recruitment of participants was based on their willingness to participate and access to social networking websites and applications; therefore, the study population does not encompass participants without those resources. Most of the responders may work in the hospitals of the different fields where the exposure to critical COVID-19 patients may be limited; therefore, their reality and perspective about COVID-19 could differ.

## Conclusions

Protecting healthcare workers is a public health priority. In this study of healthcare providers working in North Shewa zone hospitals. We are reported limited access to essential personal protective equipment during the COVID-19 pandemic. The poor perception of healthcare professionals about not having enough support from medical institutions and public health authorities raises the need to urgently implement strategies to protect healthcare workers in the time of the COVID-19 pandemic. As the pandemic continues, important clinical and policy strategies are needed to support healthcare workers. The study identified a vulnerable group susceptible to psychological distress. Educational interventions should target healthcare workers to ensure the understanding and use of infectious control measures. Ethiopian government especially the Ministry of health better allocates additional budget for health sectors. Personal protective equipment better to avail for healthcare providers in each hospital protects them from the

pandemic. Psychological support could include counseling services and the development of support systems among colleagues. In addition to funding additional budget and psychological support, the government should also provide infection prevention training, and minimize workload.

## Abbreviations

COVID-19, Coronavirus Disease-19; DB, Debre Berhan; HCP, Healthcare Provider; PPE, personal protective equipment; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

## Data Sharing Statement

Data support these findings are contained within the manuscript and will share upon request to the corresponding author.

## Ethical Approval

Ethical clearance was obtained from the Debre Berhan University Research Ethics and Publication Committee before conducting the study. Further permission was obtained from each hospital administration. Any information related to personal identification of the study participants was not recorded to maintain the confidentiality of the study. Written consent was obtained from all healthcare providers.

## Consent

The authors confirm that all caregivers provided informed consent forms.

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## Author Contributions

All authors made substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; took part in drafting the article or revising it critically for important intellectual content; agreed to

submit to the current journal; gave final approval of the version to be published, and agree to be accountable for all aspects of the work.

## Disclosure

The authors declare that they have no competing interests.

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