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A PHENOMENOLOGICAL ASSESSMENT OF THE IMPACT OF THE COVID-19 EPIDEMIC ON HEALTHCARE PERSONNEL IN INDIA AND THEIR VIEWS ABOUT THE FUTURE.

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ABSTRACT:
The COVID-19 pandemic has overwhelmed the global healthcare system, affecting healthcare workers (HCWs) in a variety of ways. The current study gives insightinto the psychological issues that HCWs confront in their career, family, and personal well-being, as well as the accompanying stigmas. Furthermore, their coping methods and perspectives on treatments to address these issues were investigated. A qualitative research was done between October and November 2021 among 109 HCWs participating in COVID- 19 management across 3 districts of Rajasthan state utilising in-depth telephone interviews and an interview guide. HCWs describe significant changes in their work-life situation, including high workload with inconsistent timings compounded by longer periods of cumbersome personal protective equipment usage, periods of quarantine, and long periods of separation from family. The biggest obstacle was being apart from family, the strain of caregiving, especially for females with newborns and toddlers, and anxiety of infecting relatives. The fear of contagion fueled stigma from the community and peers, which appeared as avoidance and rejection. Coping mechanisms included friend and family support, as well as positive experiences such as praise and acknowledgement for their role in the epidemic. The study illustrates the psychological strain experienced by HCWs providing COVID-19 care services. The outcomes of the study highlight to the necessity for need-based psychosocial treatments at the organisational, societal, and individual levels. This includes a conducive working environment that includes periodic evaluation of HCW problems, workforce rotation by engaging more staff, debunking of false information, community and HCW participation in COVID sensitization to allay fears and prevent stigma associated with COVID-19 infection/transmission, and finally need-based psychological support for them and their families.

Keywords: COVID-19, Corona, Infection, Epidemic, Nurse, Healthcare workers, Psychosocial.

INTRODUCTION:

The ongoing COVID-19 pandemic has affected people in more than one way. It is accompanied by various morbidity and mortality trajectories with long lasting effects impacting public health, with psychosocial consequences across the globe. This upsurge in COVID-19 cases has heavily burdened and in many cases overwhelmed and impaired the healthcare systems (Armocida B, et. al., 2020).

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Healthcare workers (HCWs) across the globe have experienced an increase in their work volume and intensity, additional responsibilities, and have had to adapt to new protocols and adjust to the 'new normality' (Thomas Parel J, et. al., 2020). This pandemic has been clouded

with uncertainties accompanied by high transmission rates which have challenged HCWs to a large extent. On the one hand, they need to respond to their call to serve humanity, and on the other hand, they are gripped with the fear of infection through the provision of care. This is a paradox that has resulted in psychological distress including depression, anxiety and sleep disturbance among HCWs (Du J., et. al., 2020). The WHO has recognized and affirmed the need for action to address the impact on the physical and mental health of HCWs (World Health Organization, 2021).

Furthermore, this pandemic has brought out different expressions of stigma that HCWs face with experiences of verbal and physical abuse reported to a large extent in social and print media platforms. Manifestations of stigma have been reported in India with doctors, and nurses being forced to vacate from their premises and reports of physical violence on HCWs in many parts of the nation. Similar experiences of stigma and discrimination during the COVID-19 pandemic have been reported from all over the world (McLaren H.J., et. al., 2020).

Recent studies have also documented stress, anxiety, depression and sleep-related issues among HCWs (Raj R, et. al., 2020). However, there is a dearth of qualitative data from India on the psychosocial impact of COVID-19 on HCWs. It is against this background that this study aimed to provide an insight into the psychosocial challenges faced by HCWs related to their work-life, family relationships, personal well-being, and the experiences of stigma at various levels. Another area that this study explored are the coping strategies adopted by HCWs to face these challenges and capture their suggestions on how these psychosocial challenges should be addressed. The overall purpose of this study was to help promote need- based intervention strategies for HCWs to improve their mental well-being, which would in turn help towards a better health system for patient-centred quality care.

MATERIAL & METHODS

This study was part of a cross-sectional multicentre study carried out in across 3 districts of Rajasthan state to explore the psychosocial experiences of HCWs involved in the management of the COVID-19 pandemic. The study was conducted between October and November 2021 and adopted a mixed-methods design that included both quantitative as well as qualitative investigations done in parallel. An oral ethical clearance was obtained from the respective hospitals.

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The sample size calculation for the larger study used a cross-sectional design assuming a 50 percent prevalence of psychological distress, 15 percent non- compliance with an alpha error of five percent and relative precision of 10 percent. Quantitative data were collected from 356 participants from the 3 districts viz. Nagaur, Sikar, and Jhunjhanu of Rajasthan state. Approximately, one tenth of this sample was covered for qualitative investigation to help gain a deeper and clearer understanding of the psychosocial impact of this pandemic, their coping strategies, as well as their suggestions on how to address these experiences. The total number covered was 109 participants across the sites with 9-11 respondents per site which was sufficient to reach saturation, crucial for qualitative data analysis.

Recruitment of participants and data collection: Considering the diversity of the population, purposive sampling was used to recruit participants. The initial step was to list public and private hospitals in each site that were involved in the provision of COVID-19 healthcare services. The principal investigators of different sites contacted the health authorities, explained the purpose of the study, and sought their consent and cooperation to carry out the study. The health facilities, willing to participate, were listed as potential sites for the conduct of the study.

Interview instructions utilised in our research
I. Work-life balance
We're curious about the impact COVID 19 has had on your professional life (please elaborate) The stress of labour, stigma, workplace connections and family ties are some of the topics to be examined.
Family life is also impacted by this.
We'd want to know how COVID-19 has affected your family life. (Explain more.) Prompt discussion on themes such as family time, stigma, and relationships within the family.
Sense of well-being is influenced by this third factor.
We'd like to hear how the experience of working with COVID has impacted you as a person. Inquire about concerns such as sleep and nutrition as well as work satisfaction and motivation.
During COVID-19, how did I cope?
How did you manage to deal with all of the difficulties you had as a result of COVID-19? Find out about topics such as interacting with others (family, friends, and coworkers), exercising and listening to music
Recommendations on ways to reduce negative perceptions caused by the COVID-19 incident
What do they believe should be done to alleviate the stigma that many healthcare providers are experiencing as a result of the COVID-19 outbreak? Investigate topics such as the need for information, the health care system, and the interventions in families and communities.

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Eligible study participants were HCWs involved in COVID-19 care services ranging from triaging, screening, treatment, isolation, referral services and community outreach services. These included doctors, nurses, pharmacists, ambulance workers, community workers, housekeeping staff, security guards, stretcher-bearers, sanitation workers, laboratory staff, and hospital attendants. The screening for eligibility of the study participants and interviews were carried. The interviews were conducted telephonically as compared to the preferred face-to-face interviews for the collection of sensitive qualitative data, such as what was required for the present study. This was done to ensure the safety and precautionary measures advised in view of the pandemic, the population covered and the length of the interviews. The investigators were provided intensive training on conducting the telephonic interviews which included building trust, consent procedures, the interview structure, and the likely challenges they would face in the process and other skills required in conducting telephonic interviews. Once the final list of eligible participants was prepared after the screening process, the research investigators individually contacted the eligible participants over telephone. The purpose of the study was explained with the help of a participant information sheet, and their willingness to be part of this study through audio consent was obtained. In addition, permission was obtained from the participants for the interview to be audio-recorded. The investigators fixed an appointment with the HCWs based on their convenience to ensure that the interview did not interfere with their work and time with family. In some instances, these appointments needed to be rearranged if the HCWs could not keep up the appointment due to work or family commitments. Each of the interviews lasted for 30-40 minutes. Venues for interviews included various settings such as the workplace, their homes and the care centres where they were being quarantined after their COVID-19 care duty.

The telephonic interviews were conducted using an interview guide for uniformity. The guide consisted of questions related to five core domains – impact on work–life, impact on family life, impact on the sense of well-being, coping during COVID-19 and suggestions on addressing the psychosocial challenges and mitigating the stigma associated with managing patients with COVID-19 infection. Each domain had a set of questions, followed by context-relevant probes to clarify and unpack their responses, experiences, and perceptions in relation to the phenomena under study (Box).

The interviews were conducted in the local languages (Hindi and Rajasthani) audio-recorded, transcribed, and translated to English. To ensure the safety and privacy of the participants, personal identifiers provided during the interview was encrypted.

Data analysis: Transcribed interviews were coded using a thematic approach and analyzed using NVivo software (QSR International, UK). Using the qualitative interview guide which already had distinct domains requiring exploration as the foundation, the possible codes (themes) were identified by the study team using an inductive approach. The transcripts were then independently coded by two researchers, and additional relevant themes and sub-themes were identified using descriptive content analysis from the data without applying a preconceived theoretical framework. In parallel, the researchers tracked new codes added to the coding scheme to describe the unexpected themes that emerged. The two researchers frequently met between themselves and with the site field investigators to reconcile inconsistencies in the application of codes and to ensure that emergent codes were added to

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the coding scheme. Because all coding differences were reconciled by consensus, the inter-rater reliability between the coders was not assessed. The data were analyzed and emergent themes were organized within these constructs with illustrative quotations selected for each theme. In reporting the study findings, the principles of qualitative research were followed by avoiding the quantification of codes (or themes) from our data. The study findings reported are as common themes (i.e. those that emerged most frequently) and salient themes (i.e. themes reported by a minority that are still important).

RESULTS

There was a fairly similar representation of gender in this study with 49 % females and 55 % males (Table I); the respondents were primarily in the age group between 20 and 40 years (85%) (Table I).

Table 1. Demographic profile of the study participants (n=109)

Characteristics	Values	n (%)
Gender		
Male	55	50.46
Female	54	49.54
Age group	**(yr)**	
20-30	39	35.78
31-40	53	48.62
41-50	17	15.60
Type of healthcare worker		
Doctor	19	17.43
Nurse	43	39.45
Ambulance worker	13	11.93
Community worker	8	7.34
Housekeeping/security guard	11	10.09
Laboratory staff	15	13.76

Broad domains were used that were explored through our interview guide to present the findings with themes and sub-themes that emerged under them as shown in Table II. This included

(i) work-related issues,
(ii) family-related issues,
(iii) societal-related issues,

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(iv) individual-related issues,
(v) coping mechanisms and
(vi) Suggestions on the way forward (Table 2).

Work-related issues: Various aspects emerged with regard to work-life environment which impacted HCWs. These are listed under the main theme of work-related issues and elaborated on the various sub-themes namely, changes in a work routine, increased workload, erratic work timings, challenges with personal protection equipment (PPE) and fear of infection.

Table 2. Themes and summary of key findings of the study

Themes	**Key finding(s)**
Work associated	Transformations in the daily grind
	The burden has increased
	Inconsistent schedules
	Problems Associated with Personal Protective Equipment
	Concern about One's Health
Family associated	Family members are split up
	There's no time for family
	Differences in family experiences by gender
	Concern for One's Own Family's Health
	Refusing to Inform Loved Ones about COVID Obligations
Individual level	Sleep deficiency
	Disturbance in eating habits
Society level	disgrace and rejection
Coping through COVID-19	Support from family and friends
	Help from colleagues
	Yoga/music listening
	Salutations & Religion
	Well-being-boosting experiences

Transformations in the daily grind: All research participants stated that the advent of the pandemic caused significant changes in their work-life routine. The majority of them observed a significant shift in tasks and responsibilities that went beyond their typical routine. While some found it upsetting, others reported misunderstanding about their responsibilities, particularly in the aftermath of events. This was followed by doubt about what needed to be done, which differed from the process they were used to following when dealing with patients.

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> *"There is additional stress associated with our work at COVID." Previously, we knew what we were dealing with when we received an emergency call. But today, if we go to the casualty to help a patient, we must wear our PPE. If a patient tests positive for COVID-19 and is unwell and requires emergency treatment, emergency procedures such as intubation might be difficult. We are not just on COVID duty, but we are also seeing other patients," (Doctor, 32-year, female)*

The burden has increased: Aside from the shift in duties and responsibilities, the increased workload was the most often mentioned stress cause among HCWs. "There is a lot of pressure, and we are overworked." We feel fatigued and irritated because we have to deal with the public, particularly those who do not comprehend the issue" (Ambulance worker, 32 yr old female).

Inconsistent schedules: Most respondents expressed that the erratic work timing was a challenge across all layers that included doctors, nurses, ambulance drivers, and supporting staff. Many of them also reported that this along with the workload did not allow them to take their eligible leave to go home to be with their families.

Problems Associated with Personal Protective Equipment: The novel notion of PPE protection in dealing with COVID-19 patients presented a number of challenges for HCWs, altering their work culture in a variety of ways.

(i) *"Wearing the PPE kit is difficult because once on, I can't take it off for 4-5 hours, and during that time, I can't eat or drink anything." I'm not even allowed to use the bathroom. It becomes quite sweaty inside the gear, and I'm always dehydrated because I don't drink anything despite sweating. We must constantly care to patients, and there is no way for me to remove it" (Doctor, 27 yr old male).*

(ii) *"Wearing PPE kit for an extended period of time makes me feel suffocated." It is simply wrapped in a plastic bag. I'm out of breath and sweating profusely, but we have to confront this for our own safety and the sake of society" (Ambulance worker, 32 yr male).*

Concern about One's Health: The word 'fear' was used the most by all responders. Many HCWs voiced concern about becoming infected while performing their responsibilities. This caused anxious emotions as they confronted the dichotomy of executing their duty of care carefully while being tormented by the persistent worry of becoming sick. This fear of infection was also shared by their colleagues who were not participating in COVID care tasks and avoided associating with those HCWs who were. This was surprising given that they were all responsible for patient care and could not afford to discriminate against one another.

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Family members are split up: The majority of participants indicated family-related obstacles such as long-term separation, a lack of time, fear of infection, and non-disclosure of their COVID-19-related obligations to their families.

All participants struggled to balance their career and family lives. The longest period of separation from their families was the most often mentioned difficulty. Many people described the challenges of long-distance travel away from family, which left them with a persistent sense of desire and despair. There was also the continual threat of losing their work if they did not agree to go away from home for extended periods of time as expected. This was especially noticeable among women HCWs with babies and children who had to deal with the problems of caregiving when physically absent, as well as the anxieties of infecting their children who wanted their entire attention when physically present at home. There was sorrow and shame expressed for being unable to operate as caregivers and provide care to their family, particularly youngsters, as well as meet their domestic tasks.

> *"My job has had a significant impact on my family life." During this epidemic, I am compelled to remain in my quarters. I am unable to care for my two-year-old child, and leaving her was terrible for me. My children are upset with me, and every time I contact my daughter, she does not respond. They are upset because I have to leave them so frequently. My older daughter is in class 9, and as a mother, I should spend more time with her during this stage of development and assist her with her schoolwork, but I am unable to do so. I am unable to feed them with nutritious meals and to care for them throughout their formative years. It has been 6 months that I have been dealing with this, and I feel useless since I cannot make my family run better as a housewife would," [GNM (General Nursing & Midwifery), 44-year female].*

There's no time for family: Most participants were under a lot of stress because of their hectic schedules, which left them fatigued to even spend time with their families. Working in such a circumstance was necessary for a number of them since they were responsible for financially sustaining their families.

Fear of infecting and failure to disclose COVID-19 obligations to family: All participants indicated worry about the danger of infecting their families as a result of their COVID-19 exposure. This was especially true for HCWs who were residing with their families and were always afraid of spreading illness to their families, especially those with comorbid diseases.

> *"Because I am the one responsible for my family, I am very concerned about infecting them because I am involved in the treatment of COVID-19 patients." Because my parents are elderly, I am unable to return home. My father has a heart condition and has survived cancer, and my mother has recently had spine surgery" (Nurse, 45 yr, female).*

To avoid upsetting their family members, several individuals withheld information about their responsibilities. Furthermore, they had to continuously reassure them of their safety and well-being, which was difficult in and of it.

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> *"I am living alone, away from my family, and I have not yet informed them that I work in the COVID-19 lab because I do not want them to be upset and concerned." I have not mentioned any of my difficulties or long working hours; instead, I have been having a regular discussion as if I had not been touched by any difficulties throughout the COVID-19. It's been almost six months and I still haven't told them, nor do I want to tell them" (Lab Technician, 28 yr male).*

Individual level: The influence of COVID-19 on the individual level has mostly been on the sensation of well-being, as stated under numerous sub-themes.

Sleep deficiency: According to the majority of HCWs, the increased workload associated with lengthy working hours has had an influence on their sleep pattern. Many of them were also at a higher risk of sleep deprivation due to persistent stress about work and workplace events that disrupted their sleep even when they tried to sleep.

Disturbance in diet habits: Another important issue that all of them mentioned was the inconsistency in their eating pattern. It was impossible to maintain regular eating times, which resulted in a variety of health issues. Many of them also mentioned that they had to skip meals since they had to wear the PPE outfit for lengthy periods of time.

Level of society:

Disgrace and rejection: The majority of HCWs expressed feelings of stigma and rejection as a result of caring for COVID-19 patients. This expressed itself in a variety of ways. Most of them stated that others around them (neighbours, friends, and family) made them feel like they were COVID-19 spreaders and avoided them, often making nasty remarks and showing reluctance to engage with them. As stated in the statement below, several HCWs reported having to disguise their identities in order to avoid social abuse. Some people also faced stigma from their own relatives.

> *"When people see me, they say, 'Hey, Corona!'" If they noticed me approaching from a distance, they would close their doors and windows. When they see me in the market, folks conceal their faces. They would quickly cross or overtake me by speeding their autos. When my relatives see me, they move away because they do not want to come face to face with me. There appears to be a lot of animosity in their brains" (Ambulance driver, 54 yr male).*

Coping techniques used: Following all of the obstacles that HCWs experienced, the various coping mechanisms they used were also corroborated.

Support from family and friends: All participants said that they were able to manage with the problems they experienced due to the support of their immediate family members and friends. Having another family member also involved in COVID duty was a major motivator to deal with these difficult times.

(i) *"My family is very supportive, and they told me that because I am working on COVID-19, I am getting an opportunity to contribute my service, and thus I should help as many people as I can" (Doctor, 31 yr male).*

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(ii) *"My wife also works in the hospital, in the ICU department; we both support each other as we face these difficult times together." For this, we shall collaborate, and whatever occurs, we will confront it together" (Ambulance driver, 36 yr old male).*

Help from colleagues: According to all participants, a strong sense of support from coworkers was a great motivating force that helped them cope. Many people remarked that it was this sharing forum, where many people shared similar problems that kept them motivated under terrible situations. Furthermore, several of them valued the guidance they received from higher-ups, which allowed them to fulfill their work-related tasks while also maintaining their psychological well-being.

"Because we work as a team, whenever we encounter a problem, we discuss it with the team." We bring out the best in each other, so when we're feeling down or upset, we support one another" (Doctor, 37 yr male).

Spending time with oneself through music/yoga/prayer: Many of the respondents noted their spiritual dependency, listening to music, and doing yoga as ways of coping. With their work schedules, most of them felt there was little time for physical activity such as exercise or outdoor activities, so they had to manage their time inside the limits of their job.

Well-being-boosting experiences: Positive experiences among the adversities encountered were one of the coping mechanisms that arose, manifesting as admiration and acknowledgment for their work throughout the epidemic, raising their sense of worth, and professional pride. Many participants stated that they felt they had done their job by assisting others, even if it meant endangering their lives.

HCWs proposed a variety of intervention options for dealing with the psychological difficulties they faced. The difficulties were divided into three categories: (i) organisational level, (ii) social level, and (iii) individual level. This includes a favourable working environment with periodic examination of HCW concerns, workload reduction through workforce rotation and engagement of new personnel, peer support services, and political backing. At the societal level, the focus was primarily on stigma reduction through the media's significant role in disseminating accurate information, community, and HCW engagement in COVID sensitization, and easing the anxieties associated with COVID-19 infection and transmission. This would reduce the inclination to perceive HCWs as a source of infection and increase favourable sentiments toward them. Finally, individuals were encouraged to seek need-based psychological care for themselves and their families.

DISCUSSION

This study delves into the various psychosocial factors that have affected HCWs as a result of the COVID-19 outbreak. First, the study findings highlight to organisational issues, which are represented in considerable changes in the working culture of HCWs who were unprepared for this transformation. This entailed a paradigm change across many roles and new obligations outside of their normal routine. According to recent accounts, while dealing with the social shifts and emotional strains of COVID-19, health workers battled with increased

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workloads and a rapidly changing workplace environment that differed substantially from the typical day-to-day reality (Shanafelt T., et. al., 2020). Longer working hours with unpredictable timings, as documented in the current study, led in sleep deprivation and poor eating behaviours, both of which might have long-term repercussions. Earlier research documented the psychological suffering experienced by HCWs as a result of sleep disturbance and insomnia (Dang P., et. al., 2021).

Furthermore, our study findings emphasise the difficulties associated with adhering to the protection procedure that HCWs in COVID-19 care management must follow, which requires protective equipment (PPE) and an extra quarantine process after completing their tasks. While these safeguards are intended to protect children, the impact it has on them, ranging from practical to physical pain, such as dehydration and inability to relieve oneself, is concerning. This finding was similar to another study that found that long work shifts with poor infrastructure and the requirement to wear PPE caused physical uneasiness, including breathing difficulty, among HCWs (Ornell F., et al., 2020). Another significant finding regarding their work environment was the fear of infecting themselves experienced by all levels of health care personnel due to constant exposure to COVID-19-infected individuals. This dread frequently interfered with HCWs' capacity to provide excellent and enough humane care; yet, the problems of providing care during a highly transmissible pandemic of this sort appeared to strain the limits of their tolerance.

Second, the study findings indicate to the impact on families, which had a twofold impact since HCWs were negatively impacted while away from their respective families, and families were negatively impacted due to the extended separation and procedural procedures of being part in COVID-19 care chores. The concern of infecting their family outweighed the danger of becoming ill. This dread had an influence on their families, who frequently struggled to comprehend why they acted differently by isolating themselves or being gone for extended periods of time. This was more obvious among female HCWs, with varying degrees of impact, particularly on children, as they attempted to reconcile work and family life. As a result, women had to bear the triple burden of being caretakers in the hospital, at home, and balancing these multiple tasks, which had an impact on their mental health, as previously documented (Khasne R.W.., et. al., 2020).

Third, the mental impact was mostly societal, notably with the stigma and rejection that HCWs frequently suffered, which had an indirect influence on their families and forced some of them to conceal their identities. This was mostly because they were viewed as vectors for viral transmission rather than individuals whose major function was to avoid infection and assist those who were ill. This frequently pushed some HCWs to disguise their identity in order to avoid social persecution. These findings are comparable to those of a research on Canadian health workers who not only felt fear-contagion for themselves during the 2003 SARS pandemic, but also avoided identifying as HCWs owing to stigma in their communities. Similar to a prior survey, another sign of stigma was avoidance even among their peers working in non-COVID-19 care (Dang P., et. al., 2021).

The fourth significant result was the coping techniques used by HCWs in response to the problems they encountered. Coping motivations were both external and internal. The acclaim

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they got for their participation in such exceptional circumstances was extrinsic, resulting in a sense of productivity and professional pride, which increased their sense of self worth. Apart from social and family support, spiritual belief systems provided a major coping strategy. Studies have also indicated that peer support or assistance from loved ones resulted in less burnout episodes among physicians when compared to those who did not get support.

Previous research among nurses providing patient care during severe disease outbreaks focused on the significance of self-care activities such as exercise, meditation, music, and podcast listening in coping with stress and improving psychological well-being during the crisis (Sun N., et. al., 2020).

According to the study findings, HCWs at all levels participating in COVID-19 care services confront a variety of problems in their work-life and home life, influencing their feeling of well-being in a variety of ways. The study also delves into the solutions seen by HCWs as effective in addressing these psychosocial difficulties at the organisational, societal, and individual levels.

This study does have some drawbacks. The study's restricted time frame and the requirement for telephonic interviewing as opposed to the preferred face-to-face interviews (particularly in the collection of qualitative data) were limiting factors, especially as it was done with the HCWs' work schedules or family time in mind. Several field realities were encountered in this context, particularly with regard to scheduling appointments, network challenges, interviewing in a private location, and the challenge of creating trust over the phone. Another constraint was the necessity to rely on purposive sampling due to the challenges in reaching this target demographic within the time frame specified. Given that most HCWs are females, our study was unable to effectively capture the gender disparities in dealing with the numerous psychological issues highlighted. Further research on gender-focused psychological therapies to address these problems might be conducted in this area.

Overall, the study findings advocate for remedies that need a layered response, including structural, social, and individual-level strategies and activities. There is a need to change the emphasis from providing psychological services (which is frequently advised) to need-based treatments at the organisational level. This involves management providing a supportive atmosphere to confront the current new norm of work routine. This proactive solution would try to prevent the negative psychosocial impact rather than dealing with it after the fact by offering psychological therapy. Second, the inclusion of HCWs' families in support services is critical to the HCWs' mental health and well-being. This is frequently missed. Third, there is a need for society intervention with the supply of correct information through social and print media, as well as the inclusion of HCWs as a key group in COVID sensitization campaigns to alleviate the erroneous worries connected with COVID-19 and improve HCW acceptance. These treatments may aid HCWs' mental health as they deal with the many psychosocial issues related with their engagement in COVID-19 management.

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