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Mental Health and Psychological Impact of COVID-19 on Eswatini's Healthcare Workers at a COVID-19 Designated Hospital

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Abstract: The COVID-19 pandemic imposed severe psychological strain on healthcare workers (HCWs), particularly in resource-limited settings. This study explored the mental health and psychosocial impact of COVID-19 on HCWs in Eswatini's main COVID-19 referral hospital, focusing on sources of distress and resilience. A qualitative descriptive phenomenological design was adopted within an interpretivist paradigm to capture the lived experiences and meanings HCWs attached to their work during the pandemic. Fifteen participants including nurses, physicians, a pharmacist, a radiographer, and a laboratory scientist, were purposively selected and interviewed using semi-structured guides. Data were analyzed thematically following Colaizzi's framework. Findings revealed five major themes: emotional reactions, psycho-social distress and exhaustion, resilience and coping mechanisms, impact on quality of care and motivation, and recommendations for future preparedness. The study concludes that Eswatini's HCWs endured profound psychological distress but also exhibited adaptive resilience. Strengthening institutional mental health support, ensuring continuous counseling, peer-support systems, and professional recognition are imperative to safeguard HCW well-being and enhance preparedness for future health crises.

Keywords: *Healthcare Workers, COVID-19, Mental Health, Psychological Distress, Resilience, Job Demands–Resources Theory, Eswatini.*

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I. INTRODUCTION

The COVID-19 pandemic profoundly disrupted global health systems, imposing extraordinary psychological strain on healthcare workers (HCWs). Across diverse contexts, evidence revealed that frontline professionals faced extreme physical, emotional, and ethical challenges stemming from infection risks, long working hours, and exposure to patient suffering. In the United States, reports indicated that nearly half of HCWs experienced burnout and mental health challenges, including anxiety, depression, and post-traumatic stress, due to prolonged exposure to high workloads and moral injury (Shanafelt et al., 2020). Similarly, in Australia, healthcare professionals reported emotional exhaustion, sleep disturbances, and compassion fatigue, with nurses particularly affected by fear of infecting family members and inadequate mental health support (Smallwood et al., 2021).

In Africa, resource limitations and weak psychosocial support systems compounded the psychological toll. A Kenyan study found that 42% of HCWs exhibited depressive symptoms during the first pandemic wave, largely attributed to lack of personal protective equipment (PPE), fear of contagion, and social stigma (Muchomba et al., 2021). Comparable findings were observed in South Africa, where approximately 57% of HCWs reported moderate to severe psychological distress linked to heavy workloads, moral dilemmas, and insufficient institutional support (Mogale et al., 2022). These patterns underscore that while the pandemic was global, its psychological effects were intensified in resource-constrained

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settings where healthcare infrastructure and mental health services were already overstretched.

In Eswatini, the pandemic struck a fragile healthcare system grappling with chronic understaffing and a high HIV/TB burden. The government designated one main hospital as the COVID-19 treatment centre, concentrating both the patient load and emotional burden on its workforce. Preliminary local reports indicated heightened anxiety among HCWs due to infection fears, isolation, and inadequate psychosocial support (Ministry of Health, 2021). Yet, systematic empirical research on the psychological experiences of Eswatini's HCWs remains limited. Guided by the Job Demands–Resources (JD–R) theory, this study explores the mental health and psychological impact of COVID-19 on healthcare workers in Eswatini's COVID-19 hospital, focusing on their experiences of distress, coping, and resilience within a resource-limited healthcare environment.

II. THEORETICAL FRAMEWORK: JOB DEMANDS–RESOURCES (JD–R) THEORY

The present study is guided by the Job Demands–Resources (JD–R) theory, originally developed by Bakker and Demerouti (2007, 2017), which provides a comprehensive model for understanding employee well-being, burnout, and resilience. The theory posits that all job characteristics can be classified into two broad categories: job demands and job resources. Job demands refer to the physical, psychological, social, or organizational aspects of a job that require sustained effort and are therefore associated with physiological and psychological costs. Examples of job demands include high workload, emotional strain, infection risk, and role conflict. Conversely, job resources encompass the physical, psychological, and social supports that enable individuals to manage job demands effectively, achieve work goals, and promote personal growth, such as team cohesion, training, supervision, and recognition.

According to JD–R theory, excessive demands without sufficient resources initiate a health-impairment process, leading to exhaustion and burnout. In contrast, adequate job resources stimulate a motivational process, fostering engagement, satisfaction, and resilience. These dual mechanisms interact dynamically: resources can buffer the adverse effects of high demands, while demands can erode the benefits of resources. In healthcare contexts, the JD–R framework has been widely applied to explain how exposure to crisis conditions, such as the COVID-19 pandemic, intensifies the health-impairment pathway through overwork, fear of infection, and moral pressure, whereas supportive leadership, teamwork, and faith act as motivational buffers that sustain mental well-being (Bakker & Demerouti, 2017; Greenberg et al., 2020). Within this study, the JD–R theory helps to interpret the lived experiences of Eswatini's healthcare workers as interplay between overwhelming job demands, high patient mortality, inadequate protective equipment, stigma, and limited psychosocial support, and the mobilization of personal and collective resources such as teamwork, faith, and professional duty. This framework illuminates how distress and resilience coexist and clarifies why strengthening job resources is crucial for preventing burnout and sustaining motivation among healthcare workers in resource-limited settings.

III. LITERATURE REVIEW

- *Global Perspectives on Healthcare Workers' Mental Health during COVID-19*

The COVID-19 pandemic subjected healthcare workers (HCWs) across the world to unprecedented psychological strain. As noted by Pappa et al. (2020), frontline professionals faced a combination of long working hours, heightened exposure to infection, emotional fatigue, and complex ethical dilemmas in patient care. Evidence from early global meta-analyses indicated that psychological symptoms were widespread, with anxiety affecting roughly one in four HCWs and comparable rates reported for depression, insomnia, and general distress (Salari et al., 2020). In the United States, Shanafelt et al. (2020) observed that nearly half of physicians experienced burnout, characterized by emotional exhaustion, moral injury, and depersonalization resulting from sustained pandemic pressures. Nurses, identified by Galanis et al. (2021) as among the most psychologically burdened groups, reported persistent stress and compassion fatigue arising from continuous exposure to patient suffering and the fear of infecting their families. Collectively, these findings underscore the global mental health toll of COVID-19 on the healthcare workforce.

In Australia, emerging research revealed a widespread mental health crisis among healthcare workers during the COVID-19 pandemic. Drawing on a national survey, Smallwood et al. (2021) reported that more than half of Australian HCWs experienced moderate to severe anxiety, while nearly three-quarters displayed symptoms of emotional exhaustion. The study identified several contextual predictors of this psychological strain, including inadequate access to personal protective equipment (PPE), ambiguous professional roles, and prolonged social isolation arising from strict infection-control measures. These stressors not only affected individual well-being but also undermined morale and work engagement across healthcare teams. Complementary investigations within Australia confirmed that insufficient organizational support, coupled with uncertainty about changing clinical protocols, intensified emotional fatigue among nurses and physicians alike. To address these challenges, a range of institutional initiatives such as peer-support programs, staff debriefing sessions, and online psychological counselling were implemented, which significantly alleviated distress when consistently applied (Greenberg et al., 2020).

In contrast, healthcare workers in low- and middle-income countries (LMICs) faced the pandemic amid deeply entrenched systemic constraints that magnified psychological

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vulnerability. Mukumbang et al. (2022) observed that chronic understaffing, poor infrastructure, and limited access to psychosocial services left frontline personnel severely overstretched. In Kenya, for example, Muchomba et al. (2021) found that approximately 42% of HCWs exhibited moderate to severe depressive symptoms, a pattern attributed to fear of infection, shortages of PPE, and the absence of formal mental health support within hospitals. A comparable situation was documented in South Africa, where Mogale et al. (2022) reported that 57% of frontline healthcare workers experienced significant psychological distress during the pandemic's first wave. Nurses and female staff were especially affected, as they bore the brunt of direct patient care under high mortality conditions. Many participants linked their burnout to inadequate rest periods, limited managerial appreciation, and the emotional burden of witnessing frequent patient deaths. Collectively, studies from both high-income and resource-limited settings reveal that while the pandemic's psychological toll on HCWs was global, its intensity was amplified in contexts where healthcare systems lacked sufficient structural and emotional support mechanisms.

Regional evidence indicates that spirituality, peer support, and professional solidarity were major protective factors. For instance, Boateng and Asante (2021) found that faith and social connectedness played crucial roles in coping among Ghanaian and Nigerian health professionals. However, despite such individual resilience, structural support remained inadequate, reflecting a policy gap in occupational mental health across many African health systems.

Beyond clinical stressors, the pandemic introduced profound social and moral dimensions to HCWs' psychological distress. Studies across continents have documented moral injury, a condition arising when professionals act against their moral beliefs due to systemic constraints such as rationing care or witnessing preventable deaths (Greenberg et al., 2020). In the United Kingdom and the United States, moral injury was linked to depression, guilt, and long-term trauma among frontline staff (Williamson et al., 2021).

In African contexts, stigma and social rejection emerged as unique stressors. Kenyan and Nigerian HCWs reported being ostracized by communities and even family members, who perceived them as infection carriers (Muliira & Ssendikadiwa, 2021). Similar experiences were reported in South Africa, where HCWs faced discrimination in transport and public spaces (Phiri & Molefe, 2023). Such stigmatization exacerbated isolation, undermined social support systems, and intensified psychological distress. These findings underscore the need for community sensitization campaigns to humanize HCWs and reduce pandemic-related stigma. Despite the overwhelming psychological burden, HCWs demonstrated remarkable resilience. Research from multiple contexts highlights adaptive coping mechanisms such as teamwork, peer solidarity, recreation, and faith (Hofmeyer & Taylor, 2021). In Australia and Canada, structured peer-support initiatives and counseling hotlines reduced burnout and improved morale (Smallwood et al., 2021). African studies revealed culturally embedded coping practices such as religious prayer, collective problem-solving, and meaning making, that enabled workers to endure adversity (Boateng & Asante, 2021). According to the JD–R theory, such personal and social resources mitigate stress through the motivational process, which enhances engagement and reduces the likelihood of burnout (Bakker & Demerouti, 2017).

However, reliance on individual resilience without institutional reinforcement is unsustainable. The World Health Organization (2022) emphasized that mental health support must be institutionalized through organizational policies, on-site counseling, and crisis debriefing programs. The absence of such systems in many LMICs, including Eswatini, limited the protective potential of individual coping strategies.

In Eswatini, COVID-19 intersected with a fragile healthcare system already constrained by limited human resources and high HIV/TB comorbidities. The government designated a single hospital as the main COVID-19 treatment centre, that placed immense pressure on a small group of frontline professionals. Local accounts revealed heightened anxiety, fear of infecting family members, and limited access to psychosocial support (Ministry of Health, 2021). A qualitative study by Shongwe and Huang (2021) reported that Eswatini nurses experienced severe emotional exhaustion, feelings of helplessness, and social stigma, mirroring findings from other LMICs. However, the same study noted that faith, teamwork, and professional duty served as buffers against psychological collapse.

- *Problem statement*

The COVID-19 pandemic has profoundly affected the psychological well-being of healthcare workers (HCWs) globally, exposing them to sustained stress, fear, and moral injury. Evidence from high-income countries such as the United States and Australia reveals that between 40% and 70% of HCWs reported anxiety, depression, and burnout during the pandemic due to high workloads, infection risk, and ethical dilemmas in care delivery (Shanafelt et al., 2020; Smallwood et al., 2021). In sub-Saharan Africa, where health systems were already fragile, the psychological impact was intensified by limited resources, inadequate personal protective equipment (PPE), and lack of institutional psychosocial support (Mukumbang et al., 2022). Studies from Kenya and South Africa indicate that more than half of healthcare workers experienced moderate to severe psychological distress, with stigma and community rejection worsening the situation (Muchomba et al., 2021; Mogale et al., 2022). In Eswatini, the pandemic struck a healthcare system already burdened by chronic staff shortages and a high prevalence of communicable diseases such as HIV and tuberculosis. The government's decision to designate a single hospital as the national COVID-19 treatment centre concentrated the emotional and physical strain on a limited number of frontline professionals. Preliminary reports from the Ministry of Health (2021) and

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anecdotal accounts from healthcare unions highlighted widespread stress, fear of infecting family members, and limited access to mental health services among HCWs. However, empirical research examining how these workers experienced, interpreted, and coped with the psychological challenges of COVID-19 in Eswatini remains scarce.

➢ *Objectives*

- To examine the psychological experiences and emotional challenges encountered by healthcare workers during their service in Eswatini's COVID-19 treatment facility.
- To identify the key sources of psychological distress and the coping or resilience strategies adopted by healthcare workers amid the COVID-19 pandemic.
- To assess the influence of job demands and available resources on the mental well-being of healthcare workers, guided by the Job Demands–Resources theoretical framework.

IV. METHODOLOGY

This study adopted a qualitative descriptive phenomenological design to explore healthcare workers' lived psychological experiences during the COVID-19 pandemic. Drawing on Moustakas' (1994) view that phenomenology seeks to uncover the meanings individuals ascribe to their experiences, the design enabled the researcher to capture participants' emotions, thoughts, and coping mechanisms within their natural work context. As Creswell and Poth (2018) note, such an approach is appropriate when a phenomenon is not well understood and requires deep exploration from the participants' perspectives. The study was grounded in an interpretivist paradigm, which assumes that reality is socially constructed through human interaction and that understanding emerges from empathetic engagement with participants (Denzin & Lincoln, 2018). This philosophical orientation positioned the researcher not as a detached observer but as an active interpreter of the participants' lived meanings.

The research was conducted at Eswatini's main COVID-19 referral hospital, which served as the central treatment centre during the height of the pandemic. Participants were selected through purposive sampling, a method that Palinkas et al. (2015) describe as suitable for identifying information-rich cases that provide detailed insights into a phenomenon. Fifteen healthcare workers (coded P1–P15 for confidentiality) took part, representing nurses, physicians, a pharmacist, a radiographer, and a laboratory scientist. The diversity of professional roles enriched the study's understanding of psychological responses across different categories of frontline workers. Participants qualified for inclusion if they had at least six months of experience working in COVID-19 units and provided informed consent to participate.

Data collection was conducted through in-depth semi-structured interviews between October and December 2023. Each interview, lasting approximately 60 minutes, was held face-to-face in a private space within the hospital under strict COVID-19 safety protocols. Guided by Kvale and Brinkmann's (2015) principles of phenomenological interviewing, open-ended questions were used to elicit detailed narratives about participants' fears, stressors, sources of motivation, and coping strategies. Probing questions encouraged reflection on emotional and social experiences such as stigma, teamwork, and resilience. Interviews were conducted in English, recorded with consent, and transcribed verbatim. Field notes captured contextual observations and non-verbal expressions, which Patton (2015) recommends as vital for enhancing interpretive depth and triangulating the data.

The data analysis process followed Colaizzi's (1978) seven-step phenomenological framework, which provides a structured pathway for extracting the essence of lived experiences. Transcripts were first read repeatedly to achieve immersion before significant statements relating to participants' psychological experiences were extracted. These statements were then organized into meaning units and grouped into thematic clusters. Through iterative discussions and peer debriefing, five overarching themes emerged: emotional responses to work, psychosocial distress, contextual challenges, coping strategies, and suggested improvements. To enhance rigor, Lincoln and Guba's (1985) criteria for trustworthiness guided the process: an audit trail was maintained to ensure dependability, and member checking (Birt et al., 2016) was used to confirm that participants agreed with the interpretations of their narratives.

Ethical considerations were upheld throughout the study. Approval was obtained from the Texila American University Institutional Review Board and the Eswatini Ministry of Health Ethics Committee. Participation was voluntary, and informed consent was obtained before data collection. Consistent with the ethical principles outlined in the American Psychological Association (2020) guidelines, confidentiality and psychological safety were prioritized. Identifying details were removed from transcripts, and pseudonyms were used when reporting findings. Given the emotional sensitivity of the topic, a professional counselor was on stand-by for referral, and participants were debriefed after interviews. All electronic data were securely stored with access restricted to the research team.

V. RESULTS

The analysis revealed a vivid picture of the psychological toll borne by healthcare workers (HCWs) and the forms of resilience they mobilized. Five interrelated themes emerged, each with corresponding subthemes and illustrative quotations. The following are the themes obtained: emotional reactions, psycho-social distress and exhaustion, resilience and coping mechanisms, impact on quality of care and motivation, and recommendations for future preparedness.

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- *Emotional Reactions: From Helplessness to a "Wartime" Mindset*

Participants initially described helplessness and fear, largely attributed to inadequate preparation and uncertainty about a novel pathogen. One participant reflected, "Lack of preparedness left us helpless. "We also felt helpless when we needed psychological assistance… the psychologist visited only periodically" (P7). Anxiety about personal safety was constant: "You don't want to be infected and at the same time you are obliged to be there for the patients" (P14).

As the crisis progressed, many adopted a "wartime" mentality that reframed work as collective struggle and purpose. Comments such as "We were fighting against an unknown disease" (P11) and "Today I feel like a hero because we mastered it and we conquered it" (P1) captured this evolution. Alongside this, a strong sense of duty anchored persistence: "We chose to remain behind and assist" (P11); "There was not even a single day we decided not to report for work" (P6). For some, duty also produced tension, with a few describing feeling compelled to serve despite fear.

- *Psychosocial Distress and Exhaustion*

All participants reported intense psychological distress, citing overwhelming caseloads of critically ill patients, evolving protocols, and repeated exposure to death: "Seeing many people die every day, even after you gave them the best treatment" (P15). Emotional and cognitive fatigue was common: "I was emotionally and intellectually drained" (P8).

Distress was aggravated by stigma and isolation. Several were shunned in public spaces: "We don't want you… you come from the COVID hospital" (P9), and, in some cases, at home: "I was stigmatized by my family" (P14). Perceived inadequacy of psychological support compounded strain; access to counseling was sporadic and poorly timed.

Sustained demands contributed to burnout and physical exhaustion. Long shifts amid staff shortages, combined with the burden of PPE, produced persistent fatigue: "We could wear PPEs and stay in the ward for eight hours without sitting down… it was suffocating" (P5). Some described emotional numbing as an indicator of burnout.

- *Resilience and Coping*

Despite adversity, participants mobilized teamwork and peer support as central buffers: "We were relieved because we were working as a team and we could discuss among ourselves" (P2); "The team made the work lighter" (P5). Recreational activities and brief wellness initiatives (team-building) offered respite. Spirituality and faith were frequently cited sources of strength: "I was also praying to God, knowing He is faithful" (P13). Simple decompression routines, such as watching television after shifts, provided momentary relief. Several participants nonetheless emphasized that these strategies were improvised and insufficient without structured, ongoing psychosocial services

- *Effects on Care Quality and Motivation*

Participants acknowledged that cumulative stress sometimes impaired care during surges: "We were overwhelmed… we couldn't provide all the proper care expected" (P4). Yet many also reported growth and renewed competence, including new clinical skills and improved stress management (e.g., P14). Post-peak, some colleagues considered leaving or resigning, citing burnout and perceived lack of appreciation. Lingering trauma symptoms (e.g., intrusive memories, hypervigilance) were noted, underscoring the need for post-crisis support.

HCWs navigated an arc from initial helplessness to purpose-driven resilience, while enduring sustained distress amplified by stigma and limited psychosocial support. Personal and collegial resources helped sustain functioning, but systemic supports lagged. These findings motivate the subsequent discussion on strengthening supports through an explicit job demands–resources lens.

VI. DISCUSSION

The findings align with international evidence of elevated anxiety, depression, and burnout among HCWs during COVID-19, with uncertainty, workload, and persistent exposure to death as consistent drivers. The data provide contextual depth by detailing the compounding effect of stigma and social isolation, a prominent stressor in this setting. The observed shift from helplessness to a wartime mentality reflects a meaning-making trajectory that, while galvanizing effort and cohesion, can also normalize self-sacrifice and discourage help-seeking.

Within the Job Demands–Resources (JD–R) framework, prolonged workload, infection risk, moral pressure, and stigma constitute high job demands that fuel the health-impairment process (exhaustion, depersonalization, and functional decline). Countervailing job and personal resources, team cohesion, peer debriefing, faith, emergent competence, and moments of recognition activated a motivational process that sustained engagement and buffered strain. The balance, however, was fragile: organizational resources (timely counseling access, systematic debriefing, ongoing training, adequate staffing and PPE, recognition) were frequently insufficient, amplifying the net effect of demands on well-being and intention to remain.

Two contributions are salient. First, the study foregrounds stigma as a critical external demand that erodes social support precisely when it is most needed, suggesting that HCW mental health strategies should extend beyond the facility to include community education and family-focused outreach. Second, it documents resilience as relational and multi-level rooted not only in individual faith or coping, but in team processes and meaning-making, indicating that interventions should scaffold both collective and individual resources.

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VII. LIMITATIONS

The single-site, small-sample design limits transferability. Self-selection may have favored participants' comfortable narrating experiences, and retrospective accounts may be shaped by recall. Trustworthiness strategies (member checking, audit trail) mitigate but do not eliminate these constraints.

VIII. CONCLUSION

This study provided an in-depth exploration of the psychological and emotional experiences of healthcare workers who served in Eswatini's designated COVID-19 hospital. The findings revealed that the pandemic placed extraordinary psychological burdens on frontline professionals, manifested through fear, anxiety, exhaustion, and moral distress. These experiences reflected the immense job demands associated with prolonged exposure to risk, high patient mortality, inadequate staffing, and limited psychosocial support. Yet, amidst this adversity, participants also demonstrated remarkable resilience, drawing strength from teamwork, faith, peer solidarity, and professional duty. Through the lens of the Job Demands Resources theoretical model, the study highlighted that while excessive job demands triggered an emotional strain and burnout health-impairment process, the presence of personal and social resources initiated a motivational process that enabled coping and endurance. This balance between vulnerability and resilience underscores the dynamic nature of healthcare workers' psychological responses in crises.

The study contributes to the global discourse by illuminating the lived realities of healthcare workers in a small, resource-limited African context, where systemic challenges magnified psychological distress. It advances understanding of the mental health dimensions of public-health emergencies in Eswatini and provides evidence to guide institutional interventions. Strengthening job resources such as continuous psychological counseling, peer-support systems, professional recognition, and adequate training can mitigate burnout and foster resilience in future outbreaks.

While the study was limited to one hospital and a small sample, the depth of lived accounts offers valuable insights for both policy and practice. Future research should extend this work by examining longitudinal recovery trajectories and the long-term mental health outcomes of healthcare workers beyond the acute pandemic phase. Ultimately, the study affirms that safeguarding healthcare workers' mental well-being is not merely an ethical responsibility but a strategic necessity for sustainable healthcare delivery. Building compassionate, well-resourced, and resilient health systems will ensure that those who care for others are also cared for, both in times of crisis and in ordinary service.

REFERENCES

[1]. Afzal, M., Imran, H., & Sarwar, H. (2023). *Nurses' motivation and duty during the COVID-19 pandemic in Pakistan*. Journal of Nursing Management, 31(2), 456–464.

[2]. Ardebili, M. E., Naserbakht, M., Bernstein, C., Alazmani-Noodeh, F., Hakimi, H., & Ranjbar, H. (2021). *Healthcare providers' experience of working during the COVID-19 pandemic: A qualitative study*. Journal of Nursing Scholarship, 53(5), 752–760.

[3]. Bakker, A. B., & Demerouti, E. (2017). *Job Demands–Resources theory: Taking stock and looking forward.* Journal of Occupational Health Psychology, 22(3), 273–285.

[4]. Boateng, W., & Asante, P. Y. (2021). *COVID-19 and spiritual coping: Experiences of health workers in Africa*. African Journal of Social Work, 11(3), 45–54.

[5]. Galanis, P., Vraka, I., Fragkou, D., Bilali, A., & Kaitelidou, D. (2021). *Nurses' burnout and associated risk factors during the COVID-19 pandemic: A systematic review and meta-analysis.* Journal of Advanced Nursing, 77(8), 3286–3302.

[6]. Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). *Managing mental health challenges faced by healthcare workers during the COVID-19 pandemic*. BMJ, 368, m1211.

[7]. Hofmeyer, A., & Taylor, R. (2021). *Strategies to support the psychological well-being of frontline nurses during a pandemic.* International Journal of Nursing Practice, 27(1), 129-136.

[8]. Hoover, J., Bolton, P., Clonchmore, A., Sussman, L., & Frymus, D. (2023). *Responding to the impact of COVID-19 on the mental health and well-being of health workers in LMICs*. Cambridge Prisms: Global Mental Health, 1

[9]. Kisely, S., Warren, N., McMahon, L., Dalais, C., Henry, I., & Siskind, D. (2020). *Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers*: Rapid review and meta-analysis. BMJ, 369, m1642.

[10]. Liu, Q., Luo, D., Haase, J. E., Guo, Q., Wang, X. Q., Liu, S., & Yang, B. X. (2020). *The experiences of healthcare providers during the COVID-19 crisis in China: A qualitative study*. The Lancet Global Health, 8(6), 790–798.

[11]. Ministry of Health (Eswatini). (2021). *Health sector response to COVID-19: Lessons learned report.* Government of Eswatini.

[12]. Mogale, R. S., Phiri, N., & Mahlangu, P. (2022). *Mental health and well-being of healthcare workers during COVID-19 in South Africa.* BMC Health Services Research, 22(1), 876.

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/25oct1421

[13]. Muchomba, E., Gachohi, J., & Mutua, M. (2021). *Psychological distress among healthcare workers in Kenya during the COVID-19 pandemic*. Frontiers in Public Health, 9, 665611.
[14]. Mukumbang, F. C., Ambe, A. N., & Adebiyi, B. O. (2022). *Unspoken inequality: How COVID-19 has exacerbated existing vulnerabilities of healthcare workers in Africa.* Frontiers in Public Health, 10, 861843.
[15]. Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: A systematic review and meta-analysis. Brain, Behavior, and Immunity, 88, 901–907.
[16]. Phiri, M., & Molefe, L. (2023). *Workplace support and welfare of nurses in Botswana during COVID-19*. BMC Nursing, 22(1), 150.
[17]. Rucker, A., Larsson, G., Börjesson, S., & Nygren, J. (2021). *Moral distress and psychosocial support needs among healthcare workers in Sweden during COVID-19.* Frontiers in Psychiatry, 12, 770205.
[18]. Salari, N., Hosseinian-Far, A., Jalali, R., Vaisi-Raygani, A., Rasoulpoor, S., Mohammadi, M., & Khaledi-Paveh, B. (2020). *Prevalence of stress, anxiety, and depression among the general population during the COVID-19 pandemic: A systematic review and meta-analysis.* Globalization and Health, 16(1), 57.
[19]. Shanafelt, T., Ripp, J., & Trockel, M. (2020). *Understanding and addressing sources of anxiety among healthcare professionals during the COVID-19 pandemic*. JAMA, 323(21), 2133–2134.
[20]. Shongwe, K. T., & Huang, Y. (2021). *Lived experiences of frontline nurses in Eswatini during the COVID-19 pandemic.* International Nursing Review, 68(4), 524–532.
[21]. Smallwood, N., Karimi, L., Pascoe, A., Bismark, M., Putland, M., Johnson, D., & Willis, K. (2021). *Coping strategies and mental health outcomes of frontline healthcare workers during COVID-19 in Australia*. BMC Psychiatry, 21(1), 88.
[22]. Spoorthy, M. S. (2020). *Factors associated with psychological outcomes among healthcare workers during the COVID-19 outbreak: A rapid review.* Indian Journal of Psychiatry, 62(3), 222–226.
[23]. Spoorthy, M. S., Pratapa, S. K., & Mahant, S. (2020). *Mental health problems faced by healthcare workers due to the COVID-19 pandemic: A review.* Asian Journal of Psychiatry, 51, 102119.
[24]. World Health Organization. (2021). *Occupational health and safety for health workers in COVID-19: Interim guidance* (WHO/2019-nCoV/HCW_health/2021.1). World Health Organization.
[25]. World Health Organization. (2022). *Mental health and psychosocial support guidelines for health workers: Policy brief.* World Health Organization & International Labor Organization.