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Themes and Associations Concerning The COVID-19 Pandemic: Autoethnography

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Abstract

This paper is an autoethnography written with the purpose to increase understanding of how the evidence about COVID-19 pandemic informed and impacted personal and cultural experiences. Through reflection and personal self-assessment, the authors documented narratives about changes that occurred in their lives and in society due to the COVID-19 pandemic and social isolation. They then identified personal narrative themes related to COVID-19 related experiences of 'uncertainty,' 'illness stigma,' 'increased disparities,' and 'lack of resources' across the authors' narratives. In theme related inquiries, systematic searches of research and literature were then used to develop increasing understanding about these themes on a larger scale. Finally, implications were discussed to inform COVID-19 experiences.

During December of 2019, the COVID-19 strain of coronavirus— unbeknownst to the public at the time— was rapidly spreading throughout Wuhan, China (Centers for Disease Control and Prevention, 2022). Initial symptoms of fever and shortness of breath were present in multiple groups of patients on December 12, 2019. These symptoms were later identified as an unknown pneumonia on December 31, 2019 (Centers for Disease Control and Prevention, 2022). By January 7th, 2020, Chinese officials collaborated with the Centers for Disease Control (CDC) and the World Health Organization (WHO) to identify the cause of this unknown pneumonia as the coronavirus (Centers for Disease Control and Prevention, 2022). On January 17th, 2020, screenings from Wuhan flights into the United State began in effort to begin contract tracing. The results from these screenings were found to be positive on January 20th, 2020, and the CDC promptly executed their Emergency Response system the following day. The WHO's International Health Regulation Emergency Committee convened on January 22, 2020 and decided to monitor and reconvene 10 days later, neglecting to initially declare the coronavirus as a Public Health Emergency of International Concern (Centers for Disease Control and Prevention, 2022). The WHO declared the coronavirus as a Public Health Emergency of International Concern on January 31, 2020. It is not until March 11, 2020, that the WHO declared COVID-19 a pandemic (Centers for Disease Control and Prevention, 2022).

The occurrence of the COVID-19 pandemic has challenged the norms and routines of societies and their populations. The purpose of this paper is to dissect and discuss the evidence about changes in learning, working, thinking, teaching, and behaving in relation to the COVID-19 pandemic, noting how those changes affected ourselves, the authors, as well as others and our culture. Motivations for completing this work lie within the need of self-reflection and self-assessment of culture and self. Motivations for completing this paper also lie within the impacts

of COVID-19 and the restraints it presents, affecting the ability to perform social research and collaborate in-person with others. Additionally, this paper may also be used in the future, following the resolution of the COVID-19 pandemic, to reference and understand scholarly evidence available to us amidst the pandemic.

This paper is an autoethnography, meaning that the narrators will reflect perspectives of the COVID-19 pandemic through the lens of our own perspectives, reflections, and experiences. This is achieved by journaling our personal narratives and then identifying social and cultural associations, and finally by conducting inquiries crafted by our own critical thinking and with existing academic research, evidence, and literature. Scholarly research, journal articles, and literature inquiries will follow the personal narratives advance understanding by academically correlating and acknowledging the implications of COVID related evidence relative to the personal narrated experiences and thoughts.

Narratives

Journal Writings by Author AM

Journal One, November 11, 2020: Illness Stigma

During the summer of 2020, I moved into a college house with two strangers. One of them was meeting a friend for drinks and I offered to be the designated driver. It has been five months since the disruption of our lives, and only about three months since you could once again dine-in at a restaurant.

Being the person in the house under twenty-one, it only made sense. I had been isolated from friends, family, and even strangers for so long that I figured it would be nice to be friends, or at least friendly, with my new roommates.

We arrived at the patio, and I was astonished to find that my new roommate's friend is a mutual friend of mine. Of course, we barely knew each other, but we knew enough to remember each other's names as well as the reason for our minimal--yet present--connection.

An eerily foretelling comment was made that would be ingrained in my mind for months: "I'm surprised you're still friends with them. No one I know usually makes it this far with the friends they made their freshman year".

Just a few weeks later, a friend group that defied the odds of the norm, would succumb to the expectations around them. Ruined friendships, broken leases, and tarnished reputations would become the forefront of our lives. Two positive COVID-19 tests were the catalysts that sparked and exalted these problems in our lives.

Arguments over who gave it to whom, who got it from whom, and who got it from where ignited instantly. As the only friend not living with or exposed to those affected, it was difficult to understand everything that was happening. And due to the need to be isolated from one another, digital communication invoked further miscommunication and frustration. This only furthered my emotional isolation, in addition to the physical and social isolation I had become accustomed to.

Friendships made since day one of college that had built strong enough bonds to decide to live together for years would end in seconds over the development of illness. How could relationships be so deeply affected by the development of an illness? Where does compassion go during the onset of illness? During a time of crisis and isolation, how could a life-threatening illness threaten someone's relationship and reputation?

Journal Two, November 31, 2021: Lack of Resources

The COVID-19 pandemic has unfortunately exalted vulnerable populations further from the resources they need. Businesses are either closed, limited access to public, or online only; medical offices have limited appointments, and grocery stores have limited stock to offer. Though most businesses seem to have resumed serving the public, many businesses as well as medical offices are prioritizing offering online services such as online ordering or telehealth. And, though toilet paper and Lysol seem to be available compared to the 2020 toilet paper shortage, numerous factors have continued to influence the availability of various everyday products.

At the beginning of the pandemic, when the vaccines first became available, it was difficult to find an available vaccine. During the spring of 2021, I volunteered at a local community health center. This community health center traveled to local churches and schools to supply and administer vaccines, especially to vulnerable populations. I was a part of this process in many ways such as observing the patients after the vaccine and handling paperwork.

In the summer of 2021, the community health center that I had volunteered at in the spring offered me a temporary summer position in the office department. This position involved verifying vaccination status' and offering the vaccine to those who had not had any COVID-19 vaccines on file. Throughout my employment with this company, I learned a lot about diverse populations and differing opinions about COVID-19 and the COVID-19 vaccination.

I encounter much misinformation regarding the vaccine that I had to clear up over the phone with potential vaccine candidates. Through my experience in this, it seemed that vulnerable communities were more susceptible to spreading misinformation about the COVID-

19 virus and vaccination. These populations usually had a more challenging time accessing healthcare, more difficulties affording food costs and sustainable housing, and had more complications with their health. If this population had more vulnerabilities and risk factors associated with COVID-19, why did they refuse the COVID-19 vaccination more often?

I also witnessed a refusal to acknowledge the reality of the virus and vaccination amongst other vulnerable populations throughout my town, such as the homeless population. The problems of the homeless population were further exalted because of COVID-19. Housing, food availability, and even access to public bathrooms, public shelter, and public transportation was minimized or even, at times, non-existent due to COVID-19 regulations. Yet, this population does not trust the reality of the COVID-19 population. This may be because many of those who are homeless also have underlying mental illness and are likely to experience paranoia, superstition, anxiety, or depression related to the reality of the virus. However, the problems regulations exalted for this population remain relevant. How can we address these ongoing problems now? How will we view our response to the pandemic in the future?

Journal Three, December 31, 2021: Uncertainty and Mental Health

Uncertainty... It is ironic how the normalcy of "uncertainty" has become the only certainty in our lives. "Due to the uncertainty of COVID-19" seems to have become a universal safety net to use as a reasoning, a rationale, a caution, or an excuse. There have been many influences upon the principles surrounding the uncertainty of COVID-19: The virus itself, the vaccines, the booster, and especially now--- the variants. Just when society can feel confident that this virus has become well-contained; when Americans have mostly accepted the virus as real and the vaccines are safe and effective; the Omicron variant has outscored all other and

original variants of COVID-19 and has shaken people to become skeptic, untrusting, fearful, and anxious.

We must now repeat the same cycles of uncertainty, fear, anxiety, and change once again. However, the most influential cycle we must start is adaptation.

"December 27th, 2021: the CDC (Centers for Disease Control) has shortened the isolation precautions to 5 days".

"AHA (American Hospital Association) retracts need for healthcare workers to don PPE (Personal Protective Equipment) prior to starting CPR on COVID-positive patients".

The first response following the uncertainty is feelings of fear and anxiety. In the days following the announcement of the changes the CDC and AHA has made to COVID-19-related care, nurses and healthcare workers across the nation have taken to media to post their qualms about what these changes could do to not only healthcare workers and those hospitalized, but to the entire population. "How can we trust these new precautions?", "What sources do they have to solidify their rationale?" is being asked in addition to the never-ending questions of "How much staff are we going to lose to these changes?" "How much staff do we even have left?" "How many beds do we have left?".

Amidst this pandemic, I have fallen into the emotional cycles of fear and anxiety daily. I have, of course, been able to be thankful a few times over the course of almost two years. I have been thankful for declining numbers, decreasing hospitalization, increasing vaccinations, and increasing acceptance. Despite this, I have been unable to feel relieved.

The uncertainty of change and adaptation brings about a level of anxiety that seems non-comparable to the mild or even non-existent anxiety I felt prior to the pandemic. Every day I fear for the lives of those hospitalized, for my family members who are immunocompromised, for my

family members experiencing long-term complications of COVID, that I may unknowingly have COVID, new variants, the changes made between online and in-person nursing school, and I fear my future as an RN (registered nurse). As a current healthcare worker, I have witnessed firsthand the accelerated burnout of healthcare workers during this pandemic.

This trend of burnout and anxiety leaves me to question adaptation. How do we navigate adapting to living the lives we lived before this pandemic; during the times of this pandemic, while trying to stop this pandemic? We may live in a shell of what we once had prior to this pandemic, but the uncertainty of COVID leaves us to question ourselves, others, and our system. In the United States, how has uncertainty affected the emotional states of those receiving an education, those as essential workers, and the population as a whole? How are the findings amongst these groups similar, and how do they differ? How do the policies of the U.S. differ from other countries, and have these policies influenced the findings related to uncertainty in the specified U.S. subpopulations? What are the consequences associated with these findings?

Journal Writings by Author EA

Journal Entry 1, October 2020: Injustice and Social Justice

While scrolling on twitter, I saw that #ENDSARS was trending in Nigeria. I clicked on it and suddenly, my timeline was filled with posts of shootings, protests, and dead bodies. Not long before this, the Black Lives Matter movement began trending in America so sad to say, I was desensitized to the gore. However, this felt different because Nigeria is my home. I saw so many familiar faces in the protest pictures. These are my friends and family at the forefront of danger and violence by a militia that was formed to protect us

The Special Anti-Robbery Squad [SARS] was created to fight armed robbery and other crimes. However, like everything else made to help the Nigerian people, they became corrupt

and used their power to terrorize. There are many stories of SARS harassing people for reasons like having colored hair, dreadlocks, owning a laptop or smartphone. They not only harass but they collect all their money, beat them, or throw them in jail if their demands are not met. It is the scary but true story of the world we live in.

Despite the good intentions, the protests turned bloody. On the first day, around 10 – 20 people were shot in Surulere. The violence was perpetuated by the SARS officials. They were the ones shooting, kidnapping, and killing. Worst of all, they were aided by the government. Thugs were paid to disrupt the process and tear gas protesters. The banks that people donated money through were shut down. They even renamed SARS to SWAT to avoid disbanding them. They said they will deploy them to other police units which is absolute bullshit. They do everything but what we ask for.

But people have decided to fight back. The #ENDSARS protests started on the 8th of October and grew to be a decentralized movement. Meaning that there was no one group controlling the planning or agenda. People took and gave support wherever they could find it. There were contributions of food, outdoor shelter, money, refreshment, and medical supplies. Lawyers even volunteered to represent people who were arrested by the police. It has been so nice to see the community grow and be supportive in these dire times.

What is it about the pandemic that made people desperate enough to risk their lives to fight the injustice/oppression that they have experienced their whole lives. How were we able to come together and mobilize when we meant to be farthest from each other?

Journal Entry 2, July 15, 2020: **Uncertainty of What to Believe and the Measures to Take with COVID**

My parents called me today and I could tell that they were worried about COVID. Normally we have fun and light conversations or talk about the work I must do. But now, it is all about symptoms, social distancing and me staying at home. They asked what I had been doing to keep myself safe and I told them about washing my hands, sanitizer, masking all the time and disinfecting, as necessary.

They brought up drinking herbal teas, taking dogoyaro [an herbal stick that can be boiled with pineapple skin, garlic, ginger, and turmeric], azithromycin antibiotics and malaria pills. I tried telling them that those were not proven cures or ways to prevent COVID, but they were insistent.

However, a part of me did believe that those were adequate preventative methods for COVID. But with all the information floating around, there was no way to be sure. Do I go with science, which is constantly changing and has limited availability, or go with more traditional medicine and my parents? Being in the science field, it is easier to go with the former option but there is the thought that we overlook other medicine types or view them as more primitive. However, there may be truth and effectiveness to these "primitive" medical approaches. than we think

Journal Entry 3, March 27, 2021: Guilt about Socializing and Anxiety during Quarantine

This is my third time isolating and I am so tired. I went for clinicals last week Tuesday and found out that my instructor was infected with COVID. We found out on Thursday and now I need to be isolated because I could not get an appointment and something about breeding days or whatever. My aunt says that I do not need to be isolated because if I have COVID, then everyone in the house has it since I have been cooking, socializing, and touching utensils and all that.

A part of me knows that she is right, but I am also nervous about spreading it in case I do. I have no symptoms and feel okay, but I also have constant anxiety about it. My uncle and cousin are asthmatic and that makes them more vulnerable to it. Even if I do not have it, what if it is in me and I can spread it to them? I am just worried about this whole thing.

I hate the quarantine and I feel dumb for doing it in the first place, but I know that if I do not, then I will never feel comfortable.

At least this time I do not feel guilty about having it. I had to go to clinical and I wore my mask there and everything. The last time I quarantined, it was because I went to see a friend and she found out her dad had it. That was so scary, and I just wanted to cry because I felt like a horrible person. I really missed my friend and I know that we had both been incredibly careful, but things happen when you least expect it.

I have just been binge watching one of my favorite shows and talking to my friends so I feel a bit better. Only two more days and I can get tested and be more relieved about everything. But it is like, is this how the world is going to be forever? And what of those who are doing whatever they want and never get infected. Am I just being paranoid? Or is this something that is keeping everyone safe. Honestly, I am just going to sleep a lot so the time will go by faster.

Inquiry I: Illness Stigma and COVID-19

Our first inquiry is guided by the following question: How are people worldwide who are being exposed to COVID-19 perceiving stigmatization throughout the progress of the pandemic?

Search Strategies

Academic Search Complete was utilized during the literature search with a focus on the MEDLINE with Full Text, Psychology and Behavioral Sciences Collection, SocINDEX with Full Text databases. Initially, the keywords were "stigma" and "covid-19," but that provided limited results. We then broadened our searches to include "covid-19 or coronavirus or covid-19 pandemic AND stigma or perceived stigma or illness stigma," "Covid 19 Stigma AND covid-19 or coronavirus or 2019-ncov or sars-cov-2 or cov-19" and Illness Stigma AND covid-19 or coronavirus or 2019-ncov or sars-cov-2 or cov-19"

We selected 12 academic publications and sources. Of those 12, two are a combination of qualitative and quantitative research. Five are exclusively qualitative: specifically, interviews, cross sectional, and observational studies. Our other academic inquiries are comprised of commentaries, letters to the editor, and the website of Centers for Disease Control and Prevention [CDC]. All publications were generated between 2019 – 2021 with sample sizes ranging from 18 to 311. Study sites covered the United States, India, Kenya, Egypt, Malaysia, Ethiopia, South Sudan, Somalia and Nigeria.

The following levels of evidence were generated by our sources: Bhatnagar et al. (2021) is a cross-sectional descriptive quantitative study generating evidence of qualitative level six (Schmidt & Brown, 2017, p. 8). Yuan et al. (2021) is a cross-sectional quantitative correlational study which generated level five (Schmidt & Brown, 2017, p. 8). Yu Deng et al. (2021) generates a six level of evidence, as it is a descriptive qualitative study with a sample of 5

subjects, similar to Sahoo et al. (2021) and Hall et al. (2021) who provided descriptive and narrative qualitative evidence at level of six (Schmidt & Brown, 2017, p. 8). Bologna et al. (2021) generates an evidence level of eight as it is made up of an evidence-supported argument about how the communities can be the focus to decrease COVID-19 related stigma, referring to previous use of the CORE Group Polio Project (CGPP) (Schmidt & Brown, 2017, p. 8).

Description and Discussion of Literature

Illness stigma is a social stigma which facilitates discrimination or social inequality against an individual due to their perceived association with a health condition. Uncontrollable factors, such as nationality, grouping, and stereotyping can subject an individual to illness stigma. Illness stigma in relation to COVID-19 is not a newly conceived notion. For instance, a group of individuals who have historically and drastically been susceptible to illness stigma are the AIDS/HIV+ population. Examining illness stigma through a historical lens can enable us to compare and contrast between our present and past, educate us to guide our current practices, and mitigate negative outcomes associated with illness stigma (Samal et al., 2021).

During the HIV/AIDs endemic, the fear of intimacy and sex was persistent. Some groups, due to their sexual orientation and/or identity, were vulnerable to discrimination associated with HIV/AIDS-related illness stigma. This illness stigma resulted in social isolation. Though fearfulness gradually decreased over time which, in turn, decreased the discrimination and isolation associated with illness-stigma; commonalities appeared early on during the COVID-19 pandemic, such as a fear of gathering and grouping and social isolation. Notable differences between the HIV/AIDS endemic and the COVID-19 pandemic, such as the mode of transmission and the need for social distancing and isolation, make it more difficult to identify COVID-19 related social isolations that are discriminatory-based. However, strong commonalities exist

between both historical contexts, such as the profound fear of acquiring the disease, fear concerning the origins of the disease, and fears related to doubting credibility. (Samal et al., 2021). Fears related to doubting the credibility of information about COVID-19, or rather— a lack of understanding about COVID-19, was identified as a key factor in one study examining interfamilial COVID-19 related illness stigma (Chew et al., 2021). Additionally, one qualitative study also noted an increased fear of subpar medical care and increased fear of vulnerability and found these findings strikingly similar to findings of previous studies completed on HIV/AIDS associated illness stigma (Hall et al., 2021).

Elgohari et al. (2021) and Yuan et al. (2021) utilized studies to quantitatively measure the level of stigma experienced by COVID-19 patients. Researchers in Egypt and China analyzed patients with the COVID-19 Infection Stigma Scale and the Social Impact Scale respectively. The COVID-19 Infection Stigma Scale is a "self-report quantitative tool" (p. 2) made up of questions related to feelings about the infection, disease coping and the reactions of friends and family (Elgohari et al., 2021). The results of the study concluded that the "COVID-19 Infection Stigma Scale is a valid and reliable instrument for the Egyptian people" (Elgohari et al., 2021, p. 5). The scale is found to have strong convergent validity, reliability, external and internal consistency and may "stimulate the advancement of operational research and the development of strategies to reduce the stigma related to COVID-19" (Elgohari et al., 2021, p. 6)

The Social Impact Scale is a cross-sectional study with survivors of COVID-19 and healthy controls. Subjects were questioned in domains of financial insecurity, social rejection, social isolation, and internalized shame. Using the Social Impact Scale, researchers found that "status as a COVID-19 survivor, having family members infected with COVID-19, being married, economic loss during the COVID-19 pandemic, and depressive symptoms were

positively associated with higher overall stigma levels" (Yuan et al., 2021, p. 1). They concluded that those who survived COVID-19 or are connected to them should be routinely assessed and provided with adequate psychological support as the experience can be distressing.

Illness stigma creates senses of shame, rejection, humiliation, stress, discrimination, stereotyping, and loss of social status. The introduction of illness stigma hinders coping with not only physical recovery, but also with social recovery. (Naeim et al,, 2021). Additionally, because of the social inequality created by illness stigma, social disparities may either be conceived or exalted. Social disparities have repeatedly been evident to lead to health disparities. Therefore, efforts to reduce illness stigma are essential to minimize negative social and mental health outcomes (Samal, 2021).

As discussed above are the manifestations and consequences of external stigma, or social stigma. Manifestations of internal stigma, or self-perceived stigma, may arise in those who may or in fact test positive for COVID-19. One article published by the *Indian Journal of Psychological Medicine* describes self-perceived stigma as feeling "dirty, ashamed, guilty, worthless, and meaningless" (Bhatnagar et al., 2021). It is important to recognize self-perceived stigma because persistent feelings of shame, guilt, worthlessness, and meaninglessness positively correlate with symptoms of developing mental illness.

In consideration with current available qualitative and quantitative research studies, it is apparent that COVID-19 associated illness stigma is present, persistent, and problematic. Minority groups are the most vulnerable population to face illness stigma, and this consistency was apparent throughout the COVID-19 pandemic. Additionally, healthcare providers, emergency responders, and people who convene in groups are identified by the CDC to have heightened vulnerability to COVID-19 related illness stigma (CDC, 2019). Interestingly, it is

important to note that illness stigma can happen amongst the populations identified as vulnerable to illness stigma. One study recognized the qualitative finding of two cases of healthcare workers stigmatizing their colleagues (Grover et al., 2020).

As we have identified vulnerable groups, investigated historical contexts, and referenced literature for qualitative and quantitative findings related to COVID-19 associated illness stigma, we have begun to note trends relating to illness stigma, burnout, minority group responses, and mental illness. Since the beginning of the pandemic, people worldwide are experiencing illness stigma. Symptomology consistent with these struggles brings forth ongoing mental health concerns

Inquiry II: COVID-19, Mental Health, and Uncertainty

Our second inquiry is guided by the following question: How are people worldwide perceiving COVID-19 related uncertainty, illness stigma, and burnout throughout the progress of the pandemic?

Search Strategies

Academic Search Complete was utilized during the search with a focus on the following databases: CINAHL Plus with Full Text, Academic Search Complete, Psychology and Behavioral Sciences Collection, MEDLINE with Full Text, Psychology and Behavioral Sciences Collection. Taking a lesson from the first inquiry search, we broadened our keywords from the start. They included “mental health or mental illness or mental disorder or psychiatric illness AND covid-19 or coronavirus or 2019-ncov or sars-cov-2 or cov-19 AND guilt or shame or self-blame” and, “covid-19 or coronavirus or 2019-ncov or sars-cov-2 or cov-19 AND mental health or mental illness or mental disorder or psychiatric illness OR uncertainty or unprecedented or anxiety or depression or suicide.” The retrieved sources were about aspects of uncertainty as well

as the psychological impacts of COVID-19 and mental health. Sources discussing the impact on healthcare workers were also prioritized.

We selected 11 academic sources and publications. Of those 11, Warchol-Biedermann et al., (2021), Wilson et al. (2021), Kaplan et al. (2021), and Li et al. (2020) are descriptive and correlational quantitative methods and findings. Kardas (2021) and Medhi et al. (2020) are descriptive qualitative methods and findings. Other sources included Muhktar (2019), Pai & Vella (2021), Torales et al., (2020) who reviewed past articles on the psychological effect of COVID-19 on mental health. Finally, Cavalera (2020) and Gordon (2021) discussed the current pandemic and the efforts made to provide resources and increase public awareness. All sources were published between 2019 - 2021. The sample sizes ranged from 170 - 926, and study sites included Turkey, Pakistan, New Zealand, Brazil, Italy, Paraguay, Poland, Australia, China and New York.

The following levels of evidence were generated by our sources: Kardas (2021), and Mehdi et al. (2020) generated evidence at level six using qualitative methods (Schmidt & Brown, 2017, p. 8). Warchol-Biedermann et al., (2021), Li et al., (2020), Wilson et al., (2021) and Kaplan et al., (2021) provided evidence levels of five and six, using quantitative, cross sectional and correlational study methods of collecting and analyzing data to reflect the pandemic effects and mental health, especially in cases of burnout and ineffective coping in the medical field (Schmidt & Brown, 2017, p. 8). Gordon J., (2021), and Cavalera (2020) discussed the challenges faced during the COVID-19 pandemic over the past one year, emphasizing the shame and guilt experienced which, amongst other things, has triggered and worsened mental health disorders in the public. Both articles generate an evidence level of seven (Schmidt & Brown, 2017, p. 8). Muhktar (2019), Pai & Vella (2021) and Torales et al., (2020) generate evidence level five as

they provide systematic reviews of descriptive and qualitative studies (Schmidt & Brown, 2017, p. 8).

Description and Discussion of Literature

Worldwide, people were affected by the isolation during the pandemic. According to the World Health Organization (2022), loneliness during lockdown contributed to depression following lockdown. Initially, the prevalence of major depression increased by 7% after the outbreak (Torales et al., 2020). According to a recent scientific brief released by the WHO (2022), anxiety and depression increased by 25% globally. People's struggles with work (employment, hours, etc.), troubles seeking support from loved ones, and disengagement within their communities are listed as contributing factors (World Health Organization, 2022). Risk factors for developing major depression during the pandemic period included being female, being of lower socioeconomic status, interpersonal conflicts, decreased social support system, and decreased resilience (Torales et al., 2020). Loneliness in the elderly—a declared endemic in some countries around the world prior to the COVID-19 pandemic— increased during the pandemic (Pai & Vella, 2021). However, increased negative mental health symptomatology related to increased loneliness was not consistently found in elderly populations (Pai & Vella, 2021). Heightened isolation and increased mental illness symptomatology were observed amongst women, young adults, and in those who lost some social support due to the isolation necessities of COVID-19 (Kardas, 2021; Mukhtar, 2020; Pai & Vella, 2021; World Health Organization, 2022). Frequent social media use was also identified as a risk factor due to the findings that exposure to conflicting information through media resulted in higher acute stress (Torales et al., 2020; Mukhtar, 2020).

Compared to the heightened stress associated with frequent social media use, increased uncertainty surrounding COVID-19, especially in media, was another cause for distress (Mukhtar, 2020; Torales et al., 2020). In a publication in the *International Journal of Social Psychiatry, Mukhtar (2020)* wrote: "Conspiracy theories, false claims, misinformation and disinformation (mainly exclaiming coronavirus as Unbreakable, Unstoppable, Unbeatable) are only exacerbating the mental composure of the general public." Feelings of uncertainty are a persistent feeling of a perceived threat to the present and future, making it difficult for some individuals to cope with the pandemic (Kardas, 2021). Additionally, uncertainty may distort one's perceptions of risk (Torales et al.., 2020). During the pandemic, uncertainty exacerbated fear and ignited feelings of anger, anxiety, depression, and somatic disturbances in the general public and especially those with mental illness (Kardas, 2021; World Health Organization, 2022). Therefore, this linkage between uncertainty and media may be a cause for concern of developing or worsening symptoms of mental illness during the pandemic.

In the general public, adverse mental health outcomes may be mitigated by decreasing COVID-19 related media consumption (Kardas, 2021). Misleading media regarding false showcases of resilience may also be stigmatizing and promote marginalization, as "not everyone can perceive a traumatic event as an opportunity for learning" (Mukhtar, 2020). The pressure to utilize stay-at-home orders for personal growth may also manifest feelings related to failure such as shame, guilt, regret, sadness, and anger (Mukhtar, 2020). Further, higher achievability to cope may be related to adequate preparedness and seeking appropriate help (Kardas, 2021; Mukhtar, 2020).

Another risk factor for mental health deterioration was being a healthcare worker. Inadequate personal protective equipment (PPE), contamination related to inadequate PPE,

burnout, exhaustion, frustration, hopelessness, overwork, discrimination, and lack of contact with their families are aggregating factors (Medhi et al., 2020; Muhktar, 2020; Torales et al., 2020). A common denominator within these aggregating factors may be inadequate preparedness. Prevalence and intensified PTSD in healthcare workers, especially those working in emergency departments and psychiatric wards, was found to be also relevant when addressing COVID-19 related mental health factors and COVID-19 related burnout (Muhktar, 2020; Torales et al., 2020). Further, exhaustion in healthcare workers was found to be a leading factor of suicide in this population (World Health Organization, 2022). Any and all mental health deterioration in healthcare workers may affect decision making for themselves and others, which is an important aspect of care (Torales et al., 2020).

Despite the negative associations and effects of COVID-19 with mental health, there is hope; as some have found a decrease in fear and anxiety as the pandemic progressed (Kardas, 2021). Comparatively, coping with anxiety and fear may not be apparent, however, adapting to uncertainty may be apparent, as decreased anxiety and fear levels have been observed (Kardas, 2021).

In summary, due to the progression of the pandemic, we have begun to see the progression of the public's reaction to mitigate the spread to the public's reaction to "return to normal." Efforts to return to normal, such as the re-opening of businesses and lessening of restrictions, are not yet consistent. But, by beginning to adopt changes, questions surrounding efforts of mitigation imposed by COVID-19 restrictions, as well as questioning our system as a whole, seem apparent in conversation and in the media. As discussed in the review of the literature, disparities in access to resources and disparities amongst populations posed different health risks to certain populations (Cavalera, 2020; Gordon, 2021; Kardas, 2021; Medhi et al.,

2020; Muhktar, 2020; Pai & Vella, 2021; Torales et al., 2020; Li et al., 2020; Warchol-Biedermann et al., 2021; Wilson et al., 2021; World Health Organization, 2022). These findings lead us to pose another question: In what other ways has COVID-19 disrupted and exalted disparities to resources and disparities amongst populations worldwide?

Inquiry III: Lack of Resources and Viewing the Pandemic's Effects in Nigeria

Our third inquiry was guided by the following question: In what other ways has COVID-19 disrupted and exalted disparities to resources and disparities amongst the people of the United States, Nigeria, and other countries? Nigeria was a focus of this inquiry, based on families and friends living there.

Search Strategies

Academic Search Complete was utilized during the search with a focus on the following databases: CINAHL Plus with Full Text, Humanities Full Text (H.W. Wilson), MEDLINE with Full Text, Psychology and Behavioral Sciences Collection, SocINDEX with Full Text, Sociological Collection. Keywords included "covid-19 or coronavirus or 2019-ncov or sars-cov-2 or cov-19 AND resources or supplies or vaccine or vaccinations or access or accessibility" and "covid-19 or coronavirus or 2019-ncov or sars-cov-2 or cov-19 AND pandemic or covid-19 or coronavirus AND business or company or organization or corporation or workplace or public or services ", "Nigeria AND insurgency AND Covid" and, "Anti-mask AND covid-19 or coronavirus or 2019-ncov or sars-cov-2 or cov-19". The sources brought up keywords related to governments actions concerning COVID-19, the spread of vaccination efforts, and factors that contributed to lack of resources and disparities experienced in various countries.

13 sources were selected, all published between 2020 – 2022. Sample sizes ranged from 127 – 2078, and study sites included The United States, Finland, Nigeria, Ethiopia, Germany,

The United Kingdom and China. Hebbani et al. (2022), a comprehensive analysis reviewing the lineage of COVID-19 variant, generated a level of evidence of one (Schmidt & Brown, 2017, p. 8). Gebru et al. (2021), a systematic review of descriptive studies, generates a level five of evidence, along with Ohia et al., 2020's qualitative review, and WHO's scientific brief (Schmidt & Brown, 2017, p. 8). Jones & Comfort (2020) and Taylor & Asmundson (2021) are commentaries that generated a level of evidence scoring of seven (Schmidt & Brown, 2017, p. 8). Mallinas et al. (2021) and Koehnlein & Koren (2022) are descriptive quantitative studies that generated a level evidence score of six (Schmidt & Brown, 2017, p. 8). Tijjani & Ma (2020), Oladele (2020), Asogwa et al., (2021), and (Shang, 2021) are commentaries and examinations generating a level of evidence seven (Schmidt & Brown, 2017, p. 8). One additional source was utilized by using Academic Search Complete. Keywords used for this source were limited to "police brutality and covid-19". Abang et al. (2021) is the source resulting from this singular search. Abang et al. (2021) is a single descriptive study which generates a level evidence scoring of six (Schmidt & Brown, 2017, p. 8).

Description and Discussion of Literature

The fight against COVID-19 has been a global effort. Governments all over the world have been tasked with creating and executing public health interventions, policies and measures to control the spread of COVID-19 (Tatar et al., 2021). These efforts have resulted in the production, dissemination, and administration of the COVID-19 vaccine and other pharmaceutical and non-pharmaceutical interventions and resources. However, globally, these efforts and distributions have varied wildly. Tatar et al. (2021) found that some countries have vaccinated a larger part of their population, while others have yet to begin a vaccination campaign. This differences in actions and results may lie in "the role of good governance and

indicators of government effectiveness in the purchase and administration of COVID-19 vaccines" (Tatar et al., 2021, p. 2).

A study of 172 countries was conducted to analyze the relationship between government indicators and COVID-19 cases, vaccination rates and deaths. The six indicators included "voice and accountability, political stability and absence of violence, government effectiveness, regulatory quality, rule of law, and control of corruption" (Tatar et al., 2021, p. 2). The authors found a positive relationship between high COVID-19 vaccination rates and high presence of positive government indicators. The countries with high presence of these indicators consisted of the United States, United Kingdom, New Zealand etc. On the other hand, the cluster of countries with poor governance characteristics that had not started COVID-19 vaccination when the study was carried out included mostly African and Middle Eastern Countries, such as Nigeria, Iraq, Sudan, Eritrea, Iran etc. (Tatar et al., 2021).

Poorer response to the COVID-19 pandemic can be attributed to many factors. Looking at Nigeria specifically, the presence of its fragile health care system hinders the ability to respond effectively to the current outbreaks (Ohia et al., 2020). However, this may not be evident due to the low/unknown number of reported COVID-19 cases. Ohia et al. (2020) found that "healthy people are not tested unless they have a travel history to high-index countries within a stipulated time period" (p. 280). This leads to underreporting of deaths associated with COVID-19, and there could be a higher number of infected people in Nigeria than is currently known. Without preemptive measures in place, the disease progression in infected people may then lead to intensive and critical care needs. This need cannot be met as the "inventory of ICU units would reveal dilapidated and obsolete facilities available for the management of such patients that may

require these facilities" (Ohia et al., 2020, p. 280). If better facilities do exist, they are often only accessed by the rich and elite.

This is not the first instance that essential resources have been restricted to select few. At the beginning of the pandemic, palliatives and social provisions were promised but came with maladministration and inefficiency that left the most vulnerable population empty-handed (Asogwa et al., 2021). Those palliatives were instead shared at the events of political leaders with their associates. In the past, and currently, funds have been misused and misallocated which results in those needing it most not having access to it. All these factors have been prevalent in Nigerian society for years but COVID-19 brought out dissenting voices (Oladele, 2020). For the first time, there was nothing to do but be at home and it gave people the opportunity to mobilize and actually speak out on the horrible treatments endured.

The first positive COVID-19 case was confirmed in Nigeria in February 2020 (Asogwa et al., 2021). Since then, the disease has spread to 34 of 36 states as well as the Federal Capital Territory. Oladele (2020) found that "as at 9 June 2020, there were 13,464 infected persons, 4,206 discharged persons and 365 deaths in Nigeria" (p. 94). In response, the government issued lockdowns in Abuja, Ogun and Lagos State. Offices and businesses were closed down, religious and social gatherings were banned, and interstate travel was restricted to essential services in order to control the spread of the disease (Oladele, 2020).

The Nigerian President and State Governors derived the power to issue these restrictions from The Quarantine Act. It was enacted in 1926 but was replaced in 2020 by the Control of Infectious Diseases Bill to control infectious disease spread in Nigeria (Oladele, 2020). Despite being seen as a step forward, the new Bill "gives the Director General of the Nigeria Center for Disease Control and the Minister for Health, 5 arbitrary powers which violate human

rights" (Oladele, 2020, p. 94]. These include; compulsory vaccination of Nigerians, seizure of documents, closure and/or destruction of business areas, and unwarranted arrest with the reasoning of preventing the spread of COVID-19. It goes on to provide police officials and government with immunity against legal action for actions committed. In this way, the new Bill infringes on the rights of Nigerian citizens (Oladele, 2020).

Koehnlein & Koren (2022) reported that pandemics encourage governments to rely on military and police officials to enforce certain rules but when unchecked, they open the door for violent behavior by these groups. The allowances made by the Control of Infectious Diseases Bill escalated police action against civilians. Asogwa et al. (2021) reported the occurrence of "police torture of civilians, denying people arrested by the police access to the justice system, the partiality of the judges when administering justice, the inability of the police to address the complaints of the arrested and extrajudicial killings" [p.59]. There was also evidence of profiling and degrading of citizens due to certain features such as dreadlocks, colored hair, driving cars or carrying electronics (Asogwa et al., 2021).

These acts carried out by the Special Anti-Robbery Squad (SARS) sparked the EndSars protests by the public. What began as a social media protest with the hashtag #ENDSARS grew into a mass movement that called for the disbandment of SARS as well as "provisions of appropriate compensation for the families of the victims of police brutality, the establishment of an independent panel of inquiry on police brutality both at the federal and state levels" (Asogwa et al., 2021, p. 60). The outcry reached international ears but there are still changes to be made on a fundamental level. The United Nations has called for support in providing

public health resources to enhance preventative measures and interventions for COVID-19 in places impacted by humanitarian right violations and limited access to resources (Tijjani & Ma, 2020).

Despite the physical distancing caused by the COVID-19 pandemic, people worldwide have found ways to come together in support and protests against injustices by higher powers. However, not all measures and laws put in place are intended to cause harm or violates human rights. Further preventative and therapeutic strategies are highly called for due to the virus's high morbidity and mortality rate (Hebbani et al., 2021). Measures such as the wearing of masks in public places, social distancing, quarantine, etc., have been put in place to slow down the spread of COVID-19 (Taylor & Asmundson, 2021). While some people agree with this, others are calling for a return to normalcy and restoration of civil liberties (Mallinas et al., 2021).

One country where some people are calling for a return to normalcy and restoration of civil liberties id America (Mallinas et al., 2021). The increasing political polarization of America has contributed to diverse attitudes regarding mask use and other preventative measures (Mallinas et al., 2021). Media attention has been drawn to the highly vocal but small number of people who object to wearing masks (Taylor & Asmundson, 2021). This gives the appearance that majority of people are anti-mask which is not the case. The increased PR has also spread their opinions of those who dismiss social distancing and quarantine, and vaccination CDC recommendations (Taylor & Asmundson, 2021). These attitudes are reinforced with the opinion that the protective mandates violate constitutional rights and impede on freedom (Shang, 2021). This is not evidence of a human rights violation but instead reflects psychological reactance. Taylor and Asmundson (2021) describe psychological reactance as "a motivational response to rules, regulations, or attempts at persuasion that are perceived as threatening one's sense of

control, autonomy, or freedom of choice" (p. 3). People who feel this way react with anger, arguments or denial in order to assert their freedom (Taylor & Asmundson, 2021). Protest rallies are present; however, they generally progress without reaction from military officials like the rallies of Nigeria.

Worldwide, there are areas with true actual violation of human rights which results in violence and police brutality (Abang et al., 2021). These acts of violence and police brutality are associated with perceived and actual noncompliance of government mandates (Abang et al., 2021). People are unable to gather and peacefully protest against these violations without meeting brunt force that leaves them dead or injured. For those fortunate enough to live in places where this brutality does not occur to such degree, individuals should approach their state's current mandates and protective actions with a collectivism mindset. This collectivism mindset can be as simple as addressing current research supporting evidence-based practice. For example, evidenced-based practices such as implementing proper hand hygiene, adequate contact tracing, appropriate quarantine according to exposure guidelines, and proper mask wearing are the most practical and effective ways to reduce the spread of COVID-19 and protect everyone's safety (Gebru et al., 2021).

Conclusion

The COVID-19 pandemic has led to observable changes in learning, working, thinking, teaching, and behaving within ourselves, others, and our cultures. As discussed, illness stigma has contributed to changes in the way some people and cultures are perceived. Changes in thinking, including declining mental wellness, increased fear and uncertainty, and higher acute stress have been observed. Working and teaching have been disrupted due to the nature of the pandemic, need for social distance, and increased use of telecommunication. Though there is

heightened indulgence in media, media has been found to be perpetuating mental unwellness and higher acute stress. Healthcare workers have been especially susceptible to the negative influences of the pandemic due to the nature of their work, lack of preparedness, and continued lack of appropriate resources. Struggles for people to cope with uncertainty and stress associated with the pandemic are apparent despite the general ability to adapt to a new normalcy.

Along with lack of appropriate resources, diminished ability to utilize public resources has impacted the overall population and particularly the populations that rely on public resources as means for transportation, work, and other important aspects of daily living. Fluctuating availability of COVID-19 vaccinations and appropriate PPE such as masks laid additional stressors amongst populations around the world. Furthermore, the cultivation and implementation of COVID-19 vaccinations, vaccine mandates, mask mandates, and other public means have fostered argumentative discussion, resistance, standoff, and disputes surrounding the scope of government authority. Countries around the world have faced change in their government and system, as seen in our research of Nigeria.

We as individuals, groups, and cultures have been forever changed by the COVID-19 pandemic. Though a considerable amount of negative effects is evident, ultimately, it is important to remember that we are all impacted by COVID-19. The isolating nature of COVID-19 may lead us to falsely perceive a greater sense of loneliness. To cope, we must remember that our experiences dealing with COVID-19 are not entirely individual. In consideration with ourselves, others, and our culture; accurate self-assessment and empathy may be the forefront for a return to our desired normalcy.

References

Abang, S. O., Akpan, E. E., Uko, S. U., Ajayi, F. O., & Odunekan, A. E. (2021). Covid 19 protest movement and its aftermath effect on the Nigerian state. *Journal of Public Administration, Finance & Law*, *20*, 7–18. https://doi-org.ezproxy.uakron.edu:2443/10.47743/jopafl-2021-19-01

Asogwa, K. C., Edeh, H. C., Ajah, A. C., Omeh, P. H., Asadu, M. I., Ogbuabor, D. C., & Ngwu, E. C. (2021). The state, End SARS protests and human rights violation in Nigeria. *IKENGA: International Journal of Institute of African Studies*, *22*(2), 58–81. https://doi.org/10.53836/ijia/2021/22/2/004

Bhatnagar, S., Kumar, S., Rathore, P., Sarma, R., Malhotra, R. K., Choudhary, N., Thankachan, A., Haokip, N., Singh, S., Pandit, A., Vig, S., Ratre, B. K., Mohan, A., Lorenz, K., & Guleria, R. (2021). Surviving COVID-19 is half the battle; living life with perceived stigma is other half: A cross-sectional study. *Indian Journal of Psychological Medicine*, *43*(5), 428–435. https://doi-org.ezproxy.uakron.edu:2443/10.1177/02537176211029331

Bologna, L., Stamidis, K. V., Paige, S., Solomon, R., Bisrat, F., Kisanga, A., Usman, S., & Arale, A. (2021). Why communities should be the focus to reduce stigma attached to COVID-19. *The American Journal of Tropical Medicine and Hygiene, 104*(1), 39–44. https://doi-org.ezproxy.uakron.edu:2443/10.4269/ajtmh.20-1329

Cavalera, C. (2020). COVID-19 Psychological Implications: *The Role of Shame and Guilt. Frontiers in Psychology, 11*. https://doi.org/10.3389/fpsyg.2020.571828

Centers for Disease Control and Prevention. (2022, January 5,). *CDC Museum COVID-19 Timeline | David J. Sencer CDC Museum*. U.S. Department of Health and Human Services. https://www.cdc.gov/museum/timeline/covid19.html

Centers for Disease Control and Prevention. (2019). *Reducing Stigma*. U.S. Department of Health and Human Services. https://www.cdc.gov/mentalhealth/stress-coping/reduce-stigma/index.html

Chew, C.-C., Lim, X.-J., Chang, C.-T., Rajan, P., Nasir, N., & Low, W.-Y. (2021). Experiences of social stigma among patients tested positive for COVID-19 and their family members: a qualitative study. *BMC Public Health, 21*(1), 1623. https://doi-org.ezproxy.uakron.edu:2443/10.1186/s12889-021-11679-8

Elgohari, H. M., Bassiony, M. M., Sehlo, M. G., Youssef, U. M., Ali, H. M., Shahin, I., Elrafey, D. S., & Mahdy, R. S. (2021). COVID-19 Infection Stigma Scale: psychometric properties. *The Egyptian Journal of Neurology, Psychiatry and Neurosurgery, 57*(1), 61. https://doi-org.ezproxy.uakron.edu:2443/10.1186/s41983-021-00317-0

Gebru, A. A., Birhanu, T., Wendimu, E., Ayalew, A. F., Mulat, S., Abasimel, H. Z., Kazemi, A., Tadesse, B. A., Gebru, B. A., Deriba, B. S., Zeleke, N. S., Girma, A. G., Munkhbat, B., Yusuf, Q. K., Luke, A. O., & Hailu, D. (2021). The level of risk, effects response to potential health emergencies, prevention and control method of COVID-19: A systematic review. *Human Antibodies*, *29*(2), 149–169. https://doi-org.ezproxy.uakron.edu:2443/10.3233/HAB-200421

Gordon, J. (2021, April 9). One Year In: COVID-19 and Mental Health. *National Institute of Mental Health (NIMH).* https://www.nimh.nih.gov/about/director/messages/2021/one-year-in-covid-19-and-mental-health

Grover, S., Singh, P., Sahoo, S., & Mehra, A. (2020). Stigma related to COVID-19 infection: Are the health care workers stigmatizing their own colleagues*? Asian Journal of Psychiatry, 53*, 102381. https://doi-org.ezproxy.uakron.edu:2443/10.1016/j.ajp.2020.102381

Hall, A., Joseph, O., Devlin, S., Kerman, J., Schmitt, J., Ridgway, J. P., & McNulty, M. C. (2021). "That same stigma...that same hatred and negativity:" a qualitative study to understand stigma and medical mistrust experienced by people living with HIV diagnosed with COVID-19. *BMC Infectious Diseases, 21*(1), 1066. https://doi-org.ezproxy.uakron.edu:2443/10.1186/s12879-021-06693-5

Hebbani, A. V., Pulakuntla, S., Pannuru, P., Aramgam, S., Badri, K. R., & Reddy, V. D. (2022). COVID-19: comprehensive review on mutations and current vaccines. *Archives of Microbiology*, *204*(1), 1–17. https://doi-org.ezproxy.uakron.edu:2443/10.1007/s00203-021-02606-x

Jones, P., & Comfort, D. (2020). A commentary on the COVID-19 crisis, sustainability and the service industries. *Journal of Public Affairs, 20*(4), 1–5. https://doi-org.ezproxy.uakron.edu:2443/10.1002/pa.2164

Kaplan, C. A., Chan, C. C., Feingold, J. H., Kaye-Kauderer, H., Pietrzak, R. H., Peccoralo, L., Feder, A., Southwick, S., Charney, D., Burka, L., Basist, M., Ripp, J., & Akhtar, S. (2021). Psychological consequences among residents and fellows during the COVID-19

pandemic in New York City: implications for targeted intervention.. *Academic Medicine, 96*(12), 1722–1731. https://doi.org/10.1097/acm.0000000000004362

Kardaş, F. (2021). The fear of COVID-19 raises the level of depression, anxiety and stress through the mediating role of intolerance of uncertainty. *Studia Psychologica, 63*(3), 291–306. https://doi-org.ezproxy.uakron.edu:2443/10.31577/sp.2021.03.828

Koehnlein, B., & Koren, O. (2022). COVID-19, state capacity, and political violence by non-state actors. *Journal of Peace Research, 59*(1), 90–104. https://doi.org/10.1177/00223433211063034

Li, J., Liang, W., Yuan, B., & Zeng, G. (2020). Internalized stigmatization, social support, and individual mental health problems in the public health crisis. *International Journal of Environmental Research and Public Health, 17*(12), 4507. https://doi.org/10.3390/ijerph17124507

Mallinas, S. R., Maner, J. K., & Ashby Plant, E. (2021). What factors underlie attitudes regarding protective mask use during the COVID-19 pandemic? *Personality and Individual Differences, 181*, 111038. https://doi.org/10.1016/j.paid.2021.111038

Mehdi, M., Waseem, M., Rehm, M. H., Aziz, N., Anjum, S., & Javid, M. A. (2020). Depression and anxiety in health care workers during covid-19. *Biomedica, 36*, 233–238.

Mukhtar, S. (2020). Psychological health during the coronavirus disease 2019 pandemic outbreak. *International Journal of Social Psychiatry*, *66*(5), 512–516. https://doi-org.ezproxy.uakron.edu:2443/10.1177/0020764020925835

Shang, N. (2021). "Wearing a mask or not" goes beyond a public health issue in the U.S. *Cogent Medicine, 8*(1). https://doi.org/10.1080/2331205x.2021.1950305

Naeim, M. (2021). A study of the social stigma of coronavirus (COVID-19). *Advances in Dermatology & Allergology / Postepy Dermatologii i Alergologii*, *38*(5), 899–900. https://doi-org.ezproxy.uakron.edu:2443/10.5114/ada.2021.110113

Ohia, C., Bakarey, A. S., & Ahmad, T. (2020). COVID-19 and Nigeria: putting the realities in context. *International Journal of Infectious Diseases*, *95*, 279–281. https://doi-org.ezproxy.uakron.edu:2443/10.1016/j.ijid.2020.04.062

Oladele, G. A. (2020). Emerging legal control of infectious diseases in nigeria: a violation of human rights. *Journal of Law, Policy and Globalization*, 100. https://doi.org/10.7176/jlpg/100-09

Pai, N., & Vella, S.-L. (2021). COVID-19 and loneliness: A rapid systematic review. *Australian & New Zealand Journal of Psychiatry*, *55*(12), 1144–1156. https://doi-org.ezproxy.uakron.edu:2443/10.1177/00048674211031489

Sahoo, S., Mehra, A., Suri, V., Malhotra, P., Yaddanapudi, L. N., Dutt Puri, G., & Grover, S. (2020). Lived experiences of the corona survivors (patients admitted in COVID wards): A narrative real-life documented summaries of internalized guilt, shame, stigma, anger. *Asian Journal of Psychiatry*, *53*, 102187. https://doi-org.ezproxy.uakron.edu:2443/10.1016/j.ajp.2020.102187

Samal, J. (2021). The dilemma of intimacy and other social stigmas associated with HIV-AIDS and COVID-19. *Journal of Clinical & Scientific Research*, *10*(1), 58–61. https://doi-org.ezproxy.uakron.edu:2443/10.4103/JCSR.JCSR_92_20

Schmidt, N. A., & Brown, J. M. (2017). *Evidence-based practice for nurses: Appraisal and application of Research*. Jones & Bartlett Learning.

Tatar, M., Faraji, M. R., Montazeri Shoorekchali, J., Pagán, J. A., & Wilson, F. A. (2021). The role of good governance in the race for global vaccination during the COVID-19 pandemic. Scientific Reports, 11(1), 1–7. https://doi-org.ezproxy.uakron.edu:2443/10.1038/s41598-021-01831-0

Taylor, S., & Asmundson, G. J. G. (2021). Negative attitudes about facemasks during the COVID-19 pandemic: The dual importance of perceived ineffectiveness and psychological reactance. *PloS One*, *16*(2), e0246317. https://doi.org/10.1371/journal.pone.0246317

Tijjani, S. J., & Ma, L. (2020). Is Nigeria prepared and ready to respond to the COVID-19 pandemic in its conflict-affected northeastern states? *International Journal for Equity in Health*, *19*(1), 1–4. https://doi.org/10.1186/s12939-020-01192-6

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *International Journal of Social Psychiatry*, *66*(4), 317–320. https://doi-org.ezproxy.uakron.edu:2443/10.1177/0020764020915212

Warchoł-Biedermann, K., Daroszewski, P., Bączyk, G., Greberski, K., Bugajski, P., Karoń, J., Mojs, E., Ziarko, M., Jasielska, A., Samborski, W., & Daroszewski, P. (2021). Dysfunctional coping mediates the relationship between stress and mental health in health-care staff working amid the covid-19 pandemic. *Medical Principles & Practice*, *30*(4), 395–400. https://doi-org.ezproxy.uakron.edu:2443/10.1159/000516181

Wilson, C. A., Metwally, H., Heavner, S., Kennedy, A. B., & Britt, T. W. (2021). Chronicling moral distress among healthcare providers during the COVID-19 pandemic: A longitudinal analysis of mental health strain, burnout, and maladaptive coping behaviors.

International Journal of Mental Health Nursing, *31*(1), 111–127. https://doi.org/10.1111/inm.12942

World Health Organization. (2022). *COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide*. https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

Yuan, Y., Zhao, Y.-J., Zhang, Q.-E., Zhang, L., Cheung, T., Jackson, T., Jiang, G.-Q., & Xiang, Y.-T. (2021). COVID-19-related stigma and its sociodemographic correlates: a comparative study. *Globalization & Health*, *17*(1), 1–9. https://doi-org.ezproxy.uakron.edu:2443/10.1186/s12992-021-00705-4

Yu Deng, Jixue Yang, Li Wang, & Yaokai Chen. (2021). How lived experiences of COVID-19 shape mental health: a case series of COVID-19 patients from Wuhan, China. *Alpha Psychiatry*, *22*(5), 269–274. https://doi-org.ezproxy.uakron.edu:2443/10.5152/alphapsychiatry.2021.21288