



COVID-19 Patients' Experiences during the Pandemic: A Phenomenology Study

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Abstract

Introduction: The COVID-19 pandemic caught the world community off guard, with irreversible effects, causing numerous hospitalizations and deaths across the globe. Understanding COVID-19 patients' lived experience is crucial to care assessment. Therefore, this study aims to investigate the experiences of COVID-19 patients before, during, and after hospitalization. **Methods:** The present study employed a phenomenological method, and purposive sampling was used to select participants. The individuals discharged from COVID-19 treatment in the upper southern region of Thailand were recruited to participate. Data were collected through in-depth interviews conducted by telephone, LINE, and face-to-face from July 1 to September 14, 2020. **Results:** The study included a total of eight participants selected from seven provinces located in the southern region of Thailand. The mean age of the participants was 42 years, and the mean duration of hospitalization was 22 days, with 62.5% of them having underlying illnesses. The patients' experiences were categorized into 14 distinct sub-themes, corresponding to the various stages of pre-hospitalization, throughout hospitalization, and post-hospitalization. The pre-infection lifestyles of the participants indicated a lack of understanding and misunderstanding regarding COVID-19. This study found that the participants had more fear, depression, and suicidal thoughts during hospitalization. Nevertheless, the participants unequivocally affirmed that the nurse-patient interaction, in terms of providing assistance and addressing mental health concerns, brought them a sense of solace. However, they encountered rejection from their community after being discharged from the hospital. **Conclusion:** COVID-19 survivors must remain confident in their ability to continue life and believe that they made the right choice by accepting hospital care to save their own lives and prevent the spread of the disease. Healthcare practitioners and stakeholders within the healthcare service system can utilize this knowledge of patients' experiences to assist patients in the prevention, treatment, and management of COVID-19.

Keywords: Patient's Experience; COVID-19; Hospitalization; Phenomenology; Thailand.

1. Introduction

Coronavirus disease 2019 (COVID-19) is a highly contagious infectious disease that has rapidly spread across the globe. As of October 2023, the World Health Organization [1] reported a total of 771.4 million registered cases and

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6.97 million confirmed deaths globally. According to Nicola et al. [2], the primary manifestations of the disease encompassed fever, weariness, dry cough, red eyes, loss of taste, muscle pains, nasal congestion, rhinorrhea, sore throat, and diarrhoea. As the number of cases increased due to the pandemic, the allocation of public health resources in the country became difficult in terms of personnel, budget, location, various medical equipment, and vaccination. In countries affected by COVID-19, there was also a loss of human capital, affecting the loss of income and consequently household expenses. The disease affected everyone, whether directly or indirectly [3]. In fact, the COVID-19 pandemic showcased the significance of data and scientific knowledge in constructing robust healthcare systems and promoting equitable progress toward our collective global objectives [4].

The notion of experience is intricately connected to the process of learning [5], and a form of qualitative research approach that centers on the investigation of an individual's personal experiences and perceptions within their living environment is termed phenomenology [6]. An individual's experience encompasses a collection of knowledge, comprehension, viewpoints, and skills assimilated through their personal learning journey and encounters with specific circumstances. The concept can be categorized into two distinct components of passive and proactive experiences. The former refers to the acquisition of knowledge and understanding through the consumption of information from various media sources, such as reading, hearing, and observing. On the other hand, the latter encompasses the development of skills necessary for actively engaging in activities, including defining, planning, and presenting real-life actions [7].

As the first country to identify COVID-19 cases outside of China, Thailand implemented a response widely regarded as effective and exemplary in terms of mitigating the spread of the virus during its early stages [8–10]. The Thai Ministry of Public Health [11] implemented many rules to plan, support, and prevent the spread of the pandemic in Thailand. Multiple scholarly articles originating from Thailand have documented the encounters of medical professionals, including doctors and nurses, as well as patients, inside the setting of hospitals amid the COVID-19 pandemic [12–14]. For instance, Pumipak et al. [15] conducted telephone interviews with individuals suffering from moderate to severe COVID-19 infections and receiving outpatient care in Bangkok, focusing on symptom experience and perceived health status. Similarly, Phu et al. [16] studied Thai adults who had recovered from COVID-19, investigating associations between mental health issues and long-term COVID-19 symptoms among the participants. However, there is a dearth of information about the lived experience of COVID-19 patients from Thailand, especially having a combined study on the COVID-19 patient's pre-illness history, including pre-admission, hospitalization, and reintegration into their community. Thus, this study aimed to use a phenomenological approach to fill the existing knowledge gap by investigating the experiences of COVID-19 patients discharged from the hospital and reintegrated into their community in the upper southern region of Thailand. The phenomenological approach has effectively yielded promising insights into the personal experiences of people with illnesses. Realino et al. [17] used the same methodology to study thirteen elderlies from the Philippines to gain insights into their lived experiences as COVID-19 patients and learn how they perceived and managed their infection. Shaban et al. [18] also employed this method to examine the first-hand encounters and perspectives of eleven patients in isolation with COVID-19 in an Australian healthcare system. Understanding the experiences of individuals who contracted COVID-19, including their pre-infection phase, treatment in isolation centers, and subsequent reintegration into the local population, is of utmost significance in this study, as this will assist stakeholders involved in the development of guidelines pertaining to disease management, prevention, and control.

2. Methods

2.1. Study Design

The present study employed a phenomenological method. This method elucidates the significance of experiences for every participant [19, 20], and the variability of experiences concerning COVID-19 warrants the investigation of patient experiences.

2.2. Population and Sample

Purposive sampling was used to interview COVID-19 patients in the upper southern region of Thailand according to the following inclusion criteria: recovered from COVID-19, the diagnosis of COVID-19 before admission to the hospital (pre-hospitalization), admission to the hospital inpatient department (during hospitalization), staying in the community after discharge (post-hospitalization), and willing to be interviewed. The patients were excluded from the study if they felt uncomfortable continuing the interview.

2.3. Research Instrument

Participants' information was gathered via in-depth interviews using unstructured questionnaires with a content validity index (CVI) of 0.94, as certified by three experts. The questionnaire consisted of seven major questions:

1) How were you taking care of yourself before the COVID-19 infection? 2) How did you practice self-care and transmission prevention during COVID-19? 3) Could you describe your COVID-19 experience? 4) What signs and symptoms did you notice? 5) What can you say about the laboratory investigation and community screening you underwent? 6) How did you prevent or spread infection to your home or community after discharge from the hospital? and 7) What are the obstacles and difficulties of infection with COVID-19?

2.4. Data Collection

The data collection spanned from July 1 to September 14, 2020. The individuals discharged from COVID-19 treatment were recruited to participate in the study. The researcher outlined the objectives of the study to the participants, procured informed consent, and facilitated patients in expressing their experiences and encounters about COVID-19. The interviews were performed using various available modes of contact, such as telephone, LINE application, and face-to-face interviews; each interview session had a duration of 20–40 minutes. Subsequent meeting appointments were arranged if the data collected during the interview were insufficient. The interview duration was based on the individual's health condition. The research team conducted face-to-face interviews with the patients in their homes, adhering to rigorous COVID-19 prevention measures, such as social distancing and the use of face shields and masks. If the individuals were to experience illness or express unwillingness to proceed, the interview would promptly come to a stop.

2.5. Data Analysis

Following the five steps laid out by Braun & Clarke's [21] phase, thematic analysis was used: 1) Reading and re-reading to fully grasp the material; 2) Figuring out the encoding; 3) Assigning the category or sub-theme encoding to the meanings; 4) Figuring out the themes based on the meanings and related events; and 5) Assigning the themes and reporting. We interviewed and analyzed within 24 hours, while another set of interview dates was scheduled with the same or a different interviewee if clarifications were required. Following the completion of the analysis, the participants were provided with the findings of the theme analysis to validate the interpretation. Figure 1 presents the flowchart illustrating the method used to obtain the results.

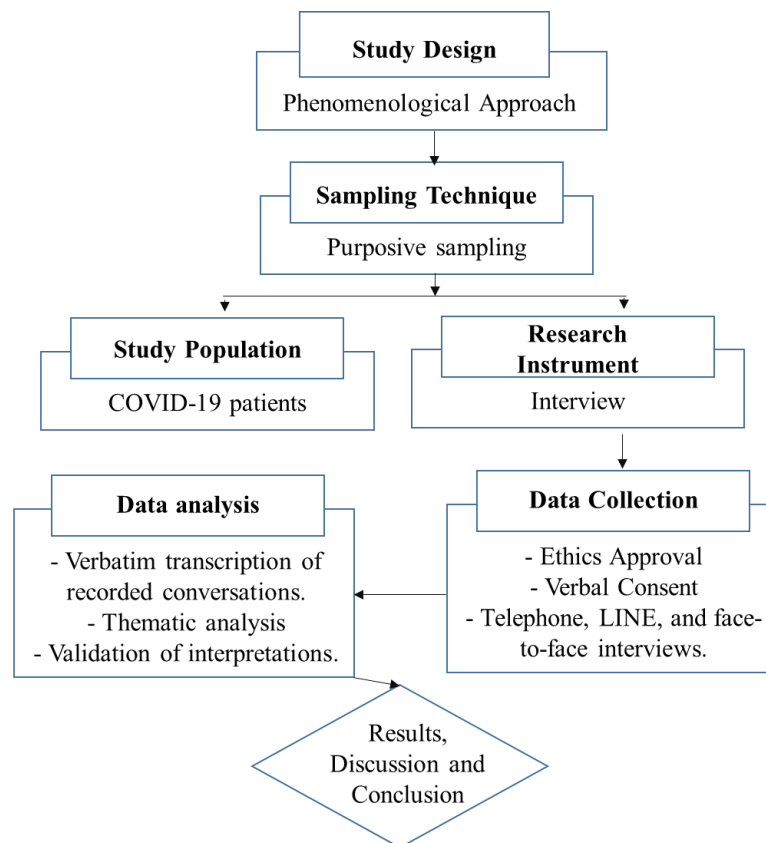


Figure 1. A flowchart illustrating the research methodology

3. Results

The study included a total of eight participants selected from seven provinces in the southern region of Thailand. Out of these participants, six individuals, accounting for 75% of the total sample, were identified as female, as indicated in Table 1. The mean age of the participants was 42 years, with a standard deviation of 15.7 years. A majority of the participants, accounting for 75% (6 individuals), reported being married. Additionally, half of the participants, comprising 4 individuals (50%), had received a primary school education, and were engaged in farming occupations. The participants' family size varied between 3 and 7, with 62.5% (5) reporting underlying illnesses. The mean duration of hospitalization was 22 days, with a standard deviation of 9.7 days. The patients' experiences were categorized into 14 distinct sub-themes, corresponding to the various stages of pre-hospitalization (Table 2), throughout hospitalization (Table 3), and post-hospitalization (Table 4).

Table 1. Sociodemography of the participants

Characteristics		No. (%)
Gender	Female	6 (75.0)
	Male	2 (25.0)
Age	Below 40 years	3 (37.5)
	40 years and above	5 (62.5)
Marriage status	Single	2 (25.0)
	Married	6 (75.0)
Educational level	Primary	4 (50.0)
	High	2 (25.0)
	University	2 (25.0)
Occupation	Student	1 (12.5)
	Housewife	1 (12.5)
	Bar worker	1 (12.5)
	Farmer	4 (50.0)
	Business	1 (12.5)
Family size	3	5 (62.5)
	4	2 (25.0)
	7	1 (12.5)
Underlying disease	No	3 (37.5)
	Yes	5 (62.5)
Length of stay in the hospital	< 10 days	1 (12.5)
	10 -19 days	3 (37.5)
	20 days above	4 (50.0)

Table 2. Pre-hospitalization consisted of five sub-themes

Sub-themes	Meaning	Reponses
COVID-19 information sources were unreliable, and people lacked knowledge of the disease.	Information on COVID-19 from celebrities, the media, and social platforms like Facebook, LINE, and Google. Most of this information was conveyed verbally without any weight or reliability.	<i>"I do not understand when I have not had the disease yet. Some say that the disease is from China, some say it is from bats, and maybe some are all miss." (P3).</i>
Do not ignore the disease just because no humans around you have become infected.	Indicated those who are unaware of or uninterested in the COVID-19 pandemic. They did not believe they were infected because they had no symptoms.	<i>"I did not care, I did not think that would come to us, but if I just knew, I would have taken caution. I also forgot that my brother worked with foreigners." (P1).</i> <i>"I do not think I will have the disease because I have almost no symptoms." (P3).</i> <i>"I protect myself by only wearing a mask. I did not have alcohol jelly at that time because there was none available for us to use. We used the alcohol jelly when my father went to the hospital." (P4).</i>
The underlying disease increases the severity of the disease.	Patients with diabetes, hypertension, hyperlipidemia, dyspepsia, and asthma before being infected with COVID-19. Patients without underlying diseases may have milder symptoms.	<i>"Yes, I have an ailment, and this may have contributed to the severity of the new disease on me." (P5).</i>
Occupational activities were increasing risks to others.	COVID-19 transmission at the workplace through interactions with foreigners in bars, beach massage centres, and coffee shops	<i>"There were three foreign tourists coming to massage. Meanwhile, I did not speak English, and I had no idea what signs and symptoms they might have, such as fever, or the country they came from." (P8).</i>
Suffer from drug side effects	Patient's experiences through the side effects of self-care with drugs. The side effects of the drugs were moderate-to-severe. Severe symptoms included chest tightness, suffocation, sweating, body hyper-temperature, nausea and vomiting, dizziness, hair loss, poor appetite, and sleeplessness.	<i>"I used a sedative drug. I could not sleep for 9 days and 9 nights because I had side effects from the drug, such as vomiting, being sleepless, and not eating anything"(P8).</i>

Table 3. During hospitalization involved six sub-themes

Theme	Meaning	Reponses
The hospital needs to confirm the infection.	Several clinical criteria required the throat swab culture to identify germs that may cause infection in the throat. At the hospital, a history is taken, the patient's health is checked, and an oropharyngeal or nasal swab test is performed.	<i>"I had four chest x-rays, but the procedure caused no pain. However, the throat swab was very painful. When the health care officer inserted a swab prop in my nose, it was very throbbing and very discomforting. I was examined four times before being confirmed" (P4).</i>
Good medical team, although live as being imprisoned.	The patient's time in the hospital. Doctors and nurses were important groups who took care of the patient like their family because the patient had no relatives or anyone else.	<i>"The nurse on duty does ask me about my symptoms from time to time, including asking about life, to cheer me up. I felt relieved that I was not alone. I had good care in the hospital" (P4).</i>
Symptom severity varied.	Patients showed different signs and symptoms during the COVID-19 infection. The mild group had no fever, could taste, and ate normally; the moderate group had inability to eat, lack of smell and taste, fatigue, and a sore throat; and the severe group had fever, inability to eat, decreased smell, abnormal taste, abdominal pain, cough, including blood, loose stools for several days, tightness in the chest, suffocation, sleeplessness, low blood pressure, and frequent hot flashes.	<i>"It looks like a cold, and my cold usually lasts a few days, but this one has an incubation period." (P3).</i> <i>"The doctor said I had a fever because of a contusion in the lungs, an infection in the lungs, and low blood pressure. I was coughing out blood and had diarrhoea for 3 days. The doctor told my daughter that I could die" (P7).</i> <i>"I could hardly speak in sentences because I felt like something was pushing against my throat cavity, and then my nose could not smell and my tongue could not taste, like symptoms of tongue numbness." (8P)</i>
Stress, anxiety, pressure, and fear of death.	The expression of COVID-19 patients during their stay in the hospital and quarantine in the isolation room for 6–30 days, depending on the severity of the disease.	<i>"My mind was falling, I do not know if death is coming or not. I have many things to do because my son is very young, and I am yet to finish many things in my life" (P8).</i> <i>"I told my daughter that I needed to commit suicide by jumping off the building. My daughter said, "Please, I should not jump off the building because if I do, I can break my legs. At this time, I want to die, but I am afraid of what would happen if I did not die" (P4).</i>
Take care of my lonely life in the hospital.	Patients are detained in the hospital in a confined space for surveillance purposes. People with severe symptoms were sent to the intensive care unit. The person who was entering the detention room had to wear personal protective equipment.	<i>"The hospital has closed-circuit television (CCTV), so when I measure blood pressure by myself and report it to the nurse via the phone in my room. The doctor called me on phone and inquired about my symptoms. The medical team with protective covers will come to check on me in the morning. The nurse let me put a finger through the door, and she will check the value because she cannot draw blood directly from me." (P4).</i>
Two sides of social media when they were the COVID-19 patient.	Some patients had good or bad experiences on social media. Some were scolded by people in the community and provinces and were therefore rejected, with cases of slander and fake news.	<i>"There were a lot of rumours that we were going to die there, but in fact, I did not die. There were many comments on social media. The comments show that people do not understand COVID-19. People were only afraid because they did not search for knowledge about the disease but were carried away only by the news." (P3).</i>

Table 4. Post-hospitalization showed three sub-themes

Sub-themes	Meaning	Reponses
Community rejection	When patients were discharged from the hospital and returned to the community, they encountered issues in society. It became tough to go somewhere due to changes in lifestyle.	<i>"I was dismayed by society because I saw so many people talking about my illness. They are paranoid and think that they may have the disease if they get closer. I heard that some said they would be infected if they came near me because they did not use personal protective equipment" (P1).</i> <i>"Almost all people in the province insulted us, saying, "Why did I come back, and why is there no detention?" (P3)</i>
Suffering from social distancing	Patients who were discharged from the hospital and had to isolate themselves at home for 14 days were separated from other people in their home, the bathroom, personal equipment, and even food.	<i>"The people around me were afraid and did not understand. If I have a little cough, they will call the doctor to check on me and give me cough medicine.</i> <i>At the same time, I do not work, so I have no money to buy gel. It was very difficult for me, but I still need to take care of myself." (P2).</i>
Self-confidence for continuing life	Patients who believed in protecting themselves from COVID-19 through exercise strengthened their bodies' immunity to the virus. They did not feel lonely, and they felt that they made the right decision by accepting treatment in the hospital.	<i>"The infection may not be exhausted; I know I may be infected again, but I am not afraid because I now have the understanding with regard to COVID-19 that I should not go to another community or province. I therefore just stay at my house doing things to remain active." (P8).</i>

4. Discussion

The Thai populace was not exempt from the COVID-19 pandemic; initially, the number of cases was minimal in the area and remained under control until December 2020. However, that changed when some individuals, including tourists, migrant workers, and citizens, circumvented the social and public health measures implemented by the Thai government [8, 22]. With a population of 71.8 million [23], Thailand had an estimated 4.76 million COVID-19 cases, of which 34488 were confirmed dead [24] as of November 3, 2023. The virus spread even more quickly in southern Thailand when Muslim visitors from Malaysia and Indonesia came back to the provinces [8]. Nonetheless, the Thai government demonstrated proficient outbreak management by strategically deploying a considerable workforce of more than 1030 surveillance members and rapid reaction teams (SRRTs) comprising various professionals, such as public health nurses, officers, and epidemiologists, carefully selected for their respective roles [25]. Furthermore, the Ministry of Public Health and the World Health Organization worked with other partners to implement COVID-19 preventative and control measures [26]. As a result, 99.3% of the confirmed patients listed above recovered and were discharged.

The average age of the participants in this study was 42 years (21–69 years), while Jindahra et al. [27] corroborated the average age range of 39.8 to 41.4 years from data on confirmed cases collected in Thailand between January 12 and May 12, 2020. According to the Centers for Disease Control and Prevention [28], the chance of getting sick from COVID-19 increases with age, with older adults (particularly those aged 50 and older) being more likely to suffer severe infections than younger people. Thailand's population is rapidly aging, with 22% of the population over 65 years. In their study, Wilasang et al. [29] found that while the death rate in Thailand declined for those under the age of 24, it increased for those between the ages of 25 and 60, with over 5% of deaths exceeding expectations. The COVID-19 outbreak was responsible for 78.4% of the excess mortality in the over-60 age group. According to a recent study, many countries have seen a sharp rise in the percentage of elderly fatalities [30]. One may ask further how older people are getting exposed to the infection. Thai culture embraces filial caring, where elderly parents live with at least one adult child or within the same compound as their children. Thus, almost 30% of households house the elderly [27]. However, Thailand's government specifically recommended older people stay at home, dissuading younger people from visiting older family members. An old age allowance of 1,000 Baht per month was proposed to help older persons partly offset the loss of income and remittances [31].

The pre-infection lifestyles of the participants indicate a lack of understanding and misunderstanding regarding COVID-19. They did not comply adequately with the guidelines for preventive measures and exhibited skepticism due to the absence of symptoms in their immediate surroundings. According to the findings of Liu et al. [32], some people lacked understanding regarding the potential transmission from asymptomatic individuals as well as the risk associated with contact with infected inanimate surfaces that could sustain the virus for extended durations. Therefore, giving unclear information regarding disease-related behaviors might lead to a lack of understanding and carelessness in both individuals and groups. Meanwhile, as things changed, accurate information was contradicted with false information that persisted in circulation, leading to misunderstandings and a lack of trust in the authorities [33]. Similarly, Shaban et al. [18] claimed that the COVID-19 experiences of their participants were characterized by a strong preference for unofficial media not approved by governments and authorities and mistrust in official information sources. In this study, since two of the individuals were associated with a job that engaged foreign workers, occupational activities also raised the chance of contracting the illness. The findings of Beale et al. [34] demonstrated the significance of work as a source of infection risk during the COVID-19 pandemic, although occupational disparities in infection risk are robust to adjustment based on workplace characteristics and vary over time. Participants also said that when they started to feel strange symptoms at home, they would self-medicate with drugs or home remedies without a prescription or lab proof. Most participants also said they had side effects like trouble sleeping, loss of appetite, aches, and vomiting from taking multiple drugs for self-care. Aygün et al. [35] further substantiated the notion that concurrent administration of numerous medications could lead to significant adverse reactions. The impact of social media on the dissemination of inaccurate information about drug use encourages the use of self-medication practices, including the utilization of unverified home remedies, without documented evidence of their safety and effectiveness [36, 37].

This finding was in agreement with the result Pumipak et al. [15] reported, as 66.3% of their interviewed participants also had underlying medical conditions. It is possible that pre-existing medical conditions and immune system frailty contributed to the increased risk and mortality rate among the elderly and others. More than 75 percent of COVID-19-related fatalities in Thailand may have been attributable to pre-existing medical conditions, according to Chailek et al. [38]. Some of the study participants additionally expressed that their pre-existing medical conditions could have contributed to the severity of their COVID-19 illness. Kompaniyets et al. [39] also noted that older age and

poverty-related health disorders, such as diabetes, hypertension, and cardiovascular disease, as well as compromised immune systems, would increase the risk of case deaths. In Thailand, a large number of the elderly are in poor health, with 16% of older adults' self-reports showing poor or really poor health remittances and over 40% of older adults expressing some limits in their functioning abilities [31]. Furthermore, the study covers a range of hospitalization durations, from 6 to 30 days, with a mean duration of 22 days. Multiple studies have demonstrated that the mean duration of hospitalization for COVID-19 patients was 14.49 days, with a standard deviation of 7.92 [40]. Notably, individuals over 60 years exhibited the longest hospital stays, while those under 40 had the shortest durations of hospitalization. The participants listed having symptoms like tongue numbness, low blood pressure, coughing out blood, diarrhoea, speaking difficulties, blocked nose, throat obstruction, sleeping difficulties, and breathing difficulties. These symptoms were also corroborated by the participants in the research conducted by Skilbeck et al. [41] and Alkaissi et al. [42].

This study found that the people under study had more fear, depression, and suicidal thoughts because they were focusing too much on their symptoms, loneliness, fewer social interactions, and exposure to frightening information about COVID-19 on social media sites. In the same vein, Realino et al. [17] reported that the participants in their study also had various fears, such as fear of death, fear of deteriorating health, fear of transmitting the virus to their family members, fear of losing their mental stability, and fear arising from news of COVID-19-related deaths. In the context of the global pandemic, social media has emerged as a vital platform for individuals worldwide, serving as a primary means of accessing news and information related to COVID-19. Additionally, it facilitates communication among users, enabling them to connect with friends, family members, and public health authorities. It is interesting to note that false information on social media platforms that sensationalized COVID-19 more than actual official news and media outlets shaped the experiences of many affected people [18].

The World Health Organization referred to this condition as the "coronavirus infodemic" [43], which causes secondary trauma and despair in a large number of people. According to Shaban et al. [18], the participants' real-life experiences of COVID-19 could be influenced by commercial news and other related media. Furthermore, the psychological discomfort experienced while hospitalized corroborates previous research on COVID-19 patients who experienced stress due to quarantine regulations, family separation, social disturbance, and life-altering experiences [18, 44]. Likewise, the participants expressed dissatisfaction with the insertion of a swab prop into their nasal cavity, citing significant throbbing and discomfort. As of the time of the study, the predominant diagnostic method employed in Thailand for the detection of throat infections in hospital settings was the process of diagnosis using throat swab culture, as reported by the Thai Ministry of Public Health in 2019 [11]. Nevertheless, the participants unequivocally affirmed that the nurse-patient interaction, in terms of providing assistance and addressing mental health concerns, brought them a sense of solace. This is in line with the findings of other studies, which highlight that nurses' caring behaviors contribute to patients' well-being [45, 46]. Analyzing seven articles, Fernandes et al. [47] reported that nurses adopted a wide range of interventions to provide humanized care for COVID-19 patients. These interventions were communication tactics, psychological comfort, collaborative decision-making, patient education, physical comfort, and symptoms control, which seemed crucial for the nurse to create a therapeutic bond with the patient.

Although the participants were released from the hospital and reintegrated into society following their recovery, they encountered rejection from the community, and society continued to seek their detection. In other words, they were intentionally excluded from interactions or relationships within the community. In the study conducted by Realino et al. [17], elderly survivors complained of isolation and felt they were no longer welcome in their community because no one interacted with them. The results presented also align with those of Fu et al. [48] and Iqbal et al. [49]. Several patients encountered stigmatization, discrimination, segregation, and loss of social standing due to a perceived association with the illness [50]. Meanwhile, "social distancing" was observed as a precaution against contracting the fatal disease, which contributed to this social stigmatization. Social distancing has been empirically demonstrated as a highly efficacious measure for COVID-19 transmission mitigation. However, it is important to acknowledge that social distancing practices can also engender adverse emotional experiences, such as feelings of neglect, alienation, isolation, and societal exclusion, among individuals who have survived COVID-19. This has compelled many infected individuals to conceal their condition to escape discrimination, preventing many from obtaining prompt medical attention. COVID-19 patients should have confidence in their decision to seek hospital care, as it would effectively curb the transmission of the disease and ultimately save their lives. Survivors, on the other hand, must remain "self-confident for continuing life" and not be afraid of the possibility of reinfection. According to Phu et al. [16], those who have previously had COVID-19 are at a higher risk of experiencing mental health problems such as worry, stress, and depression, potentially arising from the fear of reinfection, the sense of isolation, or the persistence of symptoms.

5. Conclusion

The research findings reflect the actual experiences of COVID-19 survivors who were hospitalized and then discharged upon recovery. The present study encountered limitations concerning the use of two distinct modes of in-depth interviews, namely face-to-face and telephone, due to social distancing measures in Thailand. Additionally, the severity of the disease for each participant was not measured in the analysis. The findings indicate a need for additional investigations into the varying degrees of COVID-19 illness severity and their corresponding treatment protocols during hospitalization. This study unveiled the influence of social media on the dissemination of disease information within society. Although social media is recognized as a means of social support, it can also induce anxiety and dread if not effectively regulated during a pandemic. Hence, the government and relevant organizations must cooperate in providing the public with dependable and prompt sources of information regarding disease outbreaks and their management. Furthermore, stigmatization of COVID-19 survivors is a source of mental health concern, as it can lead to not only a high level of despair, anxiety, and avoidance of medical care but also to suicide. The adverse effects of COVID-19-related stigma on individuals and the healthcare system can be mitigated by implementing training, education, and support initiatives. Thus, healthcare practitioners and stakeholders within the healthcare service system can utilize this knowledge of patients' experiences to assist patients in the prevention, treatment, and management of COVID-19. This information can also aid in the development and implementation of guidelines and policies for COVID-19 during hospitalization and in the post-hospitalization period.

6. Declarations

6.1. Author Contributions

Conceptualization, S.C. and T.P.; methodology, S.C. and T.P.; formal analysis, K.L., C.N., A.F., and S.C.; data curation, K.L., C.N., A.F., and S.C.; writing—original draft preparation, S.C., A.F., T.P., S.H.M., A.A.T., and T.T.P.; writing—review and editing, S.C., A.F., T.P., S.H.M., A.A.T., and T.T.P.; supervision, S.C.; funding acquisition, S.C. All authors have read and agreed to the published version of the manuscript.

6.2. Data Availability Statement

The data presented in this study are available on request from the corresponding author.

6.3. Funding

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6.4. Acknowledgements

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6.5. Institutional Review Board Statement

The study was approved by the Ethical Review Committee for Research Subjects and received the WUEC-20-208-01 Number from the Health Science Group of Walailak University, Thailand. Respondents were recruited after giving written informed consent.

6.6. Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

6.7. Declaration of Competing Interest

The authors declare that there is no conflict of interests regarding the publication of this manuscript. In addition, the ethical issues, including plagiarism, informed consent, misconduct, data fabrication and/or falsification, double publication and/or submission, and redundancies have been completely observed by the authors.

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