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EMPIRICAL STUDIES

Foreign-born nurses as COVID-19 survivors in the Nordic region: A descriptive phenomenological study

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Abstract

Objective: In 2020, amid limited COVID-19 vaccination access, many nurses from Black, Asian and Minority Ethnic (BAME) groups in the United States of America and United Kingdom succumbed to the virus. No fatalities among Filipino foreign-born nurses (FBNs) in the BAME groups were recorded in the Nordic region. This study explored the experiences of Filipino FBNs in the Nordic region who, during the initial 2020 pandemic wave, cared for COVID-19 patients, contracted the virus and subsequently recovered.

Methods: The research employed a descriptive phenomenological methodology to explore the experiences of six Filipino FBNs who had recovered from COVID-19 in various regions of the Nordic countries, including Finland ($n=1$), Sweden ($n=1$), Denmark ($n=2$), Norway ($n=1$) and Iceland ($n=1$). Data collection occurred through online videoconferencing between September 2020 and February 2021, utilising a semi-structured approach. The data analysis was conducted following Sundler and colleagues' qualitative thematic analysis, which is grounded in descriptive phenomenology.

Results: The data analysis yielded three primary themes and twelve sub-themes, which explored the experiences of Filipino FBNs with COVID-19 infection. The study demonstrated that unclear national guidelines impacted nurses' preparedness in caring for COVID-19 patients, contributing to their susceptibility to contracting the virus. The lack of occupational healthcare services for nurses during and after the pandemic affected their work morale in an unfamiliar setting.

Conclusion: The study provided valuable insights into the experiences of Filipino FBNs during the COVID-19 pandemic, emphasising the need for clearer guidelines, enhanced training and improved support for healthcare workers. It highlighted the psychological impact of COVID-19, emphasising the importance of mental health support and stigma reduction efforts. The study also emphasised the significance

of improving occupational health services to support the well-being and recovery of healthcare workers during and after the pandemic, with implications for developing comprehensive strategies to protect frontline healthcare workers in health crises.

KEYWORDS

COVID-19, experiences, mental health support, migrant nurses, nurses, occupational health

INTRODUCTION

According to the World Health Organization (WHO) data as of August 2023, there have been almost 800 million confirmed cases of COVID-19 worldwide, resulting in approximately 7 million reported deaths [1]. Europe has reported the highest number of confirmed cases, approximating 300 million, while Africa has reported the lowest number of confirmed cases, with almost 10 million. Additionally, the global distribution of COVID-19 vaccines has reached a cumulative total of over 13 million doses administered. These figures highlight the global impact of the COVID-19 pandemic and the ongoing efforts to mitigate its effects through vaccination campaigns [1].

Based on data provided by the International Council of Nurses (ICN) in 2020, COVID-19 has significantly affected healthcare workers in 34 countries, leading to over 1.6 million reported infections [2]. Among the 59 countries included in the ICN dataset, a total of 2262 nurse deaths related to COVID-19 have been documented. The Americas region accounted for more than 60% of the nurse fatalities reported in the ICN dataset. Specifically, Brazil, the United States of America and Mexico had the highest number of reported COVID-19 deaths among nurses [2]. These findings underscore the significant impact of the pandemic on the healthcare workforce, emphasising the need for robust measures to protect and support frontline healthcare professionals, especially nurses [3].

On 13 January 2023, an approximate count of confirmed coronavirus (COVID-19) cases in the Nordic countries indicated that Denmark had the highest tally, reaching around 3.5 million cases. Subsequently, Sweden exhibited an estimated 2.7 million cases and Norway and Finland showed approximately 1.5 million cases. Notably, Iceland, boasting a relatively diminutive population, recorded an estimation of over 200,000 cases, representing nearly half of its total populace affected by the virus [4]. Norway, Finland, and Denmark implemented stringent mitigation strategies primarily aimed at protecting the older adult population and preventing the healthcare system from becoming overwhelmed. In contrast, Iceland adopted a strict "test, trace, and isolate" approach early on, starting from March 2020. Meanwhile, Sweden relied on its citizens' responsibility for practices such as social distancing, remote work, handwashing and reducing non-essential travel [5].

During the peak of the COVID-19 pandemic in 2020, when access to COVID-19 vaccination was limited, a significant number of nurses from Black, Asian and Minority Ethnic (BAME) groups were infected and subsequently lost their lives to the virus. In the United Kingdom (UK) and the United States of America (USA), almost 100 Filipino nurses died from COVID-19 due to several factors, including a lack of adequate personal protective equipment (PPE) and the challenges posed by their immigrant work visa status, which may have hindered their ability to refuse assignments during the crisis as mandated by their employers [6, 7].

The COVID-19 pandemic had wide-ranging effects on nurses, encompassing psychological, physical and social dimensions [8–12]. Nurses encountered various impacts across these domains as a result of their involvement in responding to the pandemic. Nurses experienced heightened levels of stress, fewer flow experiences and decreased satisfaction with their work, life, work performance and overall well-being compared to pre-pandemic conditions [8]. Negative effects reported by nurses included anxiety, fear, vulnerability and psychological distress [9, 10]. The prevalence of anxiety, depression and stress among nurses was significant, with risk factors including the lack of guidelines, fear of infecting family and pre-existing chronic diseases [10]. It is crucial to provide comprehensive support and resources to address nurses' physical and mental health needs during challenging times like the pandemic [9, 10, 13].

Through the amalgamation of data in 2022 from the Kanlungan website, the National Center for Health Statistics and the 2014–2018 American Community Survey, a significant correlation was observed between Filipino healthcare workers and the incidence of COVID-19 mortality [14]. The analysis revealed that with each 1% rise in the representation of Filipino individuals within the healthcare workforce, there was a corresponding 1% increase in the proportion of Asian American COVID-19 decedents [14]. This finding suggests a notable association between the percentage of Filipino healthcare workers and the incidence of COVID-19 mortality among Asian Americans [14].

TABLE 1 Demographics of the study participants.

Participant	Gender	Country of residence	Educational level	Job description	Workplace	Years of experience	Interviewed post-COVID-19 infection (≈)
Participant 1	Female	Denmark	Bachelor's degree	Registered Nurse	Hospital	5 years	7 months
Participant 2	Female	Sweden	Bachelor's degree	Registered Nurse	Hospital	3 months	3 months
Participant 3	Female	Denmark	Bachelor's degree	Registered Nurse	Hospital	3 years	8 months
Participant 4	Female	Norway	Bachelor's degree	Registered Nurse	Hospital	6 years	9 months
Participant 5	Female	Iceland	Bachelor's degree	Registered Nurse	Hospital	8.5 years	2 months
Participant 6	Male	Finland	Bachelor's degree	Registered Nurse	Hospital	9 years	10 months

As of our current understanding, no deaths have been reported on Filipino foreign-born nurses (FBNs) taking good care of COVID-19 patients and no research has been undertaken regarding the experiences of Filipino FBNs who survived COVID-19 infection during the peak period of the pandemic in the Nordic region. This knowledge gap persists despite available data on healthcare professionals in other developed nations. Specifically, there is a lack of investigation into the experiences faced by Filipino FBNs in terms of limited access to personal protective equipment (PPE) and COVID-19 vaccination during the first wave of the COVID-19 pandemic.

AIM

The aim is to explore the experiences of nurses who were directly involved in the care of COVID-19 patients, contracted the virus themselves and subsequently recovered during the initial wave of the pandemic in 2020. Furthermore, the research aims to provide a comprehensive description of the unique lived experiences and perspectives of this minority group of Filipino FBNs, shedding light on the challenges, coping mechanisms and personal growth they encountered throughout their journey of contracting and overcoming COVID-19.

METHODS

Design & Theoretical Framework

The study employed a descriptive phenomenological approach to understanding the experiences of nurses who survived COVID-19, using key informal interviews (KIIs) with open-ended questions to promote a conversational atmosphere and gather rich insights [15]. The researcher must possess an understanding of fundamental assumptions to make significant methodological choices [16]. In this descriptive approach, our emphasis was on capturing the lived experiences of FBNs, which pertained to our subjective encounters with the world [16]. Additionally, the study utilised the consolidated criteria for reporting qualitative research (COREQ) guidelines by Tong et al. [17] to enhance reporting quality.

The authors utilised intersectionality theory to explore the experiences of Filipino FBNs who survived COVID-19 after contracting the virus while caring for COVID-19 patients. This theoretical framework was instrumental in understanding how the convergence of various social identities shaped the vulnerabilities and experiences of these FBNs. Their vulnerabilities were

solely influenced not only by their migrant status but also by multiple intersecting factors, including race, ethnicity, gender, socioeconomic status and access to resources [18].

Setting

The semi-structured KIIs were conducted virtually through an online video conferencing platform due to COVID-19 restrictions set by the authorities. Prior to the interviews, an Internet speed check was performed to ensure optimal communication quality and the ability to capture non-verbal cues and sensitive moments during the conversation. Additionally, measures were taken to ensure the absence of other individuals during the online KIIs.

Study participants

The participants in this study consisted of Filipino FBNs working in the Nordic region during the peak season of the COVID-19 pandemic in 2020 (Table 1). The selection of Filipino FBNs was based on the observation that a significant proportion of affected nurses in the BAME groups in the United Kingdom and United States of America were Filipinos. The objective was to gain insights into the phenomenon from the Nordic perspective. The inclusion criteria for participation were as follows: (a) being employed in Nordic countries in any healthcare facilities, (b) having contracted COVID-19 while providing patient care and officially diagnosed with the disease and (c) having recovered from the infection.

The authors made a deliberate choice not to impose restrictions on the number of years of experience when selecting one representative from each country for data collection. This decision was motivated by the scarcity of participants who had contracted COVID-19 during the initial pandemic wave and the observation that years of experience did not significantly impact the study. This approach was justified by the unique circumstances surrounding the novelty of the virus and the absence of substantial new information from the nurses. The mean duration of the participants' interviews conducted post-COVID-19 infection is approximately 6.17 months.

Data saturation was achieved after conducting the fifth interview, as no new codes or themes emerged during subsequent interview. It is crucial to note that data saturation is determined by the intrinsic characteristics of the sample rather than the sample size itself [19]. Additionally, the researchers ensured that the phenomena under investigation were representative of the participants' experiences rather than reflecting the researcher's perspective [20].

TABLE 2 Interview guide.

A. Personal background questions
1. Participant's information: name, gender, age, education level, workplace, years of work experience and email address.
2. Verbal reports from research participants of having been diagnosed as positive for COVID-19, self-report of their health status like how they feel about their experience.
B. Open-ended interview questions
The overall question will be as follows: Can you tell me (us) the story of your journey with COVID-19?
1. Please tell us briefly some of your background as a nurse, the nature of your work, where you work, and how long have you been working.
2. Please narrate to us how you contracted the infection.
3. Please describe how it feels like to be told you are positive for COVID-19.
4. Please tell us about what your experience was when you were at home after they told you that you are positive for COVID-19. How did you cope with the situation?
5. What can you recommend to improve the current system?

Data collection

Data collection took place from September 2020 to February 2021, utilising purposive and snowball sampling methods. During the initial phase of the COVID-19 pandemic, the researchers (FCJ and ADP) shared the study poster within a closed social media group, exclusively accessible to Filipino FBNs in the Nordic region who completed pre-acceptance questions for group membership. Researcher ADP communicated via email, delineating the research's purpose and the voluntary nature of participation, ensuring participants could withdraw at any time. The email also outlined potential benefits and risks associated with participating in the study. After a waiting period of 3 weeks, the recruitment process yielded a total of six participants from each Nordic country, resulting in the following distribution: Finland ($n=1$), Sweden ($n=1$), Denmark ($n=2$), Norway ($n=1$) and Iceland ($n=1$). The data collection process posed challenges due to the limited population of Filipino FBNs who potentially contracted COVID-19 while working.

During the study, background information such as name, gender, age, education level, workplace, years of work experience and email address was requested from the participants (Table 2). It was deemed sufficient for participants to verbally confirm during the interviews that they had been diagnosed with COVID-19 and had

recovered from the disease. No laboratory results were collected. In this study, the meaning of health data was limited to the verbal reports provided by participants regarding their diagnosis as COVID-19 positive and their self-reported health status, including their experiences and feelings.

The interviews had a duration of 45–60 min (mean = 52.5 min) and were conducted in the English language. In cases where participants initiated conversations in the national language, Filipino, the researchers (FCJ and ADP) also utilised the Filipino language for communication.

Data analysis

The texts were manually encoded (ADP) and analysed (FCJ, ADP, KVJ, and EP) using a Microsoft Word document, primarily due to the necessity of accurately handling the precise number of participants involved in the study. In this study, Sundler and colleagues' [16] qualitative thematic analysis based on descriptive phenomenology was employed. The analysis followed a specific order. Firstly, FCJ and ADP familiarised themselves with the data through open-minded reading, repeatedly reviewing the complete text. The focus was on exploring the expressed experiences in the data, examining how they were narrated, and comprehending their underlying meanings. Secondly, the data were further examined and illuminated to uncover deeper themes and meanings. Throughout this process, a constant review of the data revealed sensitive information, including instances in the recorded audio where participants requested pauses, displayed teary eyes, or expressed emotions through crying. Preliminary descriptive labels were used to give a tentative identification of the themes. Lastly, the themes were organised into a coherent and meaningful whole.

Scientific rigour and trustworthiness

The study maintained scientific rigour and phenomenological validity by considering key aspects such as reflexivity, credibility and transferability [16]. These elements were essential in ensuring the reliability and trustworthiness of the research findings.

Reflexivity is closely linked to the previously outlined methodological principles of adopting a reflective attitude and questioning one's preconceived notions [16]. Throughout the entire research process, the researchers (FCJ, ADP, KVJ and EP) upheld reflexivity by consistently challenging their understanding of the data and the themes generated [16]. Digital notes, verbatim transcriptions and audio recordings were diligently maintained, allowing for reflection and comparison with the descriptive text of the derived themes. This ensured that the interpretation of themes remained grounded in the data rather than solely relying on the researchers' understanding [16].

The study centered on the examination of credibility, specifically its interconnection with reflexivity, as a primary focus. Methodological details, including the process of conducting thematic analysis and deriving meanings from the data, were emphasised. The identification of themes encompassed experiences prior to contracting COVID-19, during the onset of the disease, and throughout the recovery period, with a focus on providing comprehensive descriptions. Quoted texts were presented in a simple and accessible manner to enhance understanding [16].

Regarding transferability, which pertains to the applicability and relevance of the findings [16], the researchers aimed to highlight the potential for replication, particularly in non-English speaking developed countries with a limited presence of FBNs. Furthermore, the study's findings can be extended to larger-scale investigations conducted in developed countries with a significant population of FBNs, particularly those actively recruiting internationally educated nurses.

Ethical considerations

The study received ethical approval from the University of Eastern Finland on Research Ethics, with reference to Statement 13/2020 dated 29th September 2020. The research adhered to the ethical principles outlined in the Declaration of Helsinki for medical research involving human subjects. The registration records were stored securely in the password-protected cloud service of the university for a period of 5 years following the study. After this timeframe, personal data will be appropriately destroyed in compliance with the Finnish Personal Data Act. No transfer of personal data outside the European Union (EU) or the European Economic Area (EEA) took place.

Participants were provided with adequate time to understand the research purpose and requirements and were encouraged to read the information and discuss it with others, if desired. Any inquiries or requests for further information were addressed by the researchers. Subsequently, participants were asked to provide their informed consent by signing a consent form prior to their participation in the study. Participation in the research was voluntary, and participants had the right to

withdraw from the study at any time. In the event of participant withdrawal or withdrawal of consent, any data collected prior to the withdrawal remained part of the research data.

RESULTS

The data analysis uncovered three themes and twelve sub-themes (Table 3) that explored the experiences of Filipino FBNs with COVID-19 infection. The study underscored how unclear national guidelines affected nurses' readiness to care for COVID-19 patients, heightening their vulnerability to contracting the virus, and highlights the profound impact of inadequate occupational healthcare services on their morale in an unfamiliar environment.

Pre-COVID-19 infection: Fear of the unknown

The pre-COVID-19 infection phase highlighted the difficulties encountered by nurses in accepting unclear organisational guidelines and national policies, as well as the challenges of performing their tasks with limited understanding and skills. This stage underscored the importance of clearer directives and enhanced training to promote optimal patient care and safety within the context of pre-COVID-19 circumstances. This consists of two sub-themes: (1) accepting unclear guidelines and (2) adapting amidst limited resources and training.

Accepting unclear guidelines

Nurses demonstrated compliance with organisational guidelines and national policies despite their lack of clarity and ambiguity, acknowledging and accepting the limitations in directives provided by their healthcare organisation and national authorities. They adapted to the uncertain and ever-changing circumstances, recognising the need to navigate and work within the constraints imposed by the unclear guidelines and policies on COVID-19 protocols.

> We don't actually have rules and regulations if ever there are cases of COVID, so *** was not ready yet at that time. The Department of Health only provided general information, and it was challenging for everyone. The difficult thing was that we felt the protocol was changing every hour.
>
> (FBN 1)

Adapting amidst limited resources and training

Nurses carried out their duties despite having limited knowledge and skills, acknowledging their own shortcomings and challenges in effectively assessing and providing care for patients. They persevered and made efforts to perform their tasks to the best of their abilities, recognising the need for further training and support to enhance their understanding and skills in patient care.

> I was just placed there without proper education or training on what we needed to know and do. I had to work in the COVID-19 unit continuously for one straight week.
>
> (FBN 2)

> There was an insufficient number of the nursing workforce in the ward who are educated about COVID-19. We requested that all

TABLE 3 Main themes and sub-themes.

Main themes	Sub-themes
Pre-COVID-19 infection: fear of the unknown	Accepting unclear guidelines Adapting amidst limited resources and training
During COVID-19 infection: living with the virus	Experiencing onset of signs and symptoms Following the protocol Doing home management Living with fear Accessing and receiving support
Post-COVID-19 infection: recovering and rebuilding period	Experiencing mental health issues Living with stigma Decreasing quality of life Improving the occupational health services Learning from the experience

nurses be educated before increasing the admission rate.

(FBN 3)

However, one nurse affirmed of receiving essential support during the designation of their unit as a COVID-19 unit. The provision of daily meetings to discuss patient management strategies and improve operational efficiency was conducted.

I can confidently affirm that we received the necessary support. When our unit was designated as a COVID-19 unit, we conducted daily meetings to discuss patient management strategies and optimize our functioning. Additionally, the nurse–patient ratio in our ward was increased.

(FBN 6)

During COVID-19 infection: Living with the virus

This main theme consists of five sub-themes: (1) experiencing the onset of signs and symptoms; (2) following the protocol; (3) doing home management; (4) living with fear; and (5) accessing and receiving support.

Experiencing the onset of signs and symptoms

Nurses recounted the initial emergence of COVID-19 symptoms, such as fever, cough and fatigue, marking the beginning of their illness. The manifestations of signs and symptoms exhibited a range of variations, encompassing both local and systemic presentations.

I feel in my lungs that there is a big hole in my lungs due to coughing. I experienced symptoms such as a sore throat, fever (38.7°C), signs of respiratory difficulty on the 10th day, body pain, persistent coughing, difficulty sleeping, hallucinations, vomiting, weakness, and a weight loss of 5 kg over a period of 20 days. Additionally, I also lost my sense of smell and taste.

(FBN 1)

First, I experienced symptoms such as a headache and allergy symptoms (flu-like symptoms). Second, I had a fever of 37.7 and tested positive for COVID-19. During this time, I also experienced an unrelieved constant headache similar to a migraine, difficulty breathing (DOB), fever with shivering at night, and a sensation of paralysis from my neck down to my lower back. I also had crushing bone pain for four days and a general feeling of malaise.

(FBN 3)

Following the protocol

Prescribed protocols set by their workplace and national authorities were followed diligently by FBNs. Their commitment to adherence ensured a proactive and responsible approach to their duties in challenging times.

The official instruction for COVID patients is that they need to be isolated for 7-10 days, so I was just in my room for 10 days literally, I never went out, I just stayed in my room.

(FBN 6)

All healthcare workers were tested for antibodies three times. We have this protocol that if you have been positive for COVID-19 but you don't have any symptoms, so you can stay at home for 7 days.

(FBN 5)

Doing home management

These FBNs resorted to self-administered home remedies based on their observations of signs and symptoms, endeavouring to cope with the situation independently in an attempt to ensure their survival.

I used paracetamol for fever, ibuprofen for pain, and soothing steamed water for dry cough and breathing woes. I also took water electrolytes for dehydration. I got antibiotics prescribed by a physician electronically for my pneumonia. I also took Vitamin C but did not help. I eat fruits and took lemon.

(FBN 1)

For the difficulty of breathing, taking fresh air for 10 minutes at the terrace helped. For fever with shivering at night time, I drink lots of warm water and lemon juice.

(FBN 3)

Living with fear

The deteriorating condition and caregiving experiences of Filipino FBNs in the context of COVID-19 have resulted in a state of fear, predominantly driven by concerns over mortality and the numerous uncertainties surrounding the COVID-19 pandemic.

> I was afraid that if I will be confined and my husband will not be able to see me. Because I know my patients when I am taking good care of the COVID patients, they just die alone and it was so hard.
>
> (FBN 2)

> I rushed to the hospital, anxiety gripping my heart tightly. The fear of the unknown loomed like a storm, questioning whether I would return home alive or not. Sleep became a daunting prospect, as I dreaded the idea of closing my eyes, unsure if I would wake again.
>
> (FBN 4)

Accessing and receiving the support

The FBNs received support from their friends and family members, encompassing physical, social and emotional dimensions. This support played a crucial role in their well-being and resilience during challenging times.

> My in-laws were supportive during the period of the illness including cooking food and delivery. My husband decided not to admit me and continue to rehabilitate me at home.
>
> (FBN 1)

> I have close communication with colleagues and family members to update them about my situation.
>
> (FBN 5)

Post-COVID-19 infection: Recovering and rebuilding period

The analysis of post-COVID-19 infection yielded five sub-themes, which encompassed the following: (1) experiencing mental health issues; (2) living with stigma; (3) decreasing quality of life; (4) improving occupational health services; and (5) learning from the experience.

Experiencing mental health issues

Going through mental health issues was one of the devasting experiences among FBNs.

> I feel depressed. It took 2 months before we were able to see our friends. It is my own decision not to see them for 2 months just to be sure that they are safe, and that I cannot spread the virus to them.
>
> (FBN 1)

> You feel depressed that you are just home and you are not allowed to go out.
>
> (FBN 2)

Living with stigma

One FBN shared a devastating experience of being stigmatised by society due to the perceived contagious nature of COVID-19, resembling the societal challenges faced during the autoimmune deficiency syndrome (AIDS) pandemic era. Stigma's profound impact on the FBN's well-being was evident in the lowering of self-esteem due to the association with contracting the virus.

> I was hurt because of the distance. During that time, if you remember during the AIDS time, it is the same feeling, although I don't have AIDS, the feeling that people distance their selves from you because they don't what to see you.
>
> (FBN 1)

Decreasing quality of life

There was a decline in the quality of life among FBNs even post-recovery from COVID-19. Among nurses in the workplace, a prevailing sentiment persists that they are not yet physically fit to resume their duties, primarily due to the significant impact on their respiratory functioning and mental capacity caused by COVID-19.

> I am still experiencing malaise, making it difficult for me to walk properly, and I am not

fit to go back to work. Shortness of breath still occurs with even minor movements and while speaking, which hinders my ability to concentrate at work. I've also noticed that my forgetfulness has worsened, although my sense of taste and smell gradually returned after almost half a year. On top of that, I occasionally experience transient headaches.

(FBN 3)

I still cannot take the stairs, when I walk 1 meter, it feels like I have run for 10 kilometers, it was hard. I am so tired, and it lasted for 3 months. Back to work, I have memory loss, some words I can recognize but I don't know, I don't remember actually.

(FBN 4)

Improving the occupational health services

Access to occupational health services during the pandemic proved crucial for FBNs, enabling them to avail direct laboratory examinations and consult with specialists to address unresolved health issues effectively. The FBNs hoped these could have been available to support their well-being during the pandemic.

We should be given the option to take a psychologist, a follow-up check-up every 2 weeks with either neurologists, cardiologist or general physician.

(FBN 1)

There were no occupational services or other therapies such as debriefing.

(FBN 3)

I did not get to the test (COVID-19 test) immediately due to limited test capacities- either with respiratory symptoms or a health personnel.

(FBN 4)

Learning from the experience

The COVID-19 pandemic served as a valuable learning experience for FBNs, highlighting the need for more responsive leadership and an adequate healthcare staff. Nonetheless, this challenging period became a teaching experience for them, fostering a deeper understanding of how to provide optimal care for COVID-19 patients.

Next time, we need preparedness. We need to be more mentally prepared to handle the cases.

(FBN 1)

It is like you become more understanding and more considerate of what they (patients) are going through, at the same time for myself I do not worry that much anymore that I will be infected. The only thing that I can see as a solution is that we need more doctors and we need more nurses and more nursing aides.

(FBN 2)

DISCUSSION

The study explored the experiences of FBNs during different phases of the COVID-19 pandemic, shedding light on the challenges they faced, their coping mechanisms and the overall impact on their well-being. The pre-COVID-19 infection phase revealed that nurses encountered difficulties in accepting unclear organisational guidelines and national policies related to COVID-19. Uncertain directives from the national authorities during the COVID-19 pandemic resulted in heightened fear and anxiety among nurses from a scientific perspective [12, 21]. The lack of reliable information in the native language during the pandemic increased the risk of international migrant workers not recognising the seriousness of the epidemic or receiving accurate information on how to protect themselves from infection [22, 23]. Despite the absence of stringent rules and regulations [24], nurses exhibited compliance and acknowledged the limitations of the directives issued by their healthcare organisation and national authorities. They adapted to the uncertain and rapidly changing circumstances, recognising the need to navigate and work within the constraints imposed by the unclear guidelines and policies on COVID-19 protocols.

Nurses found themselves performing their duties with limited knowledge and skills in COVID-19 management. Consistent with previous studies on COVID-19, the lack of nurse education and skills was found to have an impact on patient care [25, 26]. This deficiency was particularly evident in areas such as training in the implementation of new types of oxygen therapy, leading to potential delays in the treatment plan [25]. Despite recognising their own shortcomings and challenges in providing effective

care for patients, they persevered and made efforts to perform to the best of their abilities. Nurses acknowledged the need for further training and support to enhance their understanding and skills in patient care, particularly in the context of COVID-19.

In comparison with Filipino FBNs in this study, a separate study encompassing BAME healthcare workers, predominantly comprising 70% doctors and 30% nurses, revealed that individuals from various nationalities such as Indians, Black Africans, Malaysians and Singaporeans were also affected by increased COVID-19 fatalities [27]. These participants identified several common factors contributing to the rise in COVID-19-related deaths among healthcare workers, including pre-existing co-morbidities, inadequate access to PPE, genetic factors, insufficient testing for COVID-19 among healthcare workers and deficiencies in vitamin D levels [27].

The COVID-19 infection phase further highlighted the experiences of FBNs during the peak of the pandemic. The FBNs described their experiences during the onset of signs and symptoms of COVID-19. Various manifestations of COVID-19 symptoms were reported, including fever, cough, fatigue, respiratory difficulty, body pain and changes in senses like taste and smell. Previous studies have reported similar signs and symptoms in relation to the current findings [10, 28]. The symptoms exhibited a range of variations, from mild to severe, encompassing both local and systemic presentations. Despite the challenges posed by the constantly evolving pandemic situation, FBNs adhered to the prescribed guidelines for patient care and personal protection. They strictly followed self-isolation protocols and sought testing as per official instructions when experiencing symptoms or exposure to COVID-19 even though getting the test was challenging. Access to COVID-19 tests during the peak season of the pandemic posed a significant challenge for nurses [29, 30].

Resorting to self-administered home management measures to cope with the illness was also done by FBNs. Nurses reported using medications like paracetamol and ibuprofen to manage fever and pain, while steamed water was used to alleviate dry cough and breathing difficulties. Drinking energy drinks and increasing fluid intake were strategies employed to address dehydration. Some nurses were prescribed antibiotics electronically for pneumonia, and vitamin C was taken to boost immunity, although its efficacy was not found to be helpful. Previous studies have documented the utilisation of steam inhalation, drinking herbal juices, decoctions and hot water in East Asia [31–33] and the use of vitamin C and concoctions containing garlic, lemon, ginger, other native herbs and warm water in Africa as preventive measures against COVID-19 [34–36]. However, the pharmacological rationale for their effectiveness has not been conclusively proven [37].

Living with fear emerged as a prominent emotional aspect during the COVID-19 infection phase, where nurses experienced anxiety and fear due to uncertainties related to the disease, including concerns about transmitting the virus to their family members, fears of mortality and worries about potential long-term health consequences. The emotional distress was further exacerbated by the fear of being isolated and unable to have contact with their loved ones. These concerns and experiences have been supported by findings in previous studies [8–10, 12]. On the other hand, accessing and receiving support from friends and family members played a crucial role in the well-being and resilience of FBNs during the COVID-19 infection phase. Support was provided in terms of physical assistance, emotional encouragement and social connection. Nurses acknowledged the importance of maintaining communication with colleagues and family members to update them about their health status and receive necessary support during their recovery.

The post-COVID-19 infection phase marked the aftermath of the virus's impact on FBNs' lives. The study identified that FBNs had feelings of moral distress, depression, anxiety and post-traumatic stress related to their COVID-19 experiences. Previous studies supported the findings of this research [8–13]. The pandemic had taken a toll on their mental well-being, and they expressed the need for psychological support and counselling services. Nurses disclosed feelings of emotional distress and observed social distancing from others, even after recovering from COVID-19 and testing negative. In describing their experience, one FBN drew a comparison between this situation and the stigmatisation encountered during the AIDS pandemic, emphasising the enduring impact of stigma [38] on their well-being. Consistent with the encounters of Filipino FBNs in this study, a separate investigation involving COVID-19 survivors revealed similar instances of facing stigma and fear following recovery from the virus [39]. Hence, ensuring both physical rehabilitation and comprehensive psychosocial support is critical to effectively meet the needs of these survivors [39].

This study also highlighted a decreasing quality of life among FBNs even after recovering from COVID-19. Nurses reported persisting physical symptoms such as malaise, shortness of breath and transient headaches, which affected their ability to perform daily activities and return to work. Cognitive difficulties, including forgetfulness and difficulty concentrating, were also reported, further impacting their daily functioning and quality of life. In a previous study, the negative impact of burnout resulting from occupational circumstances was evident

in the perceptions of nursing staff working during the COVID-19 pandemic, influencing their quality of life negatively [40].

The pandemic placed significant strain on health systems, necessitating enhanced support and preparedness, particularly considering the experiences recounted by the minority group of FBNs in Nordic society. This strain extended beyond frontline healthcare workers to impact various sectors of healthcare organisations, encompassing healthcare administrators, human resources, occupational health and allied health services. The resultant challenges also affected the broader support infrastructure for frontline healthcare workers.

This study further underscored the importance of improving occupational health services for FBNs during and after the pandemic. Access to direct laboratory examinations and consultations with specialists to address unresolved health issues was crucial in supporting their well-being and ensuring timely medical interventions. The FBNs expressed the need for better access to healthcare resources and regular check-ups, particularly for post-COVID-19 symptoms. According to Walton et al. [41], employers must prioritise the prompt provision of occupational health services, including mental health support, to staff members. Additionally, timely testing should be made available to ensure that self-isolating staff can have confidence in their appropriate actions.

The COVID-19 pandemic served as a valuable learning experience for FBNs, highlighting the importance of responsive leadership and an adequate healthcare workforce. The challenging period also served as a teaching experience, fostering a deeper understanding of providing optimal care for COVID-19 patients and the need for preparedness in handling similar situations in the future. The current data align with previous studies that highlighted the importance of organisational preparedness, adequate leadership, staffing and policy provision during the COVID-19 pandemic [9, 14].

This study emphasised the critical role of these factors in effectively managing and responding to the challenges posed by the pandemic. Given the recruitment of Filipino FBNs in the Nordic countries, nurse managers must establish a conducive and inclusive work environment. This will foster collaboration, mutual respect and comprehension of diverse cultural needs among personnel originating from varied cultural backgrounds within the workplace [42]. In the context of intersectionality theory [18], the experiences of these nurses, predominantly women and married individuals, intersected with various factors influencing their vulnerability. Their roles as primary earners, sending money to support their families in the Philippines, necessitated continued work to meet both personal and familial needs. Limited access to resources, notably inadequate availability of COVID-19 tests, heightened their vulnerability. This increased vulnerability extended beyond the nurses themselves, potentially exposing their family members due to their work-related exposures. Moreover, as most of these participants are women and married, they faced added responsibilities, needing to address their family's needs post-work, thereby intensifying their physical exhaustion.

CONCLUSION

The study provided valuable insights into the experiences of FBNs during different phases of the COVID-19 pandemic. It underscored the need for clearer guidelines, enhanced training and improved support for healthcare workers in pre-pandemic and pandemic situations. The study also highlighted the psychological and emotional impact of COVID-19 on FBNs, emphasising the importance of mental health support and stigma reduction efforts. Moreover, it emphasised the significance of improving occupational health services to support the well-being and recovery of healthcare workers during and after the pandemic. The findings of the study hold implications for developing comprehensive strategies to protect and support frontline healthcare workers in pandemics and other health crises. In addition to supporting FBNs who endured COVID-19 during the pandemic, it is imperative to provide comprehensive support for support systems and allied healthcare personnel, such as healthcare management, human resources and occupational health. This multi-level support is essential for enhancing resilience and overall efficacy in the delivery of healthcare services during future pandemics.

Based on the similarity of these findings to previous studies involving other BAME healthcare workers, there is a need to conduct additional empirical research involving other nationalities within the Nordic region.

AUTHOR CONTRIBUTIONS

FCJ and ADP contributed to the research design and data interpretation, with FCJ taking the lead in drafting and revising the entire research. ADP was responsible for data collection, while both FCJ and ADP performed the data analysis. KVJ and EP supervised the manuscript, and all researchers participated in the editing and final revision of the manuscript.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

The research obtained ethical approval from the University of Eastern Finland Committee on Research Ethics, and additional ethical considerations are outlined in the ethics section of the study.

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