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Navigating Nurses' Lived Social Experiences during a Health Crisis in Sarawak: A Phenomenological Study

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ABSTRACT

Introduction: Health is a dynamic and holistic state of well-being rather than merely the absence of illness. Social well-being among nurses is both a personal necessity and a professional imperative, as their interactions with patients, colleagues, families, and institutional systems fundamentally shape their professional identity and psychosocial health. **Objectives:** To explore the social experiences of nurses in Sarawak during the COVID-19 pandemic, with a focus on how their interactions with patients, colleagues, families, and healthcare systems shaped their sense of social well-being. **Methods:** Using a phenomenological approach, this qualitative study explored the lived, relational dimensions of nurses' experiences. Data were collected through face-to-face semi-structured interviews with ten purposively selected nurses, continuing until data saturation was achieved. Thematic analysis followed the six-phase framework. **Results:** Four themes emerged: disrupted personal freedom and diminished social engagement; fractured family bonds and emotional strain; stigmatization and societal rejection; and multi-dimensional camaraderie. Nurses described feelings of isolation, disrupted routines, and strained familial ties, yet also found strength in shared experiences and institutional support. **Conclusion:** Social well-being emerged as a dynamic, relational construct shaped by both vulnerability and resilience. The integration of existential structures offers a deeper understanding of how nurses' social realities were disrupted and redefined during the pandemic. These findings underscore the need for psychosocial support, relational leadership, and stigma-reduction strategies to safeguard nurses' well-being during public health crises.

Keywords: Nurses; Phenomenology; Social Experience; Well-being

INTRODUCTION

Health is increasingly recognized as a dynamic and holistic state of well-being encompassing physical, mental, and social dimensions, rather than merely the absence of illness. It reflects how individuals live their daily lives, regulate emotions, build meaningful relationships, and adapt to their surrounding environments (Krahn *et al*., 2021). Despite this, the social dimension of health, particularly social well-being and lived social experience, remains underexplored, often overshadowed by its physical and mental counterparts in both scholarly and clinical discourse.

Social well-being refers to an individual's perceived quality of social life, encompassing their sense of connectedness, social value, and meaningful contribution to society. It comprises five dimensions: social integration, social acceptance, social contribution, social actualization, and social coherence, each reflecting one's perceived role and belonging within a broader social context. While well-being has been extensively studied across spiritual (Jaberi *et al*., 2019), mental (Stelnicki *et al*., 2020), emotional (Park *et al*., 2023), psychological (Priya & Singh, 2023), and hedonic or subjective domains (Diener *et al*., 2018), the relational and communal aspects of health remain insufficiently examined, particularly within high-intensity healthcare environments.

Philosophical traditions originating in Ancient Greece distinguished between two fundamental

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conceptions of well-being: hedonic well-being, which centers on the pursuit of pleasure and the avoidance of pain (as advocated by Aristippus), and eudaimonic well-being, which emphasizes purpose, virtue, and the realization of one's potential (as articulated by Aristotle) (Abbas *et al*., 2024). Contemporary scholarship has expanded upon these classical foundations by incorporating social well-being as a relational and public dimension of wellness, reflecting an individual's capacity for integration, contribution, and functioning within society (Colenberg *et al*., 2021). Thus, well-being is increasingly understood as a subjective, contextual, and multifaceted phenomenon, shaped by personal values, life experiences, and sociocultural environments (Jarden *et al*., 2021). Hedonic and eudaimonic frameworks provide insights into happiness and purpose, but they do not fully capture the relational realities of nursing practice during a public health crisis, where well-being is intertwined with maintaining connections with patients, colleagues, and family members under conditions of social disruption.

The importance of social well-being is especially pronounced in times of crisis. During the COVID-19 pandemic, nurses played central roles in providing high-quality care under unprecedented clinical and emotional demands (Almaghrabi *et al*., 2020). While the physical and psychological demands of frontline care have been widely discussed, nurses' social experiences, how they navigated disrupted relationships, strained communication, and altered social roles remain insufficiently understood, particularly in the context of Sarawak. In such underrepresented settings, sociocultural diversity, geographical dispersion, and resource distribution may further influence nurses' social realities. Social well-being is not only a personal necessity but also a professional imperative, as interactions with patients, colleagues, families, and institutions underpin professional identity and psychosocial health (Hassmiller & Wakefield, 2022).

The pandemic disrupted these social interactions (Hosseinzadeh *et al*., 2022). Prolonged working hours, physical isolation, enforced distancing, and cumulative emotional exhaustion fractured social bonds and eroded the foundation of social well-being (Arlinghaus *et al*., 2019). These disruptions contributed to role ambiguity, emotional fatigue, and social disconnection. Although public health narratives often emphasize biological determinants of health, a social and existential perspective is essential to understanding the human experience in times of crisis (Holt-Lunstad, 2022). Nurses frequently prioritized patient care over personal needs while contending with communication breakdowns, fragmented teamwork, and fears of clinical error (Nabavian *et al*., 2023; Villar *et al*., 2021). These cumulative challenges diminished life satisfaction and hindered opportunities for posttraumatic growth. Nonetheless, social connectedness and meaning-making proved critical to resilience, with shared understanding and caregiving purpose sustaining emotional endurance despite isolation (Mo *et al*., 2020).

In this study, social experience is conceptualized as the lived, relational dimension of nurses' professional and personal life, encompassing interpersonal relationships, family dynamics, workplace interactions, and societal perceptions. This research foregrounds social well-being, often overlooked in favor of psychological and physical outcomes. By integrating four lifeworld existentials: 'lived body' (corporeality), 'lived time' (temporality), 'lived space' (spatiality), and 'lived other' (relationality) within a Sarawak context, the study provides a culturally grounded understanding of how social experiences are disrupted and reconstructed during public health crises (Van Manen, 2017). Similar hermeneutic phenomenological approaches have captured the depth of lived experiences in healthcare contexts, such as those by Chen and Balang (2025), Tamayo *et al.* (2024)and Alrasheeday *et al.* (2023). Interpreting nurses' narratives through these existential structures illuminates how social well-being is experienced, disrupted, and redefined during crises , contributing to understanding the emotional, relational, and organizational support systems necessary to safeguard nurses' well-being.

Methodology

Study Design

This study employed a phenomenological design to explore how nurses in Sarawak made sense of their social experiences during the COVID-19 pandemic and how these experiences shaped their sense of social well-being. Rooted in phenomenology, which emphasizes the exploration of subjective meaning within lived contexts, this approach seeks to understand human experience as it is perceived and interpreted by individuals (Pope & Mays, 2020).

The study draws on hermeneutic phenomenology, also known as interpretive phenomenology, which originates from the philosophical work of Martin Heidegger. Heidegger introduced the concept of Dasein, or "being-in-the-world," to describe the inseparable relationship between individuals and their lifeworlds (Heidegger, 1962). According to Heidegger, human beings are always already situated in a world that influences how they understand themselves and others, even if such understanding is not always explicitly articulated. This positional stance forms experience as inherently interpretive, shaped by historical, social, and relational contexts.

Building upon Heidegger's philosophical foundations, Van Manen (2017) advanced interpretive phenomenology as a method well-suited to exploring experiences of pedagogical and existential significance. He described phenomenology as a reflective practice oriented toward uncovering the meaning structures of lived experience.In this study, Van Manen's (2017) four lifeworld existentials 'lived body' (corporeality), 'lived time' (temporality), 'lived space' (spatiality), and 'lived other' (relationality) provided provided a structured yet flexible framework for interpreting the complex, deeply personal, and relational experiences of nurses. This lens allowed for an in-depth understanding of how nurses' identities, interpersonal connections, and sense of social well-being were profoundly reshaped by the relational, temporal, and spatial disruptions of the COVID-19 pandemic.

Aim

To explore the social experiences of nurses during the COVID-19 pandemic in Sarawak, with a focus on how their interactions with patients, colleagues, families, and healthcare systems shaped their sense of social well-being.

Sample and Setting

A purposive sampling was employed to recruit ten nurses from the Infectious Disease Ward of a major hospital in Sarawak. The inclusion criteria included registered nurses with at least 12 months of clinical experience who had worked in the isolation unit and provided direct care to patients with confirmed COVID-19 infections. In line with Creswell and Creswell (2018), a sample size ranging from ten to fifty participants is considered appropriate for qualitative research, depending on the study's focus and research questions. Recruitment was guided by the principle of data saturation, whereby no new themes or insights emerged from the data. To ensure a broad representation of perspectives, maximum variation sampling was used. Participants were selected based on differences in work experience, age, sex, and educational background, allowing the study to capture the diverse and complex nature of nurses' lived social experiences during the COVID-19 pandemic.

Data Collection

Participants meeting the inclusion criteria were purposively selected and contacted for participation following ethical clearance and informed consent. Interviews were scheduled at a mutually agreed date, time, and location. All interviews were conducted in a quiet, private room within the hospital premises to ensure a safe, confidential, and comfortable setting conducive to open and uninterrupted dialogue.

Data were collected through semi-structured, face-to-face interviews, which were audio-recorded and transcribed verbatim. Interviews were conducted in either Malay or English, depending on participants' language preferences, to ensure clarity, comfort, and authenticity of expression.

The interview process began with an open-ended introduction to establish rapport and encourage spontaneous sharing. Initial greetings and casual conversation, such as "*How are you today?*" and "*Have you eaten yet?*" were used to create a relaxed atmosphere. The researcher then introduced herself using prompts such as "*My name is …, and I would like to ask you some questions about your experiences working during the COVID-19 pandemic in Sarawak. Please briefly tell me about yourself and your background*." This initial engagement aimed to build trust and foster a conversational tone.

An interview guide was developed in alignment with the study aim to explore nurses' social experiences, with each question designed to elicit narratives related to interpersonal relationships, family dynamics,

workplace interactions, and societal perceptions during the pandemic. Guiding questions included, "*Can you describe your experience in caring for patients with COVID-19?*" and "*How was your time with your family affected during the pandemic?*" Additional questions such as, "*How did the COVID-19 pandemic affect your family members when they learned that you were required to care for infected patients?*" were used to explore familial concerns. Probing questions, including "*Can you further explain or clarify what you mean by that?*" and "*Can you give an example?*" encouraged deeper reflection and elaboration. These questions facilitated rich narratives concerning the intersection of personal, familial, and professional experiences.

Data Analysis

Data were analyzed using Braun and Clarke's (2021) six-step inductive thematic analysis, which includes familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. This method was selected for its flexibility and capacity to capture nuanced, subjective experiences by identifying patterns and meanings embedded within qualitative data, making it particularly appropriate for exploring the lived experience of frontline nurses during the COVID-19 pandemic.

The researcher immersed herself in the interview transcripts through repeated readings to develop a comprehensive understanding of the content. Salient phrases and expressions reflecting the social experiences of nurses were identified and coded. These codes were then organized into preliminary themes that represented recurring patterns across participants' narratives. The research team collaborated throughout the analysis to refine the themes, resolving discrepancies through iterative discussion and re-examination of transcripts until consensus was reached.

Rigors of the Study

To ensure methodological rigor, the study adhered to Lincoln and Guba's (1986) criteria of trustworthiness, encompassing credibility, dependability, confirmability, and transferability. Credibility was enhanced through member checking, purposeful sampling for participant diversity, and triangulation via reflective journaling and iterative interview practice. Dependability was established through detailed documentation and an external audit to verify the consistency and logic of the research process. Confirmability was supported by maintaining audit trails, reflexive journals, and regular supervisory meetings to ensure analytical objectivity. Transferability was achieved by providing rich, contextual descriptions of the setting and participants' experiences.

Ethical Considerations

The research obtained ethical clearance from the National Medical Research Registry, Malaysia with reference number NMRR-21-127-58279 IIR on 25th February, 2021.

Prior to each interview, participants were fully informed about the study's purpose and procedures. They were assured of the confidentiality of their data and their right to participate voluntarily or withdraw at any time without consequences. Written informed consent was obtained from all participants. Interviews were scheduled at participants' convenience to minimize disruption to their daily routines.

To ensure anonymity, multiple measures were implemented beyond the use of pseudonyms. All identifying information, including names, specific workplace locations, and personal details, was removed during transcription. Data were de-identified at the point of transcription, and any potentially recognizable contextual information was modified to prevent indirect identification. In reporting the findings, quotations were carefully presented to preserve meaning while avoiding disclosure of identifiable details. Participants' demographic characteristics are presented in Table I without any traceable identifiers. All raw data were accessible only to the research team and were securely stored in password-protected files.

RESULTS

The participants, aged between 28 and 43 years, represented diverse ethnic backgrounds, including Chinese, Malay, and Bidayuh, and brought varying levels of professional expertise to the study. All held nursing

diplomas (Table 1), and their years of clinical experience, ranging from 4 to 21 years, not only shaped their professional competence but also played a critical role in influencing their social experiences during the pandemic.

Table 1: Socio-demographic Characteristics of the Participants

Sample	Pseudonym	Gender	Age	Race	Marital Status	Education	Work Experience
1	Laura	Female	43	Chinese	Married	Diploma	21 years
2	Naomi	Female	28	Malay	Single	Diploma	6 years
3	Amanda	Female	29	Bidayuh	Married	Diploma	4 years
4	Teresa	Female	38	Malay	Married	Diploma	12 years
5	Malik	Male	33	Bidayuh	Married	Diploma	9 years
6	Imran	Male	34	Malay	Married	Diploma	9 years
7	Felicia	Female	29	Bidayuh	Single	Diploma	4 years
8	Wendy	Female	31	Malay	Married	Diploma	9 years
9	Umaira	Female	36	Malay	Married	Diploma	14 years
10	Claudia	Female	41	Bidayuh	Single	Diploma	18 years

Thematic analysis was conducted, yielding four key themes that encapsulate the social experiences of nurses during the COVID-19 pandemic in Sarawak: (1) disrupted personal freedom and diminished social engagement, (2) fractured family bonds and emotional strain, (3) stigmatization and societal rejection, and (4) multi-dimensional camaraderie. Following the analytic phase, these themes were furtherinterpreted through Van Manen's (2017) four lifeworld existentials – 'lived body', 'lived time', 'lived space', and 'lived other' - to providea deeper understanding of nurses' lived experiences. Each theme is presented in relation to the relevant existential dimensions, thereby elucidating its relational and experiential significance.

Theme 1: Disrupted Personal Freedom and Diminished Social Engagement

Theme 1 illustrates how nurses' social experiences during the COVID-19 pandemic were profoundly shaped by the lifeworld existential spatiality ('lived space') and temporality ('lived time'). Through the lens of Van Manen (2017), 'lived space' was experienced not merely as a physical setting but as a constraining and altered environment that reshaped nurses' sense of freedom and belonging. Familiar spaces once associated with comfort, rest, and social interaction were replaced by restrictive environments such as hospital wards and designated hostels. These spaces were experienced as confining and impersonal, leading to feelings of isolation and detachment.

Simultaneously, 'lived time' was disrupted as nurses' daily rhythms and sense of temporality became dominated by prolonged working hours and repetitive routines. Time, once associated with rest, leisure, and social engagement, was reconfigured into a cycle of work and confinement, diminishing opportunities for recovery and social connection. The loss of meaningful "off days" reflects a temporal dislocation, where time felt compressed and monotonous rather than restorative.

Wendy (P8) described how these intertwined spatial and temporal disruptions affected her well-being: *"…Before this, we have an off day; we can go to release tension… But when there's a pandemic, we work 12 hours and then it's like we go to work and return to work…"*

Similarly, Felicia (P7) articulated the constraining nature of 'lived space', likening it to confinement: *"…Staying at the hostel feels like in the locked up… I just slept at the hostel and not talking to anyone."*

Together, these accounts demonstrate how altered spatial environments and disrupted temporal rhythms limited nurses' personal freedom and diminished their social engagement, reshaping their lived experiences during the pandemic.

Theme 2: Fractured Family Bonds and Emotional Strain

This theme elucidates how nurses' lived experiences during the COVID-19 pandemic were shaped through the existential dimensions of relationality ('lived other') and temporality ('lived time'). Interpreted

through the lens of Van Manen (2017), 'lived other' reflects the meaning of relationships as experienced in everyday life. During the pandemic, these relationships were not only physically disrupted but also emotionally strained, as nurses experienced a profound sense of disconnection from their families. Separation due to hostel accommodation, quarantine measures, and prolonged working hours reconfigured their relational world, transforming closeness into distance and presence into absence.

Concurrently, 'lived time' was experienced as loss and interruption. Nurses were not only physically absent but also temporally disconnected from significant family moments, resulting in a sense of missed time that could not be reclaimed. The inability to participate in daily interactions and important life events contributed to emotional distress and a fragmented sense of familial continuity.

Imran (P6) expressed the emotional weight of this separation: *"...There is a sad feeling in my heart that I am far from my family. I'm not lying; I'm going to cry.*"

Amanda (P3) illustrated the temporal disruption through a missed life event: *"...He (my husband) came back on the day I delivered when I had already been admitted to the hospital."*

Similarly, Umaira (P9) revealed the emotional consequences of prolonged separation: *"...When I was able to meet my daughter after 3 months... she didn't want me..."*

Beyond separation, the persistent fear of transmitting the virus further reshaped relationality, as nurses experienced hesitation and emotional distancing even when reunited with loved ones. Amanda (P3) noted: *"...When we come back from work, we are afraid to be close to our family."*

Additionally, experiences of stigma extended this disruption of relationality beyond the immediate family, contributing to social exclusion and further emotional strain, as reflected in instances where family members faced rejection or exclusion from social participation.

Collectively, these experiences demonstrate how disruptions in 'lived other' and 'lived time' fractured familial bonds and intensified emotional strain, reshaping nurses' relational and temporal worlds during the pandemic.

Theme 3: Stigmatization and Societal Rejection

Theme 3 highlights how nurses' lived experiences during the COVID-19 pandemic were shaped through the existential dimensions of the 'lived body' and relationality ('lived other'). Interpreted through the lens of Van Manen (2017), the 'lived body' reflects how individuals experience themselves physically and emotionally in relation to the world, while the 'lived other' captures the significance of relationships and social interactions.

Nurses were simultaneously positioned as healers and as potential carriers of the virus, which profoundly affected both their embodied experiences and their social relationships. The constant fear of infection heightened bodily awareness and hypervigilance. Teresa (P4) described this embodied anxiety: *"...Before one shift we can shower up to 5 to 6 times... Even if we feel like we have a little flu, we feel like 'ehh am I okay?"*

Despite strict adherence to Personal Protective Equipment (PPE), public fear persisted, affecting social interactions and prompting subtle forms of exclusion. Amanda (P3) noted: *"...Even though I claim that I wear full PPE..."*

Malik (P5) experienced direct social rejection: *"...They closed all the doors and windows because they were afraid."*

This combination of heightened bodily vigilance and social avoidance led to emotional withdrawal and a sense of marginalization. While some, like Felicia (P7), observed gradual improvements in public perception, others, such as Claudia (P10), highlighted ongoing misconceptions and inequities: *"...Outsiders assume ID ward does not have many patients... we have the same workload as other wards..."*

Through these experiences, the pandemic reshaped nurses' embodied self-awareness and social relationships, revealing how societal stigma and fear influenced both physical and relational dimensions of

their lived experience.

Theme 4: Multi-dimensional Camaraderie

This theme illustrates how nurses cultivated resilience and a sense of belonging through meaningful relationships, interpreted through thelifeworld existential of relationality ('lived other') and embodied experience ('lived body'). From the perspective of Van Manen (2017), 'lived other' captures the significance of interpersonal connections, while the 'lived body' reflects how shared experiences and physical presence contribute to emotional and psychosocial well-being. Despite disruptions in family and social life, nurses derived emotional strength from supportive relationships with family, colleagues, and institutional actors. Family encouragement remained a vital source of motivation. Imran (P6) noted: *"...My wife and parents always give advice, give words of encouragement."*

Similarly, Wendy (P8) and Umaira (P9) described ongoing family support, and Laura (P1) highlighted her daughter's daily video calls as a source of connection: *"Is mom back yet?"*

Peer support within the workplace fostered emotional refuge and a sense of solidarity. Wendy (P8) shared: *"We are there for each other... it's different from support through WhatsApp or video call."*

Claudia (P10) added: *"...I just chat with friends, friends in the ward..."*

Support extended beyond immediate teams. Cross-departmental solidarity and acts of care from superiors reinforced nurses' embodied and emotional resilience. Teresa (P4) recalled: *"...Dr T gave us the prescribed vitamin... Sometimes she buys... bird nest..."*

Umaira (P9) added: *"...She buys ice cream for us... it feels like we are tired inside, and people outside care."*

Public recognition and institutional support, including allowances and equipment donations, further bolstered morale. Felicia (P7) noted: *"The allowance helps a lot."*

While Teresa (P4) shared: *"Many people donated coolers and fans."*

Access to psychological support services, such as the Public Service Companion/Counsellor helpline, provided additional emotional relief. Naomi (P2) reflected: *"...We can share our problem... felt relief."*

Through these experiences, nurses' relational and embodied lifeworlds were reinforced, demonstrating that multi-dimensional camaraderie encompassing familial, peer, institutional, and societal support was crucial in sustaining well-being and resilience during the pandemic.

DISCUSSION

The social experiences of nurses during the COVID-19 pandemic in Sarawak can be meaningfully understood through the four existentials of Van Manen (2017): 'lived time', 'lived space', 'lived body', and 'lived other' (Table 2). This lens reveals how nurses' perceptions of time, space, body, and relationships were disrupted and redefined. Notably, 'lived other' stood out, highlighting the vital role of social connectedness in sustaining nurses' well-being.

Table 2: Interpretation using Van Manen's Four Existential Lifeworlds

Van Manen's Lifeworld	Mapped Themes
Lived Body (Corporeality)	Theme 3: Stigmatization and Societal Rejection Theme 4: Multi-dimensional Camaraderie
Lived Space (Spatiality)	Theme 1: Disrupted Personal Freedom and Diminished Social Engagement
Lived Time (Temporality)	Theme 1: Disrupted Personal Freedom and Diminished Social Engagement Theme 2: Fractured Family Bonds and Emotional Strain
Lived Other (Relationality)	Theme 2: Fractured Family Bonds and Emotional Strain Theme 3: Stigmatization and Societal Rejection Theme 4: Multi-dimensional Camaraderie

Lived Time

The COVID-19 pandemic disrupted nurses' temporal rhythm, turning structured routines into monotonous cycles of work and emotional fatigue. Prolonged shifts, movement restrictions, and isolation blurred the lines between personal and professional time, leaving little room for rest or meaningful social engagement. This experience aligns with Heidegger's notion of temporality as a lived, experiential flow rather than measurable clock time. The fragmentation of time led to a loss of freedom and connection y*et al*so created opportunities for introspection and resilience. These altered temporal experiences reshaped nurses' sense of continuity and identity, reflecting their capacity for adaptation under extreme conditions (Thrysoee *et al*., 2022; Sun *et al*., 2020).

Lived Space

Nurses' spatial experiences were radically redefined as the pandemic collapsed the boundaries between safe and clinical environments. Familiar spaces such as homes and hospital wards became sites of surveillance, solitude, and emotional detachment due to infection control protocols and isolation measures. Space, once a source of comfort and belonging, became infused with fear and exclusion (Jesus *et al*., 2021). Stigma further compounded this disruption; some nurses were denied services or socially distanced by loved ones. These spatial shifts illustrate the emotional cost of caregiving during a crisis, where redefined environments eroded bonds and reshaped nurses' place in both personal and professional contexts (Chen & Balang, 2025; Alrasheeday *et al*., 2023).

Lived Body

The pandemic made nurses' bodies both instruments of care and symbols of vulnerability. Physically, they endured long hours, discomfort from PPE, and constant exposure to infection. Socially, their bodies became stigmatized as potential vectors of disease, leading to distancing even from family. This paradox, being both caregivers and perceived threats, shaped their identity and emotional well-being. As Robinson and Stinson (2021) note, the caregiver's body becomes a relational site where fear and social meaning converge. Thus, the 'lived body' experience revealed how physical presence in care, while essential, exposed nurses to misunderstanding, rejection, and isolation (Chen & Balang, 2025).

Lived Other

Relationality was at the core of nurses' social experiences. While familial bonds were strained by separation and self-isolation, they remained a vital source of emotional grounding. Peer support within clinical settings emerged as a powerful buffer against burnout, offering solidarity and shared strength. Gestures from colleagues and medical professionals, such as sharing food, vitamins, and words of encouragement, became essential in sustaining morale. These moments, intertwined with space, turned clinical environments into places of refuge and connection (Muz & Erdoğan, 2021). Public appreciation, financial incentives, and community support further reinforced nurses' sense of value and belonging during the crisis (Ling & Balang, 2025).

Limitations

This study was conducted in a single infectious disease ward in Sarawak, which may limit the transferability of findings to healthcare settings with different organizational structures or cultural contexts. As a qualitative inquiry, the findings are context-specific and not generalizable to broader populations. Future research should explore nurses' social experiences across diverse regions and cultural contexts and employ longitudinal designs to examine the long-term psychosocial impacts of the pandemic on professional identity, interpersonal roles, and social well-being.

Conclusion

This study aimed to explore the social experiences of nurses in Sarawak during the COVID-19 pandemic, with a focus on how their interactions with patients, colleagues, families, and healthcare systems shaped their sense of social well-being. Using an interpretive phenomenological approach, the findings reveal that nurses' social well-being is a dynamic, relational, and contextually grounded construct, profoundly shaped by

disruptions in time, space, embodiment, and relationships.

The study demonstrates that nurses navigated multiple challenges, including social isolation, fractured family bonds, stigmatization, and altered work environments, while simultaneously exhibiting resilience through peer support, institutional encouragement, and familial connections. These findings underscore the importance of recognizing social well-being as a core component of holistic health and highlight the relational and existential dimensions that underpin professional identity and coping during crises.

Importantly, this study contributes to nursing scholars by foregrounding the often-overlooked social dimension of nurses' lived experiences in a Sarawakian context, offering culturally and regionally relevant insights that enhance understanding of how nurses negotiate their social realities under pandemic conditions. From a practical perspective, the findings have clear implications for nursing practice and policy. Healthcare institutions should prioritize psychosocial support services, relational leadership, stigma reduction strategies, and work-life balance initiatives to safeguard nurses' well-being, foster resilience, and maintain high-quality patient care during public health emergencies.

Future research should examine the long-term evolution of nurses' social well-being and conduct comparative studies across diverse cultural and healthcare contexts to better understand how social experiences influence professional identity, relational health, and workforce sustainability. By highlighting the interplay of relational, temporal, spatial, and embodied dimensions, this study provides actionable knowledge for supporting nurses as both professionals and individuals within interconnected social worlds.

Recommendations

Based on the findings of this study, several recommendations are proposed to enhance nurses' social well-being during public health crises.

Foremost, healthcare institutions should prioritize enhancing psychosocial support services to alleviate the emotional burden experienced by nurses, particularly in relation to disrupted social experiences during public health crises. The provision of on-site counseling, peer support networks, and structured debriefing sessions is essential not only for fostering emotional resilience but also for addressing social isolation, relational strain, and emotional fatigue. In Malaysia, the Ministry of Health (MOH) has implemented a range of Mental Health and Psychosocial Support Services (MHPSS) for healthcare workers, including the Psychosocial Support Helpline, Psychological First Aid (PFA) sessions, pre- and post-deployment mental health screenings, Mental Health Alert Cards, and an increased presence of counselors in district-level health clinics. Public mental health initiatives such as the "*Let's Talk Minda Sihat*" campaign, first-line responder suicide prevention training, and inter-agency mental health advocacy further promote destigmatization and social connectedness. These services support the existential dimensions of the 'lived body' and the 'lived other' by addressing both individual well-being and relational health, helping nurses rebuild belonging, trust, and emotional safety within and beyond the healthcare environment.

Promoting work-life balance should also be a key institutional focus. Prolonged shifts, social isolation, and disrupted temporal rhythms contributed significantly to emotional fatigue and burnout among nurses. Introducing flexible scheduling, enforcing mandated rest periods, and structured opportunities for family reconnection can restore continuity and well-being, supporting the 'lived time' dimension of nurses' experiences.

In addition, fostering a culture of relational leadership and solidarity is equally critical. The camaraderie observed among nurses during the pandemic should be institutionalized through empathetic leadership, inclusive decision-making, and meaningful recognition of contributions. Nurse leaders should actively listen, empower, and advocate for their teams, reinforcing the 'lived other' dimension by validating professional identity and sustaining morale.

To address stigma and social exclusion, healthcare authorities and professional bodies such as the Ministry of Health Malaysia and the Malaysian Nurses Association should implement targeted public education campaigns to dispel misconceptions and humanize frontline healthcare workers. These initiatives are

essential for mitigating fear-driven responses, safeguarding nurses and their families from social ostracism, and fostering public empathy and respect. By restoring safety, dignity, and inclusion, these efforts support 'lived space'dimensions and contribute to a more supportive and inclusive societal environment for the nursing profession.

Finally, resilience and crisis preparedness should be embedded into nursing curricula and continuing professional development programs. Training in crisis communication, emotional regulation, ethical reasoning, and adaptive leadership equip nurses to navigate complex and uncertain clinical environments. These educational strategies are aligned with all four of Van Manen's lifeworld existentials: 'lived body', 'lived time', 'lived space', and 'lived other' to promote a holistic and sustainable approach to workforce readiness during future health crises.

Conflict of Interest

The authors affirm that there are no conflicting objectives

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