International Journal of Community Medicine and Public Health
Ganta A et al. Int J Community Med Public Health. 2026 Apr;13(4):2077-2083
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20260732

Review Article

Exploring post-pandemic burnout and mental health among healthcare workers in India: a narrative review on prevalence, risk factors and impact

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Received: 04 February 2026
Accepted: 27 February 2026

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ABSTRACT

Healthcare workers are essential to any health system, but often they face high levels of burnout and mental health issues. In India, problems such as workforce shortages, overworked health systems, and long hours could make it even more challenging. This narrative review looks at evidence about burnout, depression, anxiety, stress, and sleep problems among Indian healthcare workers and how these issues affect their daily lives and healthcare services. We conducted a thorough search for studies on this topic from January 2020 to January 2026 using PubMed and Google Scholar. The results show that a significant number of Indian healthcare workers experience burnout and have reported higher rates of anxiety and depression. Studies indicate that post-pandemic rates are increasing, causing a significant mental health burden and worsening health care delivery. Burnout is often linked to medical errors, lower-quality care, decreased life satisfaction, absenteeism, and workforce loss. Various factors can contribute to burnout, including individual circumstances, work conditions, institutional support, and cultural effects. Key contributors to burnout were found to include younger age, female sex, longer working hours, poor infrastructure, and mental health stigma. This review emphasizes the need for comprehensive strategies to support the mental health of India's healthcare workers. Interventions should occur at multiple levels, including mental health screenings, well-being programs in healthcare institutions, workforce expansion, and digital mental health resources.

Keywords: Burnout, Healthcare workers, Mental health, India

INTRODUCTION

Frontline healthcare workers and professionals form the foundation of any healthcare organization. They play a vital role in daily clinical operations, managing healthcare delivery that requires both physical and psychological involvement. This is often accompanied by a heavy workload and limited resources, particularly in developing countries like India.[1] Globally, there is growing awareness that individuals working in healthcare settings are at a significant risk of occupational burnout and psychological distress.[2,3] The Indian healthcare system faces a high patient load but has limited mental health services. The pandemic's impact has likely exacerbated the strain on healthcare services. Currently, healthcare workers in India are dealing with chronic burnout and adapting to ongoing systemic pressures in the post-COVID-19 pandemic environment.[1]

In India, the healthcare workforce operates under uniquely challenging conditions. The country has one of the lowest doctor-to-population ratios in the world, with wide disparities between urban and rural areas.[4] India has only 0.3 psychiatrists, 0.05 psychologists, and 0.03 social workers per 100,000 population, according to the WHO Mental Health Atlas.[5] The health system is further burdened by poor infrastructure, high patient volumes, hierarchical work cultures, and limited remuneration, all of which contribute to occupational stress and burnout.[1,6]

Burnout is classified under the ICD-11 as a syndrome related to the workplace that can impact healthcare. It is defined as a syndrome resulting from unmanaged workplace stress, leading to feelings of exhaustion, negative emotions towards work, and decreased professional effectiveness.[7] The COVID-19 pandemic served as an unprecedented source of stress for healthcare professionals (HCPs) worldwide, and Indian health workers were no exception. Multiple studies conducted during the pandemic reported alarmingly high rates of depression, anxiety, insomnia, and burnout among Indian HCPs, with prevalence rates exceeding those recorded before the pandemic.[8,9] While the acute phase of the COVID-19 pandemic has passed, emerging evidence indicates that the psychological effects persist long-term, with residual burnout continuing to affect healthcare workers in the post-pandemic world.[10,11]

In India's healthcare system, the well-being of frontline healthcare workers is a significant concern. This review examines the critical issues of burnout and mental health challenges faced by these workers. It tries to explore the prevalence of these issues, their causes, and their impact at various levels, including healthcare delivery. Our goal is to raise awareness about this important topic and emphasize the urgent need for support to protect those who care for us.

METHODS

This review evaluates the existing literature for the prevalence of burnout among healthcare workers in India and its impact on mental health issues such as depression, anxiety, stress, and sleep problems. The aims of the review are to: summarize how often burnout and psychological problems occur, identify the main risk factors leading to burnout, and explore how burnout affects daily life, sleep quality, and the delivery of healthcare services.

We screened the titles and abstracts of PubMed and Google Scholar to determine the relevance to our review objectives. Studies were included if they met the following criteria: Focused on healthcare workers, including doctors, nurses, or other clinical workers in India and if they reported at least one of the following outcomes measured by using standardized or validated tools for burnout, depression, anxiety, stress or sleep quality/disturbance (e.g., Maslach burnout inventory, Copenhagen burnout inventory, DASS-21, PHQ-9, GAD-7, PSQI, Epworth sleepiness scale). Advanced filtering was done to include original research articles, systematic reviews, and meta-analyses.

We used specific exclusion criteria during the review process at both the title/abstract and full-text stages. We excluded studies that focused on patients, caregivers, students, or the general population without a separate healthcare group. We also excluded studies that were not conducted in India or did not provide clear, specific data for India. Furthermore, editorials, commentaries, letters, viewpoints, and conference abstracts were also left out.

A PubMed search, focusing on burnout, mental health, and sleep terms, specifically targeting healthcare professionals in India from 2020 to 2026, retrieved 3,671 records. Additionally, we reviewed approximately 176 articles from Google Scholar based on their relevance. Of the 3847 records screened, 3727 were excluded at the title/abstract level as not relevant (e.g. non-HCP populations, non-Indian settings, non-mental health outcomes). 120 full-text articles were assessed for eligibility. After removing duplicates and screening titles, abstracts, and full texts for relevance, 48 articles were included in conducting the review.

PREVALENCE OF BURNOUT AMONG INDIAN HEALTHCARE WORKERS

Table 1 summarizes the findings of Key Indian studies on burnout and mental health among healthcare workers which were published after 2020. Kesarwani et al conducted a review of burnout among Indian HCPs.[1] This review combined data from 15 studies involving 3,845 HCPs and used the Maslach burnout inventory (MBI) to measure burnout. They found that 24% of HCPs experienced emotional exhaustion, 27% dealt with depersonalization, and 23% had a reduced sense of personal accomplishment. Factors that increased the risk of burnout included being younger in age, female sex, being unmarried, and working in difficult conditions. Globally, a systematic review done by Rotenstein et al found that burnout among doctors' ranges from less than 10% to over 80%, depending on how it is defined and measured.[12] In India, the reported rates are generally lower. Heterogeneity of the tools and definitions used makes it difficult to compare burnout data across studies and countries.

The COVID-19 pandemic appears to have markedly influenced the mental health of healthcare workers in India. A review of studies by Mathias et al found that 33% of these workers experienced depression, 29.5% had anxiety, and 33.5% faced stress.[8] In a cross-sectional survey done by Suryavanshi et al during the pandemic on 197 healthcare professionals from 13 Indian states, reported that 47% had depression, 50% had anxiety, and 45% had a low quality of life.[9] Those with moderate to severe depression and anxiety were three times more likely to have a low quality of life.[9] In a study done by Kaushik et al, it was found that among 240 nurses in a hospital, reported that 50.8% experienced stress, 74% had anxiety, and 70.8% had depression using the DASS-21 scale.[13] A recent post-pandemic study by Sidiq et al examined burnout among 578 HCPs working in hospitals in Rajasthan, using the Copenhagen burnout inventory (CBI).[10] The study found that 68.1% of HCPs experienced overall burnout. Specifically, 67.5% reported work-related burnout, 56.4% personally felt burnout, and 48.6% experienced burnout related to caring for patients.[10] Nurses

had the highest burnout rates, with 84% reporting work-related burnout and an average burnout rate of 87.8%, and the nursing profession was a strong predictor of higher average burnout scores ($p<0.05$).

A study on burnout among healthcare workers published in the Journal of the Association of Physicians of India (JAPI) in 2025 found that about 25% of professionals still experience all three types of burnout, as measured by the MBI.[11] A qualitative study of mental health professionals in India (2025) further documented experiences of emotional depletion, helplessness, blurred personal-professional boundaries, and work-life imbalance as hallmarks of burnout.[5] A systematic review done globally in 2024 found that recent meta-analyses report burnout prevalences ranging from over 70% among nurses and doctors to 56% in dietitians and 43% in emergency workers.[2]

RISK FACTORS

Burnout and psychological distress among Indian healthcare workers are multifactorial. These causes include personal factors, work conditions, institutional policies, and cultural effects. Studies indicate that younger workers frequently experience higher levels of burnout. This is likely due to the challenges they face when starting their careers and their lack of experience in coping with stress.[1] In the study by Siddiq et al, healthcare workers aged below 30 years had significantly higher odds of patient-related burnout ($\beta=9.56$, 95% CI: 3.15-15.97, $p=0.003$*).[10] Female healthcare workers reported higher levels of anxiety and emotional exhaustion across multiple Indian studies, attributed in part to their dual demands of work and domestic responsibilities.[1,13] Interestingly, Sidiq et al's study found that males reported higher personal burnout (61.8% versus 48.3%; $\beta=4.45$, $p=0.034$*), suggesting that the gender-burnout relationship may differ across burnout domains and measurement tools.[10] Unmarried status, lower levels of resilience, and absence of a support network could act as additional individual risk factors.[1]

Long working hours and heavy patient loads are documented as major causes of stress among healthcare workers. In a study, over 25% of health care providers in India reported working more than 60 hours a week, and longer hours were strongly linked to feeling burnt out both personally and at work.[10] Indian nurses frequently work in irregular shift patterns that disrupt biological rhythms and sleep.[16] Night shifts and rotational duties have been shown to predict poor sleep quality and elevated anxiety.[15,16] Junior doctors and resident doctors are particularly vulnerable, often working for longer 36-hour shifts with limited rest.[22] Exposure to traumatic events, including patient deaths, violence from patients' relatives, and medically complex cases, constitutes a chronic emotional stressor. For mental health professionals, compassion fatigue and secondary traumatic stress add a further layer of risk.[5] Additionally, a history of COVID-19 infection was independently associated with higher average burnout scores ($\beta=8.87$, 95% CI: 3.99-13.75, $p<0.001$*).[10]

India's healthcare system is characterized by chronic underworking, a lack of infrastructure, and a scarcity of resources.[1] Government hospitals, which serve the majority of the population, often lack basic facilities, and HCPs in these settings face disproportionately high burnout.[7] Environmental stressors at work, including lack of knowledge, lack of manpower, and fear of infection, were independently associated with a 46% increased risk of combined depression and anxiety (OR: 1.46, 95% CI: 1.15-1.85).[9] Poor administrative support, delayed salary payments, lack of promotion pathways, and limited access to psychological services worsen the problem and could contribute to burnout.[5] A qualitative study done in 2025 had identified that underpayment is a critical contributor, and most of them work more than seven hours a day.[5] The lack of sick leave provisions for psychological symptoms is another institutional gap and mental health stigma remains deeply embedded in Indian society.[5,17] Healthcare workers themselves are not immune to this, and studies report that mental health professionals feel unable to seek help due to societal expectations that they should be psychologically strong to deal with any emotional and mental health difficulties.[5] The hierarchical system in Indian hospitals, characterized by conflict between professionals over treatment approaches, further impacts collaborative support. Gender-specific expectations, such as increased scrutiny of female health workers and patient-related boundary challenges, add to the burden of the problem.[5]

IMPACT ON FUNCTIONING, SLEEP, AND HEALTHCARE DELIVERY

Burnout and psychological distress do not remain confined to the workplace and generally proceed into every aspect of a healthcare worker's daily life, worsen sleep quality, and ultimately compromise the care delivered to patients. Burnout can have a cascading effect that extends beyond the hospital or clinic. Healthcare workers experiencing emotional exhaustion have reported chronic fatigue, irritability, reduced motivation, and social withdrawal, which could diminish their quality of life and their capacity to engage in routine personal activities.[1] A recent study on mental health professionals reported blurring of boundaries between personal and professional life, leading to emotional exhaustion even on days when they are off, and impacting personal relationships due to emotional unavailability.[5]

Suryavanshi et al found that 45% of Indian HCPs reported poor quality of life during the pandemic, depression (OR: 3.19, 95% CI: 1.30-7.84) and anxiety (OR: 2.84, 95% CI: 1.29-6.29) were independently associated with poor quality of life.[9] Cognitive functioning is especially weak when we lack sleep or are under constant stress. Sleep deprivation impairs memory, attention, concentration, and learning. Poor sleep can cause daytime drowsiness and microepisodes of sleep during wakefulness, which can lead

to poor task performance, increased errors at work, and emotional issues such as irritability/aggression.[14] In extreme scenarios, prolonged wakefulness can produce psychotic-like symptoms ranging from simple visual or somatosensory perception changes to hallucinations.[14] Indian healthcare workers who experience burnout were found to be more prone to depression, anxiety, substance abuse, marital problems, and physical health disorders, including cardiovascular disease and metabolic syndrome.[1] Sleep deprivation could further impair physical health such as raised blood pressure, hypothalamic-adrenal axis dysfunction, and immune suppression.[15] These combined effects create a vicious cycle of poor physical and mental health further reducing coping strategies perpetuating and intensifying burnout.

Sleep disturbance is both a consequence and a cause of burnout, with a bidirectional relationship that is pronounced among shift workers, especially healthcare staff. Sleep deprivation among night-shift health workers on rotation evaluation (SNORE) study, a hospital-based observational study conducted at a tertiary care centre in Tamil Nadu which was published in the Indian Journal of Psychiatry in 2025, found that 82.3% of health workers working on rotational night shifts have reported less than 7 hours of sleep, with a mean sleep duration of only 5.43±1.38 hours during night-shift periods.[14] The burden of excessive daytime sleepiness was found to be 16.4%, and the overall burden of sleep deprivation measured by Epworth sleepiness scale (EPSS) scores was 30.7%.[14] EPSS scores have decreased significantly with increasing hours of sleep, with 61% lesser odds of excessive sleepiness for each additional hour of sleep (OR=0.39, 95% CI: 0.30-0.51).[14] Female gender and married status were significantly associated with sleep deprivation, reflecting the additional effect of domestic responsibilities on a compromised sleep schedule.[14]

A large multicenter study of 850 Indian nurses across 25 hospitals in four different zones of the country has reported that 32.6% had overall poor quality of sleep measured on the PSQI, with 55.2% reporting moderate impairment in sleep efficiency and 58.5% reporting mild daytime dysfunction due to sleepiness.[15] Extra night shifts (OR 1.09, 95% CI: 1.04-1.14) and additional shift hours (OR 1.08, 95% CI: 1.06-1.10) were significantly associated with poor sleep quality.[15] Anxiety and stress odds were also significantly linked to poor sleep, with depression emerging as a significant contributor in multivariate analysis.[15] A pilot study from Puducherry (2025) had reported that among nurses working in a tertiary hospital, 56.7% had poor sleep quality (PSQI>5), with a mean PSQI score of 6.9±3.7. The study also reports that 36.7% had anxiety and 20% reporting stress on the DASS-21.[16] Higher perceived stress scores were significantly associated with both psychiatric morbidity and poor quality of sleep in this population.[16] The consequences of these sleep deficits extend into working hours, including fatigue, reduced attention and vigilance, deteriorating mental health, and altered circadian rhythms that affect body temperature regulation, metabolism, and adaptation to shift work.[14] Long-term health implications could include increased risk of type 2 diabetes, cardiovascular disease, and obesity particularly among those with prolonged night-shift exposure.[15]

IMPACT ON HEALTHCARE DELIVERY AND PATIENT SAFETY

The downstream effects of burnout and sleep deprivation on patient care are well-documented and alarming. A systematic review and meta-analysis by Garcia et al analyzed 21 studies and found a probability of superiority of 66.4% that burnout is associated with worse patient safety outcomes.[18] Healthcare units with higher burnout scores showed deterioration of teamwork climate, safety culture, and job satisfaction, all of which directly influence care quality.[18] Sleep-deprived nurses have been found to have reported an 87.9% risk of medication errors in earlier studies.[15] Burnout can impair the cognitive resources needed for accurate clinical decision-making and judgement. One study has found that each additional patient assigned to a burned-out nurse had an increased the patient's risk of hospital-acquired infection.[18] Sleep deprivation causes inattention and increased reaction times, directly relevant to a high-stake clinical environment.[14] Global evidence suggests that physician burnout can lead to lower patient satisfaction, impaired quality of care, and increased risk of malpractice litigation.[19] Professional tiredness is associated with reduced teamwork effectiveness, which could negatively affect collaborative clinical environments such as the intensive care unit and operating theatre.[18]

Burned-out healthcare workers report increased unplanned absenteeism, with 35% more likely to be absent for more than one day within the past month.[20] Attending work while psychologically impaired is equally concerning, as burnt-out doctors who continue working may deliver suboptimal care, creating risks that can be difficult to detect.[21] In India, where the health workforce is already insufficient, burnout-driven attrition amplifies the problem. Dissatisfied healthcare workers increasingly seek employment elsewhere or transition out of clinical practice, widening existing workforce gaps, particularly in rural and underserved areas.[22] A longitudinal study, done in 2025 has highlighted that nurses were the most vulnerable group, and faced greater stress with less benefit from reductions in working hours.[23]

INTERVENTIONS

A range of individual-level interventions have been studied for their ability to mitigate burnout among HCPs. These include mindfulness-based stress reduction, resilience training, cognitive-behavioural techniques, yoga, and peer support programmes.[24] At the institutional level, strategies include flexible rostering to ensure adequate rest between shifts, designated floating staff to cover absences, reduction of administrative work, creation of a

psychologically safe environment, and provision of on-site counselling services.[3] Hospitals that implement peer support programmes, regular mental health check-ins, and supervisory mentorship have reported improvements in staff morale and retention.[25] Essential modifications such as mandatory rest hours after night-shift rotations, scheduled breaks during night shifts have been recommended as evidence-based starting points.[14]

In India, hospitals particularly lack dedicated occupational health departments, employee assistance programmes, or formal policies on well-being of healthcare workers.[7] India is making notable stride in digital mental health. The Tele-MANAS helpline, launched under the National Tele Mental Health Programme, is operating across 36 States/Union Territories by providing 24×7 mental health support.[26] Capacity-building programmes are being implemented through NIMHANS for medical officers and community health officers, and digital training for primary mental healthcare.[27] While these platforms primarily serve the general population, there is significant scope to develop dedicated pathways which could offer support to healthcare workers offering confidential space, burnout assessments, and building support networks without the stigma of in-person consultation.

Table 1: Summary of key Indian studies on burnout and mental health among healthcare workers.

Author (year)	Study design	Sample	Setting	Tool(s)	Key findings
Kesarwani et al (2020)[1]	Systematic review and meta-analysis	3,845 HCPs (15 studies)	India (multi-site)	MBI	Pooled burnout rates: EE 24%, DP 27%, PA 23%
Suryavanshi et al (2020)[9]	Cross-sectional	197 HCPs	13 states, India	PHQ-9, GAD-7, QoL-1	Depression 47%, anxiety 50%, low QoL 45%
Kaushik et al (2021)[13]	Cross-sectional	240 nurses	Tertiary hospital, Karnataka	DASS-21	Stress 50.8%, anxiety 74%, depression 70.8%
Mathias et al (2023)[8]	Mixed-methods systematic review	Multiple Indian studies	India	Various	Pooled depression 33%, anxiety 29.5%, stress 33.5%
Sidiq et al (2024)[10]	Cross-sectional	578 HCPs	Jaipur division, Rajasthan	CBI	Overall burnout 68.1%; work-related 67.5%, personal 56.4%, patient-related 48.6%
Chellaiyan et al (2025)[14]	Observational (SNORE study)	293 HCPs	Tertiary hospital, Tamil Nadu	EPSS, SRHS	Sleep deprivation 82.3%; excessive daytime sleepiness 16.4%
Kaur et al (2024)[15]	Cross-sectional	850 nurses (25 hospitals)	Four zones of India	PSQI, DASS-21	Poor sleep quality 32.6%; daytime dysfunction 58.5%
Nehru et al (2025)[16]	Pilot study	30 nurses	Puducherry, India	PSQI, DASS-21, PSS-4	Poor sleep quality 56.7%; anxiety 36.7%; stress 20%
JAPI (2025)[11]	Cross-sectional	HCPs	India	MBI	~25% with all three burnout domains elevated
Sinha et al (2025)[5]	Qualitative	Mental health professionals	India	In-depth interviews	Themes: emotional depletion, boundary blurring, stigma, underpayment

MBI - Maslach burnout inventory; CBI - Copenhagen burnout inventory; DASS-21 - depression anxiety stress scale-21; PHQ-9 - patient health questionnaire-9; GAD-7 - generalized anxiety disorder-7; PSQI - Pittsburgh sleep quality index; EPSS - Epworth sleepiness scale; PSS-4 - perceived stress scale-4; SRHS – self reported hours of sleep; QoL - quality of life; EE - emotional exhaustion; DP - depersonalisation; PA - personal accomplishment; HCPs - healthcare professionals

LIMITATIONS OF THE CURRENT EVIDENCE

The current literature on healthcare workers' burnout in India reveals that there are several notable limitations. One major concern is that most studies are cross-sectional, which hinders our ability to draw causal connections and understand the underlying dynamics of burnout. This research gap calls for a more comprehensive approach to fully grasp the challenges faced by healthcare workers. Second, there is significant heterogeneity in the instruments used to measure burnout (MBI, CBI, single-item measures) and sleep quality (PSQI, EPSS, self-reported hours), making pooled comparisons challenging. Third, most studies have been conducted in tertiary care settings, with rural and primary care settings being underrepresented.[1,14]

In the pandemic era, there has been a surge in publications, many of which are valuable but may have introduced selection and publication biases toward higher-prevalence findings. Qualitative evidence is limited to small samples in specific regions and may not be generalizable across India's diverse healthcare landscape.[5]

CONCLUSION

Burnout and psychological distress among healthcare workers often represent a public health problem that developing countries like India shouldn't afford to ignore. With approximately one-quarter of health care workers experiencing significant burnout, as per studies based on the MBI, and up to 68% on the CBI, countries like India should be better equipped to address burnout at multiple levels, including organizational and policy levels. Recent data following the pandemic show increased rates of depression and anxiety among health care workers, resulting in a poor quality of life and night-shift workers experience significant sleep deprivation. This decline in well-being can significantly impact both the workforce's health and the quality of healthcare delivery. The impact extends from impaired day-to-day cognitive and emotional functioning through to documented increases in medical errors and workforce attrition. The risk factors are deeply embedded in India's healthcare system, from chronic underworking and poor infrastructure to sociocultural stigma and inadequate training. While promising developments such as Tele-MANAS and digital training programmes signal a growing awareness, translating that awareness into sustained institutional and policy action remains the decisive challenge. It is essential to prioritize the mental well-being of our healthcare workers as a critical component of India's public health agenda. By focusing on their mental health, we can enhance their ability to provide quality care and support to the nation.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Ganta A, Patlolla VRP. Exploring post-pandemic burnout and mental health among healthcare workers in India: a narrative review on prevalence, risk factors and impact. Int J Community Med Public Health 2026;13:2077-83.