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ASSESSING THE IMPACT OF MENTAL HEALTH AND RESIDENCE ON NOVEL CORONA VIRUS AWARENESS

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ABSTRACT

This study examined differences in COVID-19 awareness by residential setting and mental health checklist score among adults in Sonipat district, Haryana, India. The source manuscript reports a purposively selected sample of 300 participants, comprising 150 urban and 150 rural residents. Participants were also classified into two groups according to their Mental Health Checklist scores: 149 scored 31 or below and 151 scored above 31. Descriptive statistics and independent-samples t-tests were used to compare awareness scores. Urban participants had a higher reported mean awareness score than rural participants, 15.19 compared with 14.29; the reported difference was statistically significant, t(298) = 2.2767, p = .0235. Participants with checklist scores above 31 had a higher reported awareness mean than those scoring 31 or below, 14.91 compared with 13.70, with a reported t magnitude of 3.1086 and p = .0021. Under the scoring interpretation supplied in the manuscript, higher checklist scores indicate more mental and physical health difficulties. The second comparison therefore runs against the hypothesis that better mental health would be associated with greater awareness. The findings suggest possible residential and psychological differences in awareness, but they require cautious interpretation because the reported group summaries contain inconsistencies and individual-level data were unavailable for verification. The study supports further investigation of accessible health communication and psychological support across residential settings without establishing causal effects.

KEYWORDS: COVID-19 awareness; mental health; urban residence; rural residence; Sonipat; health communication.

1 INTRODUCTION

The COVID-19 pandemic created a need for clear public information alongside substantial disruption to everyday life. Communities had to interpret changing messages about infection, prevention, and access to care while also managing uncertainty about employment, education, and family responsibilities. Awareness of the disease

became an important subject for psychological and public health research because information alone does not determine how people understand risk or respond to it.

COVID-19 is the disease caused by severe acute respiratory syndrome coronavirus 2, or SARS-CoV-2. The World Health Organization characterized the outbreak as a pandemic on 11 March 2020 (WHO, 2020). This distinction between the virus and the disease is important for consistent terminology. Earlier coronavirus outbreaks, including SARS and MERS, provided historical context, but the COVID-19 pandemic involved its own social conditions and public communication challenges.

The present investigation focuses on awareness among adults living in Sonipat district, Haryana. It considers two comparisons: urban versus rural residence and lower versus higher Mental Health Checklist scores. Residence may be associated with differences in information access, services, and educational opportunities. Psychological difficulties may influence information seeking and the interpretation of risk. Neither relationship should be assumed to operate in a single direction.

The manuscript originally refers to a wider set of variables, including gender, education, and dependence proneness. However, its reported statistical results address residence and mental health checklist grouping only. The rewritten analysis therefore distinguishes the broader conceptual background from the comparisons for which numerical findings are actually supplied.

1.1 COVID 19 and public awareness

The term “novel coronavirus” refers to a coronavirus newly identified in a population. Coronaviruses are a family of viruses; they are not the same viruses that cause influenza. Disease names should be used without geographic or ethnic labels that could encourage stigma. Clear terminology helps prevent confusion and supports respectful communication with affected individuals and communities.

The source manuscript describes concern about respiratory symptoms and other manifestations of illness, as well as widespread disruption to schools, workplaces, travel, and social contact. These descriptions belong to the historical pandemic context of the study. They should not be read as a statement of current restrictions or as individualized medical advice. Undated case totals and mortality estimates are not used here because the manuscript does not supply a consistent reference date or population denominator.

Awareness can include recognition of disease-related information and knowledge of preventive measures. It should nevertheless be distinguished from attitudes, actual protective behavior, and clinical outcomes. A person may know a recommendation without being able to follow it because of work, household conditions, or limited resources. In this study, awareness is represented by the reported scale score; the available results do not separately quantify these other constructs.

1.2 Residential setting and access to services

Urban and rural communities may differ in access to reliable information, transport, health facilities, and digital communication. These differences provide a rationale for comparing awareness, but residence is an imperfect indicator of the resources available to any individual. Some rural residents have strong communication networks, while some urban residents face substantial exclusion from information and care.

The source discussion draws attention to the importance of primary health services for rural populations and to obstacles such as travel distance, limited staffing, and communication difficulties. Its broader material on sanitation and child undernutrition illustrates structural health inequalities. Those topics provide contextual background rather than evidence that sanitation or nutritional status explained COVID-19 awareness in this sample.

An effective interpretation of residential differences must therefore avoid treating geography as a direct measure of intelligence, motivation, or willingness to adopt preventive practices. The reported awareness score concerns a specific instrument. It cannot justify broad judgments about the capacities or behavior of urban and rural communities.

1.3 Mental health and awareness

Mental health encompasses emotional, psychological, and social functioning. During a public health crisis, people may experience worry, uncertainty, isolation, anger, sleep disturbance, or changes in mood. Such experiences can shape how information is sought and interpreted. They can also be affected by the information environment itself.

Concern about illness may encourage some individuals to obtain more information. For others, distress may make information difficult to evaluate or may lead to avoidance. These possibilities create an empirical question rather than a reason to assume that higher or lower distress must always correspond to greater awareness. The study uses checklist scores to form comparison groups, not to establish clinical diagnoses.

2 REVIEW OF RELATED LITERATURE

The source manuscript organizes its literature discussion around risk perception, information seeking, emotional responses, psychiatric vulnerability, community influences, and living conditions. These themes are retained below. Many works cited in that discussion do not have complete entries in the supplied reference list; these citation gaps are identified in the editorial notes rather than filled with invented bibliographic details.

2.1 Risk perception and psychological preparedness

The original review links perceived exposure and perceived severity to attention to health information, citing Eisenman et al. (2009) and Brewer et al. (2007). In the context of the present study, this suggests examining how people understand the relevance of a health threat to their own circumstances. Perceived risk and factual knowledge are related concepts, but they should not be treated as identical measures.

Psychological preparedness may involve the ability to interpret information, recognize uncertainty, and identify appropriate sources of support. A communication strategy can be understandable yet still fail if its audience lacks the practical means to respond. Research on awareness should therefore consider both the content of messages and the conditions in which people receive them.

2.2 Information seeking and media exposure

The source cites the Pew Research Center (2020) and Kim and Kim (2020) in its discussion of information seeking. It presents curiosity, uncertainty, and media exposure as possible influences on how people learn about a new disease. These processes may differ across age groups, educational backgrounds, and residential settings.

Exposure to a large volume of material is not equivalent to accurate understanding. Contradictory messages, unverified claims, and repeated alarming reports may complicate interpretation. Media literacy and the availability of trusted local explanations are therefore relevant to the study's rationale, although neither was measured separately in the reported comparisons.

2.3 Fear and uncertainty

The manuscript discusses fear as a response to perceived threat and cites work concerning COVID-19-related fear, stigma, and psychological distress, including Ahorsu et al. (2020), Ornell et al. (2020), and Sakib et al. (2020). It also connects uncertainty with school closure, economic disruption, and concern for relatives. These experiences provide context for examining psychological correlates of awareness.

Fear should not automatically be interpreted as beneficial or harmful. It may encourage attention to information, but it may also interfere with judgment or increase avoidance. The original manuscript includes severe outcomes and individual case reports within this discussion. Such reports illustrate possible distress; they cannot establish the frequency of these outcomes in Sonipat or explain the results of the present sample.

2.4 Depression and anxiety

The source refers to Hao et al. (2020) when discussing psychological symptoms among psychiatric patients and comparison participants. It also cites Dubey et al. (2020) concerning health-related anxiety. These discussions support attention to pre-existing vulnerability and to the possibility that a public health crisis can change how bodily sensations and health information are interpreted.

The present dataset, as described, does not contain separate diagnostic assessments of anxiety or depressive disorders. Consequently, differences in checklist groups cannot be presented as differences between clinically diagnosed patient populations. The checklist is a reported measurement tool whose identity, scoring, and validation require clarification.

2.5 Obsessive compulsive symptoms

The manuscript cites Fontenelle and Miguel (2020) in discussing the overlap between contamination-related concerns and public messages about hygiene. It raises the possibility that excessive fear can complicate the distinction between proportionate preventive behavior and distressing compulsive behavior. This is a contextual issue in the literature review, not an outcome assessed in this study.

A clearer account avoids equating ordinary hygiene practices with a psychiatric disorder. It also avoids the source's unsupported implication that obsessive-compulsive symptoms necessarily lead to violence. The relevance to awareness research is the need to understand how a message is interpreted and whether it produces useful understanding or excessive distress.

2.6 Schizophrenia and severe mental illness

The original discussion cites Fischer et al. (2020), Maguire et al. (2019), Narasimha et al. (2020), and Yao et al. (2020) when considering people with severe mental illness or substance-related difficulties. It emphasizes the importance of reliable communication and continuity of support. Individual examples in the source should not be generalized to all people with a diagnosis.

Support needs depend on a person's circumstances, symptoms, resources, and access to care. Neither awareness nor preventive behavior can be inferred from a diagnostic label alone. The current study does not establish how any particular clinical group understood or responded to COVID-19 information.

2.7 Hospitalized patients and psychosocial vulnerability

The manuscript discusses restrictions on visits and disruption to routine activities in institutional care, citing Li and Zhang (2020), Bojdani et al. (2020), and Xiang et al. (2020). These conditions may be relevant to emotional well-being and communication. They are not evidence that the participants in this community sample experienced the same conditions.

The source also identifies older adults, caregivers, people with chronic illness, patients, and relatives as groups that may need additional support during a crisis. The study's own exclusion of people with chronic illness limits its ability to address several of these groups. That difference between the literature review and the sampled population must remain explicit.

2.8 Social norms and community communication

The original review cites Centola (2010) and Lapinski and Rimal (2005) in considering the role of friends, families, and community networks. These relationships may influence which messages people encounter, whom they trust, and whether a recommendation seems socially supported. Community communication may therefore complement formal media campaigns.

However, social influence was not directly tested in the supplied results. It remains a possible explanatory context rather than a demonstrated mechanism. Further research would need to measure communication sources, perceived norms, and actual behavior before drawing conclusions about these processes.

2.9 Housing conditions and family relationships

The manuscript discusses how restrictions changed the use of homes for work, study, caregiving, and recreation. Crowding, insufficient quiet space, financial pressure, and uncertainty about employment may affect family relationships. Greater time together can also create opportunities for mutual assistance and shared coping.

The source refers to family cohesion and conflict using citations including Hobfoll and Spielberger (1992), Cano et al. (2018), Perino et al. (2015), and Uruk et al. (2007). It also discusses economic strain and housing-market disruption. These topics are retained as background considerations; neither household cohesion nor housing-market conditions were analyzed in the reported t-tests.

3 OBJECTIVES AND HYPOTHESES

The first objective was to compare COVID-19 awareness scores between urban and rural adults in Sonipat district. The second was to compare awareness scores between participants classified by the reported Mental Health Checklist cutoff. These objectives concern group differences and do not establish that residence or mental health caused differences in awareness.

Hypothesis 1 proposed that urban participants would demonstrate significantly higher COVID-19 awareness than rural participants.

Hypothesis 2 proposed that participants with better mental health would demonstrate significantly higher awareness than those with poorer mental health. Under the manuscript's stated scoring interpretation, scores of 31 or below correspond to fewer mental and physical health difficulties, while scores above 31 correspond to more difficulties. The direction of the reported second result must be evaluated against that interpretation.

4 RESEARCH METHODOLOGY

4.1 Design and setting

The manuscript describes a comparative, observational investigation of adults in Sonipat district, Haryana, India. It reports independent-samples t-tests for residential and checklist-defined groups. The collection dates are not supplied. The original methodology alternates between proposed and completed procedures; the account below reports what the manuscript states without implying independent confirmation that every procedural step occurred as described.

4.2 Sample and sampling procedure

The reported sample comprised 300 adults selected through purposive sampling. Residence groups contained 150 urban and 150 rural participants. The same total sample was classified by checklist score into 149 participants scoring 31 or below and 151 scoring above 31. These are separate classifications, not four independently recruited samples.

Table 1 Reported sample distribution

Classification	Group	Number
Residence	Urban	150
Residence	Rural	150
Checklist score	31 or below	149
Checklist score	Above 31	151

4.3 Eligibility criteria

The source specified adult residents of Sonipat, educational attainment above Class VIII, inclusion of men and women, and willingness to participate. It used the expression "normal individuals" without supplying an operational definition. This wording should not be interpreted as a clinical assessment or a sufficiently defined eligibility criterion.

The listed exclusions were temporary residence, chronic illness, disability, refusal of consent, and unwillingness to cooperate. Disability is reported here as an exclusion stated in the source, not endorsed as a necessary research practice. The manuscript does not explain how these exclusions were assessed or justified. Their use restricts the population to which the results might apply.

4.4 Personal information schedule

A personal data sheet was intended to collect demographic information, including age, gender, and urban or rural residence. The available results do not provide age distributions, gender counts, or education distributions. No independent analysis of those characteristics can therefore be reconstructed from the manuscript.

4.5 COVID 19 awareness measure

The source identifies an English-language Novel Corona Virus Awareness Scale developed by Dr. Sadique Razaque of Vinoba Bhave University, Hazaribagh, and published by Prasad Psycho Corporation, Varanasi. The number of items, score range, scoring rules, and administration instructions are not supplied. These details should be checked against the instrument manual before the measure is described as validated for this population.

The manuscript reports a KR-20 reliability coefficient of 1.1. A value above 1 is outside the permissible upper bound for this coefficient and cannot be accepted as evidence of reliability. No replacement value has been invented in this rewrite. The original manual or calculation is needed to resolve the error.

4.6 Mental health measure and grouping

The methods section names a Hindi mental health instrument developed by Pramod Kumar and published by National Psychological Corporation, Agra, while other sections refer to it as the Mental Health Checklist. The exact instrument title and scoring manual require confirmation. The source reports a sample mean of 30.6 and uses 31 as the grouping cutoff.

For the reported comparisons, participants scoring 31 or below form the lower-score group, and those scoring above 31 form the higher-score group. The source interprets higher scores as indicating more mental and physical health problems. It does not establish that this sample-derived cutoff is a validated clinical threshold. It should therefore be described as an analytic grouping rule, not a diagnosis.

4.7 Data collection and ethics reporting

The manuscript states that participants were to be approached, informed about the study, and asked for consent. It describes administration of the instruments in a single session, followed by statistical analysis. Details of recruitment sites, response rates, handling of incomplete forms, and assistance with English-language items are absent.

Institutional ethics approval, an approval number, and a detailed confidentiality procedure are not reported. Their absence from the text does not establish that approval or safeguards were absent in practice, but such information cannot be supplied without documentation. No ethics declaration has been invented.

4.8 Statistical analysis

The reported analysis used means, standard deviations, standard errors, and independent-samples t-tests, with .05 as the significance threshold. Both supplied tests use 298 degrees of freedom and report two-tailed p values. Confidence intervals for the mean differences are also given.

Individual-level data were not available for this rewrite. Distributional assumptions, variance assumptions, missing data, and possible confounding cannot be checked. The reported inferential statistics are retained as source-reported values; they should not be read as an independently verified reanalysis.

5 SIGNIFICANCE AND RELEVANCE OF THE STUDY

The investigation addresses the need to communicate health information in ways that reach different residential and psychological groups. Understanding where awareness scores differ can help identify questions for targeted communication research. It does not, by itself, establish which intervention will work or whether a difference in scores changes infection risk.

The source emphasizes the disruption associated with the pandemic, including limits on transport, education, employment, and social activity. Those concerns help explain the rationale for studying awareness at the time. Statements that vaccines were unavailable or that restrictions continued indefinitely are not retained as current facts because the study period is unspecified and such conditions changed over time.

The wider project description anticipated contributions concerning gender, education, and dependence proneness as well as residence and mental health. The supplied results cannot support findings for those additional variables. Their potential contribution is best presented as an agenda for future research rather than as an outcome of the reported analyses.

6 RESULTS

6.1 Residential differences in awareness

Urban participants had a reported mean awareness score of 15.19, compared with 14.29 among rural participants. The corresponding standard deviations were 3.39 and 3.46, respectively, with 150 participants in each group. The reported urban-minus-rural mean difference was 0.90 points.

Table 2 Reported awareness scores by residence

Statistic	Urban	Rural
Mean	15.19	14.29
Standard deviation	3.39	3.46
Standard error of mean	0.28	0.28
Number	150	150

The source reports t(298) = 2.2767, p = .0235, and a standard error of the difference of 0.395. The reported 95% confidence interval for the mean difference was 0.12 to 1.68. On the manuscript's stated .05 threshold, this comparison supports Hypothesis 1. The finding concerns awareness scores and should not be described as a difference in intelligence or as a measured effect of urban living.

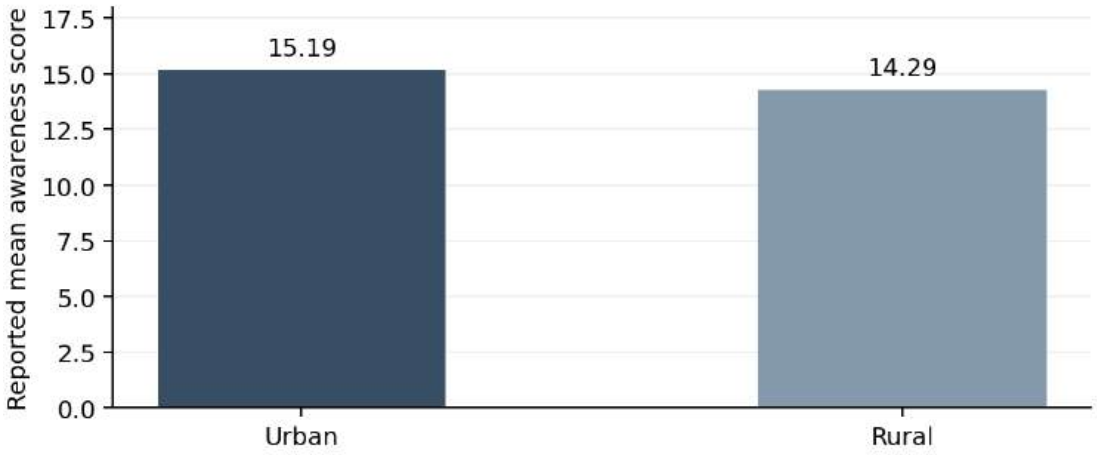


Figure 1 Mean awareness by residence. Recreated from the source-reported means.

6.2 Awareness by mental health checklist group

The group scoring 31 or below had a reported mean awareness score of 13.70, while the group scoring above 31 had a mean of 14.91. Standard deviations were 3.35 and 3.38, with group sizes of 149 and 151. The reported lower-score-minus-higher-score difference was -1.21 points.

Table 3 Reported awareness scores by checklist group

Statistic	Score ≤31	Score >31
Mean	13.70	14.91
Standard deviation	3.35	3.38
Standard error of mean	0.27	0.28
Number	149	151

The results section reports a t magnitude of 3.1086 with 298 degrees of freedom, p = .0021, and a standard error of the difference of 0.389. The stated 95% confidence interval was -1.97 to -0.44. The direction of the difference favors the higher checklist-score group. If higher checklist scores represent more difficulties, as the manuscript states, this result does not support Hypothesis 2.

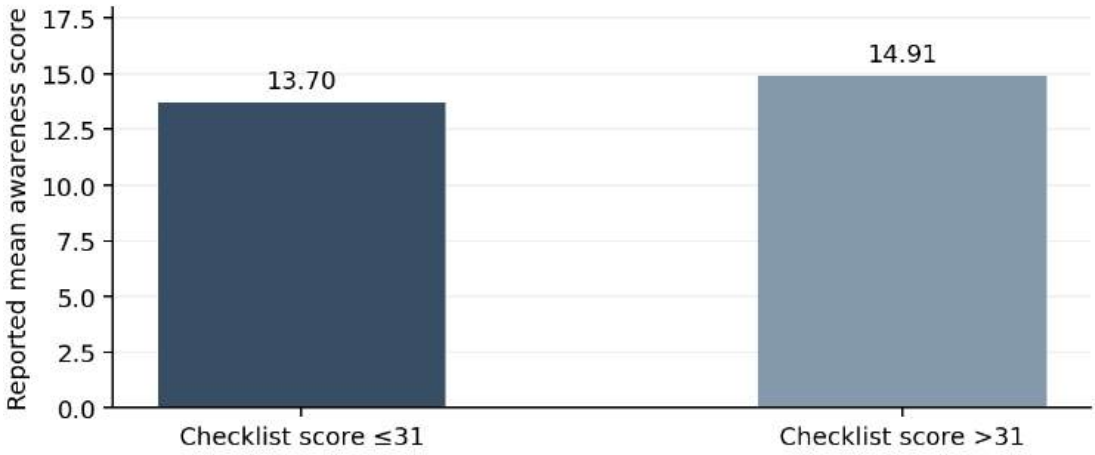


Figure 2 Mean awareness by checklist group. Recreated from the source-reported means.

6.3 Consistency of reported results

The source gives .0021 for the mental health comparison in its results and discussion but .00021 in its conclusion. This rewrite uses .0021 as the repeatedly reported value while recording the discrepancy. A signed t statistic for the stated negative difference would ordinarily also be negative; the source's positive statistic is therefore described as a magnitude.

A further inconsistency concerns the overall awareness mean implied by the two classifications. The residence table implies a mean of 14.74 for 300 participants. The checklist table implies approximately 14.31 for the same total sample. Both cannot describe the same outcome scores for the same complete set of participants as presented. The difference is too large to be explained by rounding to two decimal places. The tables are retained for transparency and require reconciliation with the original data.

7 DISCUSSION

7.1 Interpreting the residential comparison

The reported urban advantage is consistent with the study's first hypothesis. Differences in information access, educational opportunity, local services, or communication networks are plausible explanations. However, these explanations were not measured in the reported comparison. Residence may also be associated with other characteristics that influence scores.

The source discusses rural work patterns, internet availability, and access to health communication. These considerations can guide the design of further studies, but the present results do not show that rural participants used particular preventive practices less often. Awareness and actual behavior must remain distinct. The manuscript's references to attitudes and practices are not supported by separate tables or measures in the supplied results.

The finding also does not establish that every urban resident is more aware than every rural resident. Group means summarize distributions with overlapping individual scores. Communication planning should avoid

stigmatizing rural populations and should assess local needs rather than treating a residence category as a complete explanation.

7.2 Interpreting the mental health comparison

The checklist result requires especially careful wording. Under the source's stated scoring direction, the group reporting more difficulties also had the higher average awareness score. It would be incorrect to relabel this group as having better mental health merely because its awareness score was higher. The original conclusion's description of healthier living is inconsistent with the scoring explanation.

One possible interpretation is that greater concern about illness encouraged some participants to seek information. Another is that exposure to information increased worry, or that a third factor influenced both. Differences in service contact or social support are further possibilities raised in the source. None of these mechanisms was tested, and the study cannot determine the direction of the relationship.

The reported result therefore challenges the second directional hypothesis rather than confirming it. It also shows why checklist identity and scoring must be verified. If the scoring interpretation in the source is wrong, the substantive conclusion could change. Instrument documentation and individual-level data are necessary before a firm interpretation is made.

7.3 Public health communication and psychological support

The study's rationale supports making communication understandable, locally accessible, and sensitive to emotional distress. Educational material can explain uncertainty without relying on fear or blame. Trusted local health workers and community organizations may help identify barriers to understanding, but the effectiveness of such approaches should be evaluated rather than assumed.

Greater awareness should not be equated with psychological well-being. A participant may know more while also feeling more distressed. Health communication and access to support can therefore be complementary priorities. The present study does not establish that increasing awareness will improve mental health or that treating distress will necessarily improve awareness scores.

7.4 Scope of inference

Purposive selection, the single-district setting, education-related eligibility, and the stated health and disability exclusions limit generalizability. The comparison groups were not randomly assigned. Differences cannot be interpreted as causal impacts of residence or mental health, and the data do not justify conclusions about the entire population of Haryana or India.

The conflicting group summaries are a more immediate limitation than sampling alone. Until they are resolved, even the descriptive pattern must be treated as provisional. Statistical significance cannot compensate for uncertain reporting. The most useful next step is to reconcile the instrument details and numerical tables with the original records.

8 CONCLUSION

The source reports higher COVID-19 awareness among urban than rural participants and among participants with checklist scores above 31 than among those scoring 31 or below. The residence comparison supports the first stated hypothesis. Under the reported checklist interpretation, the mental health comparison runs against the second hypothesis.

These are reported associations from a purposively selected sample, not demonstrated causal effects. Interpretation is constrained by incomplete methods reporting, an invalid reliability value, inconsistent p-value reporting, and incompatible overall means implied by the tables. The findings should remain provisional until checked against the original data and instrument manuals.

Accessible health communication and attention to psychological needs remain reasonable topics for further investigation. This study provides questions for that work, but it does not establish that changes in living conditions or awareness alone produce improved health, happiness, or preventive behavior.

9 RECOMMENDATIONS FOR FURTHER RESEARCH

Future research should verify the awareness scale and mental health instrument, report their scoring and psychometric properties, and use a justified approach to grouping or analyzing checklist scores. Continuous-score analyses could retain information lost by dividing participants around a rounded sample mean.

Researchers should consider larger and more inclusive samples across districts and report recruitment dates, demographic distributions, consent procedures, and ethics oversight. Analyses could examine whether residential differences persist after accounting for education, age, income, information sources, and access to services. These variables should be measured directly rather than inferred from place of residence.

Further studies could distinguish factual knowledge, attitudes, risk perception, preventive practices, and emotional distress. Longitudinal designs would help investigate temporal relationships, while evaluated communication interventions could test whether information becomes more understandable and useful. Research involving different age groups or other infectious diseases should use appropriate measures and avoid unnecessary exclusion.

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