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RESEARCH **Open Access**

Analysis of the Readiness of Primary Health Center Nurses in Encountering Community Stigma during the COVID-19 Pandemic

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Abstract

The COVID-19 outbreak has resulted in public fear of transmitting infection. Nurses in dealing with the COVID-19 outbreak also obtained stigmatized due to discrimination received by COVID-19 sufferers. The objective of the study is to identify the dominant factor to determine the occurrence of stigma experienced by nurses when caring for COVID-19 patients. The research design was qualitative and quantitative, with a sample of 121 Primary Health Center nurses who were performed by convenience sampling. Data analysis with Multiple Linear Regression presented that overall, there was a significant correlation between knowledge in preventing COVID-19, Personal Ability and Organizational Ability to stigma from society experienced by nurses with ANOVA or F test results (229.427) with p = 0.000. Morever, there is a strong and significant relationship between knowledge, self-efficacy and organizational ability to community stigma (R Square = 0.964). The dominant factor that affects stigma as seen from the t-test is self-ability = 14,828 (p=0.001) followed by organizational ability= -8,790 (0.001) and knowledge = 5.050 (p=0.001). It was concluded that the limitations of human resources and special infrastructure for people with COVID-19 were the trigger for the occurrence of stigma. It is hoped that the maintenance of well-being among health workers is at the forefront by beginning at the policy-making level to offer enhanced support for health workers who play a critical role during large-scale disease outbreaks. The psychological implications are mostly negative and urgently need greater attention to be mitigated, potentially through the involvement of psychologists, given better awareness and education. It is expected that further researchers can explore the phenomenon of the experience of nurses who suffer from COVID-19 in dealing with the stigma that occurs to them.

Keywords: COVID-19, Nurses of Primary Health Center, Stigma.

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1. INTRODUCTION

The COVID-19 outbreak is a public health emergency because there is a fear of infection transmission. Individuals who are declared positive for being infected by the COVID-19 virus, living their lives will be difficult because from a physical point of view, the individual will experience changes associated with the development of the disease. A person infected with COVID-19 is generally difficult to accept in society, considered dangerous, isolated, labeled bad. This view makes the patient even more depressed. Patients with COVID-19 tend to be ostracized by family, friends and the environment. Even at the beginning of the COVID-19 pandemic, some sufferers experience discrimination in health services. Thus, the stigma of COVID-19 sufferers at the beginning of the incident is obvious in the community. Stigma is an attribute, behavior, or social reputation which is discredited in a certain way (Kohrt et al., 2018)

Stigma and discrimination against COVID-19 sufferers has an impact on the spread of the COVID-19 disease. Stigma and discrimination can discourage a person from taking the test and cause people to feel reluctant to seek information and ways to protect against COVID-19 (Manik et al., 2021). Stigma and discrimination will also create isolated or marginalized communities; discrimination has caused the human rights of COVID-19 sufferers to have been violated, particularly in the right to freedom from discriminatory treatment, and the stigma of COVID-19 sufferers has an impact on a person's unwillingness to show their status as a COVID-19 sufferer (Abudi et al., 2020). Social stigma has become the prior cause of COVID-19 survivors experiencing stress, anxiety, worry, heartache, high emotions, and trauma (Prastika et al., 2022).

Lack of knowledge from health professionals themselves causes many challenges in health services such as primary health center and creates a stigma about disease and sufferers who suffer from the disease (Zarei et al., 2015; Kohrt et al., 2018). The capacity of health services to respond to emergencies plays a key role in disease management. Awareness, readiness, and alertness of health professionals as the front line are tremendously important in dealing with complications of related diseases. Nurses play an essential role as one of the health workers who are at the forefront of patient care (Kieft et al., 2014)

Some literature reports on nurses' perceptions and experiences of their role in epidemic responses such as anxiety, discriminatory treatment (Lam & Hung, 2013) and the awareness of nurses about the patient's condition and needs are still lacking (Lam et al., 2019). Such treatment can produce a negative impact on people with COVID-19, as well as their care givers, families, friends and communities. A person who does not have the disease but shares the same characteristics as this group may also experience stigma (World Health Organization, 2020).

At the beginning of COVID-19, nurses' readiness to deal with infectious disease outbreaks was still lacking, many things were not understood in handling COVID-19, not only from the medical aspect (virus structure, spread mechanism, treatment method, prevention and spread methods) but there are non-medical factors that need to be studied (eg. related to lock down policy or not) (Mas'udi & Winanti, 2020).

COVID-19 is a disease that has recently been recognized by the public. Thus, Primary Health Center nurses need to possess a perception of knowledge about COVID-19 disease and study clinical appearance and not be influenced by myths circulating in the community rather than evidence-based information. Based on these reasons, the researchers collected views from nurses who practice at the Primary Health Center of Jakarta, Bogor, Depok, Tangerang, and Bekasi (Jabodetabek) regarding the perception, awareness, and familiarity of COVID-19 through the interview method.

The results of the preliminary study showed that the Primary Health Center nurses discovered that the forms of discrimination received by COVID-19 sufferers from the environment were family rejection (shunned by the family), separation of eating utensils, being ostracized, and rejection from the surrounding environment such as village residents and the work environment. Discrimination occurs due to environmental fears of contracting the COVID-19 disease which causes sufferers to be isolated. Stigma and discrimination are not only committed by ordinary people who do not have sufficient knowledge about the disease of people with COVID-19, but can also be done by health workers. Education regarding the prevention and spread of COVID-19 as well as the importance of mental health during the COVID-19 pandemic needs to be improved so that the public does not misinform in perceiving COVID-19 (Novita & Elon, 2021).

Health workers must have the ability to understand the promotive and preventive patterns of COVID-19 in the community, and in hospitals or clinics, they must be able to design programs and policies to accelerate the handling of Covid-19 (Hastuti, & Djanah, 2020). Knowledge is significantly essential to deal with stigma because social stigma occurs due to lack of public knowledge about the ongoing pandemic phenomenon, prejudice and discrimination against individuals or groups who have received certain labels associated with COVID-19 (Abudi et al., 2020). Health workers who work as employees in a health service in dealing with COVID-19 must have their own abilities, as quoted from research Sujianto (2010), self-ability has a positive effect on an employee's performance, self-ability is needed by an employee in working, particularly during the COVID-19 pandemic. Yenti et al (2014) asserted that self-ability can be realized by being honest, responsible, visionary, disciplined, cooperative, fair, and caring so that the duty becomes productive, as one of the determinants of the success of one's performance. The organizational ability of health workers is required to deal with the COVID-19 situation, especially in promotive and preventive efforts, and strengthening the role of community empowerment in the health sector, and integrating health workers starting from the lowest level in the community, which is the primary health center (Putri et al., 2018). The factors of knowledge, self-efficacy and organizational skills that have been described above are believed to have contributed to the ability of nurses to deal with stigma when caring for COVID-19 sufferers. Research has proven that lack of knowledge is a risk factor for stigma against COVID-19 patients and health workers (p-value 0.005). Knowledge is closely related to stigma labels for people with COVID-19 (Muliawati et al., 2021). It is also proven that there is a close relationship between knowledge and the stigma of COVID-19 in the community in Medan City (Siregar et al., 2022). Knowledge that is less risky is 2.13 times more likely to stigmatize COVID-19 sufferers and health workers (Oktaviannoor et al., 2020). Ignorance about the mechanism of transmission, overestimation of the risk of transmission, and inappropriate negative attitudes towards COVID-19 sufferers are closely related to the growing stigma of COVID-19 sufferers (Mas'udi, & Winanti, 2020)

The management of community stigma against COVID-19 can be performed by increasing public knowledge about COVID-19, increasing the participation of peers, family and community support. The role of nurses can influence people's behavior. The role is associated with increasing knowledge for the prevention of COVID-19. Community nurses at the Primary Health Center are responsible for providing nursing care in an effort to deal with negative stigma in the community, providing health education related to COVID-19 disease information.

Conducting health education in the prevention of COVID-19 can be through social support from peers and family. Primary Health Center nurses are crucial to increase

competence regarding knowledge, awareness, and severity of COVID-19, perceived personal ability to handle and manage COVID-19, organizational ability to handle and manage COVID-19 to overcome obstacles in handling and managing COVID-19 so that it does not arise societal stigma.

Based on the existing descriptions and thoughts, it is important to identify the readiness of Primary Health Center nurses in the Jakarta-Bogor-Depok-Tangerang-Bekasi (Jabodetabek) area in handling community stigma against COVID-19 sufferers. The objective of the study is to identify the dominant factor to determine the occurrence of stigma experienced by nurses when caring for COVID-19 patients.

2. RESEARCH METHOD

This research is conducted by employing a mix of quantitative and qualitative methods. The research design is cross sectional, the combination research strategy used in this research is the Concurrent Triangulation Strategy. The independent variables encompass Knowledge (X1) (knowledge of COVID-19 prevention; knowledge of preventing self-awareness related to COVID-19, and knowledge of preventing COVID-19 management), Personal Ability (X2), Organizational Ability (X3) and the dependent variable, which is Perceived Stigma (Y).

Instrument variable Knowledge (X1): knowledge of COVID-19 prevention (X.1.1) consists of 10 statements using the Gutman scale with true and false formats; while knowledge of self-awareness prevention related to COVID-19 (X1.2) 8 statements; knowledge of prevention of COVID-19 management (X1.3) 23 statements; personal ability (X2) 14 statement items; organizational ability (X3) 15 statements and perceptions of perceived stigma (Y) 15 statements and all employ a Likert Scale

The instrument validity and reliability test was conducted on 30 respondents from Nurses of Depok primary health center is Cinere and Limo with the following results: knowledge of COVID-19 prevention (X.1.1) using Pearson Correlation, obtained a significant value = 0.000 - 0.046; prevention of self-awareness related to COVID-19 (X1.2) = 0.399 – 0.679 and r = 0.778; knowledge of self-awareness prevention related to COVID-19 (X1.2) = 0.610 – 0.955 and r = 0.788; knowledge of prevention of COVID-19 management (X1.3) = 0.368 – 0.677 r=0.897; Personal ability (X2) = 0.548 – 0.864 and r = 0.940; organizational ability (X3) = 0.327 – 0.704 and r = 0.864; perception of Stigma (Y) = 0.323 – 0.751 and r = 0.875. Based on the analysis of the validity and reliability tests, all research instruments can be employed to collect research data and distribute them to respondents.

During the COVID-19 pandemic, data collection was conducted online using the G-form. The sampling technique was convenience sampling and a large sample of 121 nurses who were only open for 1 month (21 August – 20 September 2021). Quantitative data analysis used Multiple Linear Regression, and Anova test, while qualitative data analysis used Colaizi. Data were collected from respondents after obtaining approval from the Health Research Ethics Commission (KEPK from Universitas Pembangunan Nasional Veteran Jakarta No. 421/VIII/2021/KEPK).

3. RESULTS AND DISCUSSION

Table 1. Demographic Data of Primary Health Center Nurses in Jabodetabek Area (and=121).

Variable	n	%
Age		
23 – 32	91	75,2
33 - 42	20	16,5
43 -52	6	5,00
> 52	4	3,33
Total	121	100.0
Gender		
Male	19	15.7
Female	102	84,3
Total	121	100.0
Education		
D3 Nursing	73	60.3
S-1 Nursing	5	4,1
Nurses	42	34,7
S-2 Nursing	1	0,8
Total	121	100.0
Length of work		
< 5	47	38,8
> 5	74	61,2
Total	121	100.0

Table 1 shows that most of the nurses aged 23–32 years were 91 people (75.2%); female 102 people (84.3%); educated D3 Nursing people (60.3%); and length of work more than 5 years 74 people (61.2%).

Table 2. Distribution of Knowledge, Personal Ability, Organizational Ability Perception of Stigma felt by Primary Health Center Nurses in Jabodetabek Area (n=121).

Variable	Mean	Median	SD	IQR	Min-Max	SE
Knowledge (X1):						
Knowledge of COVID-19 prevention (X.1.1)	6,60	7.0	0,493	1	6 – 7	0,45
Knowledge of self-awareness prevention related to COVID-19 (X1.2)	24,48	25,0	3,421	4	14 – 31	0,311
Knowledge of prevention of COVID-19 management (X1.3)	68,45	70,0	9,275	13	38 – 84	0,843
Total Knowledge (X1)	95,53	101,0	12,313	17	58 -121	1.119
Personal Ability (X2)	41,25	42,0	5,386	7	23 – 51	0,490
Organizational Ability (X3)	34,77	34,0	6,378	6	25 – 57	0,580
Perceived Stigma (Y)	44,62	46,0	6,772	8	21 -53	0,570

Table 2 shows knowledge of COVID-19 prevention (X.1.1) an average of 6.6 and a standard deviation of 0.493. The data variance is less varied. For the other variables, the standard deviation shows that the data varies. Data on self-awareness prevention knowledge related to COVID-19 (X1.2), knowledge of preventing COVID-19 management (X1.3), personal ability (X2), organizational ability (X3) and perceived stigma perception (Y) appear to have extreme values (data distribution is not normal), then the data limit can be used the median value and the inter quartile range (IQR).

Table 3. Relationship between knowledge of COVID-19 prevention, awareness of COVID-19 prevention, and management of COVID-19 prevention (n=121).

Variable	C-19 Prevention Knowledge	C-19 Prevention Awareness	Preventive Management C-19
Pearson Correlation C-19 Prevention Knowledge:	-	0.077	0,145
Sig (2 – tailed		0,687	0,114
C-19 Prevention Awareness		-	
Pearson Correlation:	0.037		0,808
Sig (2 – tailed	0,687		0,000
Preventive Management C-19			-
Pearson Correlation:	0,145	0,808	
Sig (2 – tailed	0,114	0,000	

Table 3, explains that knowledge of COVID-19 prevention and awareness of COVID-19 prevention results in a weak correlation because the value is 0.077 > 0.5 (range of correlation values), with no negative sign indicating that increasing knowledge allows increasing awareness of COVID-19 prevention. Knowledge of COVID-19 prevention with COVID-19 prevention management has a weak correlation also 0.145 <0.5, the more knowledge of COVID-19 prevention, the more COVID-19 prevention management increases. There is a correlation between awareness and management of Sig.2 tailed 0.000 < 0.05.

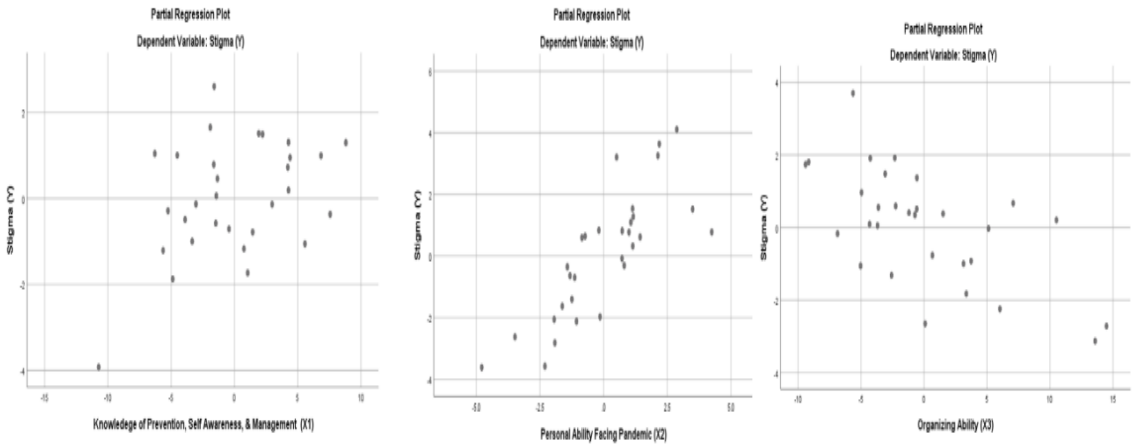

Figure 1. Scatterplot of classical assumption test for variables of knowledge, self-efficacy, and organizational ability on perceived stigma perceptions.

Figure 1 shows that based on the results of the Classical Assumption Test, it was revealed that: a) There is no multicollinearity between independent variables because all values are below 0.6 (X1-X2 = 0.007; X1 – X3 = 0.134; X2 – X3 = – 0.921); b) Classical

assumption test of Heteroscedasticity: i.e. All scatterplots of the three independent variables do not form a pattern, thus, there is no heteroscedasticity, or also called homoscedasticity, where the points spread below or above the origin point (number 0) on the Y axis and have no regular pattern; c) Test of the classical assumption of normality test is to perceive if the data distribution is normally distributed or not. The regression equation is considered good if it has data on the independent and dependent variables with normal distribution, it can be identified using histogram graphs (normal if the curve line is normal) and Normal Probability Plots (occurs if the line/point follows the diagonal line).

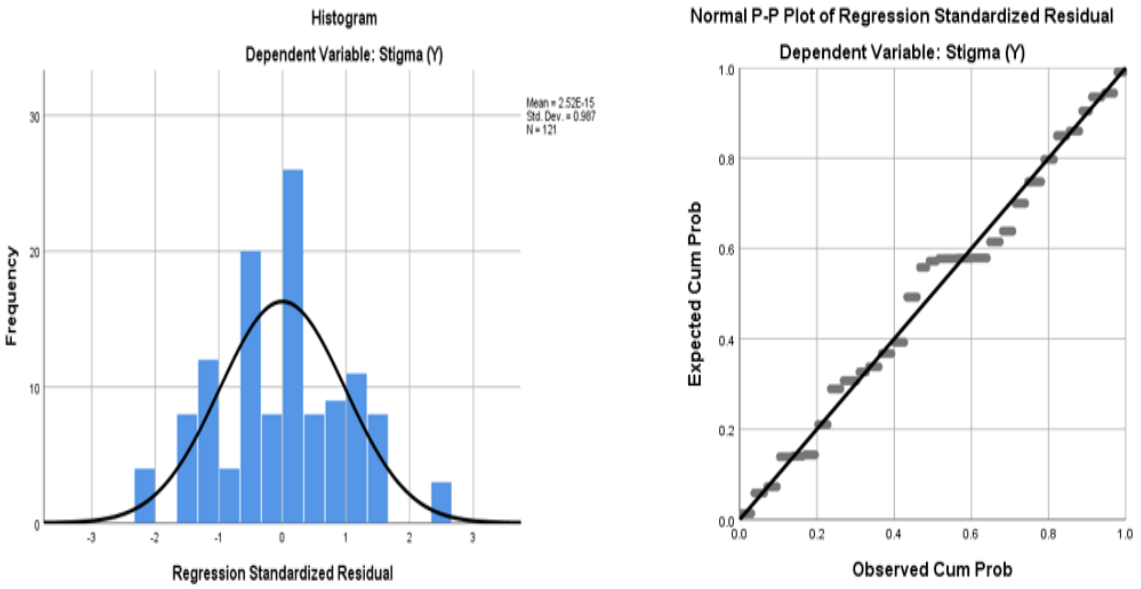

Figure 2. Normality Test.

d). Classical assumption test of a good regression Equation Autocorrelation is that it has no autocorrelation problem. One measure of autocorrelation is the Durbin Watson (DW) test. The results of the data obtained DW = 2,309 means 2,309 > +2, meaning that there is a negative autocorrelation.

e). The multicollinearity diagnostic test obtained that all VIF values were not more than 10, and the tolerance number was below 1. Thus, there was no multicollinearity between independent variables (see table 4). Looking at the results of the classical assumption test, the data can be processed using multiple Linear Regression, with the results:

Table 4. Results of ANOVA data for Jabodetabek Primary Health Center Nurses (n=121).

	Sum of Squares	**df**	***Mean Square***	**F**	**Sig.**
Regression	4556,275	3	1518,75	1081,19	.000[b]
Residual	164,237	117	1,404		
Total	4720,512	120			

Table 4 explains, from the ANOVA or F test, the calculated F is 1081.19 with a significant level = 0.000. Then, this regression model can be employed to predict Stigma, or it means that knowledge of COVID-19 prevention, personal ability and organizational ability together the same effect on the perception of stigma felt by nurses.

Table 5. Multiple Linear Regression Test Results for Jabodetabek Primary Health Center Nurses (n=121).

	Unstandardized Coefficients		***Standardized Coefficients***		**t**	**Sig**	**Statistical Collinearity**
	Beta	**Std. Error**	**Beta**	**Std. Error**			**Tolerance VIF**
(Constant)	5,016	1,307		3,839	0,000		
Knowledge: Prevention, Self Awareness and Management (X1)	0,120	0,024	0,237	5,050	0,000	0,136	7,379
Personal Ability to deal with the Pandemic (X2)	0,804	0,054	0,690	14,828	0,000	0,137	7,287
Organizational Ability (X3)	-0,160	0,018	-0,162	-8,790	0,000	0,873	1,145

Table 5 shows that the regression equation/formulation is as follows: Y = 5.016 + 0.120 X1 + 0.804 X2 + (-0.160) X3 with a constant meaning of 5.016, it is stated that if there is no COVID-19 knowledge variable, personal ability, and organizational ability, the stigma value is still 5.016. The X1 regression coefficient of 0.120 means that each additional 1 point of knowledge of Covid-19 will increase the understanding of stigma by 0.120. The X2 regression coefficient of 0.804 means that each additional 1 point of personal ability will increase the understanding of stigma by 0.804. While the X3 regression coefficient of -0.160 means that every 1-point reduction in organizational ability will reduce the perception of stigma by -0.160. Perceiving the results of the regression coefficient test all significant figures <0.05. It shows that the existing regression model can be used to predict stigma scores in the future.

Table 6. Summary of Models of Jabodetabek Primary Health Center Nurses (n=121).

R	***R Square***	***Adjusted R Square***	***Std. Error of the Estimate***	***Durbin Watson***
0.982a	0.965	0.964	1.185	2.309

Table 6 explains the R Square value of 0.965, meaning that 96.5% of the variation in stigma can be explained by the variables of COVID-19 knowledge, self-efficacy and organizational ability while the remaining 3.5% can be caused by other factors.

The results of qualitative data obtained information on the difficulties of nurses in caring for and dealing with community stigma for people with COVID-19, limited human resources, limited infrastructure, particularly special rooms for treating COVID-19 sufferers, limited time in providing health education, differences in level of knowledge and perceptions with community about COVID-19, difficulties in tracing, and non-compliance with COVID-19 sufferers during self-isolation to stay at home. However, the strength of nurses is the ability to perform health protocols such as wearing PPE (Personal Protective Equipment) according to standards, communicating therapeutically, educating, providing counseling, having empathy, and conducting cross-sectoral collaboration.

DISCUSSION

The results of the study (table 1) present that the age of nurses is dominated by young adults. This age category is a productive age, in which a person still has the ability to be agile in activities, and is trying to develop an identity to achieve stability, and is a determinant of someone to choose a suitable job for the individual's career and at this productive age as well as strengthening career choices to achieve the goals to be achieved (Supriatin, 2015). Most of the sexes are dominated by women, because the nursing profession is more in demand by women, because women instinctively have a soft soul and have a mother instinct (Kozier, 2012). The opposite statement from the research results stated that the male sex who worked as a nurse did not have much opportunity to improve their social status (Limiñana-Gras et al., 2013).

Other research confirms that male nurses are slower to develop their careers in nursing (Barrett-Landau & Henle, 2014). Qualitative research from OConnor (2015) discovered that Men have difficulty identifying themselves in the nursing profession and have little intrinsic motivation away from the motivation to become nurses.

It is also stated from research that female nurses have more social competence than male nurses who have more roles in leadership, so that masculine stereotypes change due to changes in male social roles (Aranda et al., 2015).

Most nurse education at the Primary Health Center is Diploma 3 Nursing. It is in accordance with the mandate of the Nursing Act, that implementing nurses in the field must have a minimum Diploma 3 Nursing education (Presiden Republik Indonesia, 2014). Even though they only have a Diploma 3 Nursing education, there is no need to doubt the competence of these vocational nurses, because they have more than 5 years of working experience. If it is perceived by the level of the nurse's career level, they are already at PK 2 level (Peraturan Menteri Kesehatan RI No. 40/2017, 2017). It is also emphasized in Peraturan Menteri Pendayagunaan Aparatur Negara Dan Reformasi Birokrasi RI Nomor 35 Tahun 2019, 2019 that nurses who are certified D-III (Diploma III) in Nursing have the Functional Position of Nurse in the skill category, while nurses with the certificate of Nurse have the Functional Position of Nurse in the category of expertise. Nurses who work at the Primary Health Center are permanent employees and civil servants. It is rare for freshly graduated students to work at the Primary Health Center as temporary workers unless they enter the Civil Servant Candidate (PNS) route (results of interviews with two different Primary Health Center Administrative Staff).

The results of the study (Table 3) discovered that there was a correlation between knowledge of COVID-19 prevention, awareness of COVID-19 prevention, and management of Covid-19 prevention. Moreover, there was also a correlation between knowledge and the desire to prevent the occurrence of COVID-19, as emphasized by Notoadmojo, (2012) that knowledge is an important factor to change someone to do something, although in the data there is a weak relationship but still has a role for someone to do something. Braveman & Gottlieb (2014) conveyed that knowledge is a predisposing factor to change a person, in addition to genetics, environment, health, and policies that apply in social life, and as a basic cause of one's health success. Research of Sinurat et al (2021) presents that there is a relationship between the self-awareness of the people of Sibolga and behavior in suppressing the spread of COVID-19 by implementing the 5 M behaviors that have been announced by the government (maintaining distance, using masks, washing hands, avoiding crowds, reducing mobility). Research results prove that nursing students can understand how to prevent COVID-19 after being given health education and campaigns in preventing COVID-19 (Albaqawi et al., 2020). It is also corroborated by Koren et al., (2021) that it is crucial to apply the latest knowledge in

protecting healthcare professionals and nursing staff caring for patients with COVID-19; Health care providers should educate nurses/other health workers about the dangers of communicable diseases, including proper use of personal protective equipment, proper personal hygiene practices, and related environmental measures.

The results of the correlation between variables from the multiple linear regression analysis process of all variables, both knowledge of prevention-awareness of prevention and management of COVID-19 prevention as well as variables of self-ability and organizational ability, revealed that there is a correlation and a close relationship to Stigma. Duan et al., (2020) conveyed that there are 3 profiles of a person in dealing with the COVID-19 stigma, which are 35.98% refused, 48, 13% confused, 15.89% accepted, and generally people with a high level of education, threatening feelings, symptoms of anxiety arise, and are familiar with quarantine cases (COVID-19) have a high probability of being stigmatized. Stigma experienced by a person will have a negative impact on life both economically and psychologically, thus, it is necessary to take the right approach, especially from religion (Hashmi et al., 2020)

The results of the study (Table 5) found that the dominant factors influencing stigma seen from the t-test were self-efficacy (X2) = 6.841 (p = 0.000) followed by organizational ability (X3) = 2,214 (p = 0.000) and knowledge of COVID-19 prevention (X1) = 2.214 (p = 0.036). Personal or self-ability is defined as a person's ability to complete various tasks in a job he does and make a person safe at work accompanied by a sense of satisfaction and success (Pool et al., 2007). Nurses who provide services to patients understand how they work and interact socially in the patient's environment, who takes into account patient safety (Fryer, 2012).

It is essential for the employee to possess self-ability which are the knowledge, attitudes and skills (Rasul et al., 2009). There are 10 skills that must be possessed in order to increase self-efficacy, encompassing the ability to communicate and interpersonal relationships, problem solving, self-motivation, work under pressure, organizational skills, team spirit, learn skills, skills using data, assess diversity, and negotiate (Syahrudin, 2018). The second order that affects the stigma which occurs in society is organizational skills are skills related to creating structure and order, increasing productivity, and prioritizing tasks that must be completed immediately, versus tasks that can be postponed, delegated to others, or eliminated at all, and it is proven from research results that the ability to commit to an organization improves the quality of nurses' work (Diana et al., 2022). In pandemic conditions, it is necessary to have good organizational arrangements so that the health service system that will assist in managing the disease is prohibited. The movement of people across borders is prohibited, the impact of which can reduce the burden on health care institutions (Donev et al., 2013). The third order that affects stigma is knowledge. According to Noar & Zimmerman (2005); Yanti et al., (2020) and (Li et al., 2021), knowledge is a factor to change a person's healthy behavior and show a positive attitude to healthy behavior. Knowledge must be possessed so that a person can act on the situation he is in, as conveyed by (Kelly & Barker, 2016), to change someone's behavior from something bad to better must be based on knowledge, because knowledge is an important factor for changing behavior (over behavior).

As elaborated by The United Nations International Children's Emergency Fund, (2020), the level of stigma associated with COVID-19 is based on three main factors: a) COVID-19 is a new disease and much remains unknown; b) Feelings of fear of the unknown; and c) Associating that fear with others; thus, it creates confusion, anxiety and fear among the people. Research from Manik et al., (2021) revealed that from a total of 11 nurse participants who were interviewed, four main themes of perceived stigma in caring for COVID-19 patients emerged, which are rejection, feelings of sadness and fear,

sources of support, and professional vigilance; and the social stigma experienced by nurses comes from co-workers and the community and the impact of psychological pressure. Hence, support from family and co-workers strengthens nurses in dealing with social stigma. Nurses in Iran as researched by Ahmadidarrehsima et al., (2022) experience stigma while caring for COVID-19 patients. They encounter many personal and professional challenges. What they feel is four main themes and ten sub-themes: a) physical, psychological, and social burden of care (excessive workload; fear, anxiety, worry; unpleasant social experiences; affection fatigue) b) unmet needs (personal needs and professional needs), c) positive experiences (pleasant social experiences and) inner satisfaction), and d) strategies (problem solving strategies and mitigation strategies stress symptoms). Research in Turkey conducted by Kackin et al., (2021) discovered that nurses who treat COVID-19 patients also experience psychosocial problems which are categorized as stigma in the form of an adverse impact on nurses, with three main themes found: a) the theme of the epidemic effect (working conditions, psychological effects and social effects; b) the theme of short-term coping strategies (normalization, thinking about rejection, avoidance, expression of emotions and distractions); and c) needs themes (psychosocial support and resource management).

The strength of this research is that the COVID-19 pandemic condition has many supporting journals to be studied, which makes it easier for researchers to analyze and discuss problems that occur in Primary Health Center nurses. The weakness is that filling out the questionnaire cannot be competeled directly, because the situation is still in the Large-Scale Restriction period, in which filling out the questionnaire is performed through the g-form, so for open-ended questions, the researcher has not been able to dig deeper into open-ended questions.

4. CONCLUSION

The perception of stigma felt by nurses while providing services to patients with COVID-19 during the pandemic was experienced by Primary Health Center nurses. The readiness of nurses to treat patients with COVID-19 in terms of prevention knowledge, self-awareness and management related to knowledge and mentality, including the category of new disease outbreaks. Nurses should continue to cooperate with the COVID-19 Task Force in their area in preventing community stigma through communication, information, and education on how to prevent an increase in cases and treat COVID-19 patients. The effective nurses' actions to always promote to the community and cultivate a cohesive health culture need to be performed. It is also important to create a media that can transmit scientific knowledge, and promote positive interaction and social cohesion between stigmatized groups and dominant groups, and create space for stories that maintain group identification among people involved.

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