

Social stigma towards nurses taking care of patients with COVID-19 in Indonesia: A mixed-methods study

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Abstract

Background: The condition of the Indonesians' unpreparedness for the COVID-19 pandemic has caused anxiety and fear. The public's fears of COVID-19 cases have led to a negative stigma. As part of health workers in disaster management's main pillars in health services, nurses are most vulnerable to infection and not free from the stigma.

Objective: This study aimed to describe the social stigma against nurses taking care of patients with COVID-19 and experiencing suspected or probable or confirmed COVID-19 cases in Indonesia.

Methods: This study was a mixed-method study using a sequential explanatory design-participant selection model. The selection of respondents used the convenience sampling technique. The number of respondents in the quantitative stage was 118 respondents. For qualitative data, selected participants were respondents with a stigma score of more than 21 nurses and willing to continue the interview process. There were 11 participants in the qualitative stage. This study used the modified Stigma Scale of the Explanatory Model Interview Catalog for quantitative data and four semi-structured questions to obtain qualitative data. Quantitative data were processed in descriptive statistics, and a thematic analysis was performed to analyze the qualitative data.

Results: The highest stigma score of 118 respondents was 37, and the lowest score was zero. The stigma score had a mean of 12.28 ($SD \pm 7.9$). The higher the score obtained leads to a higher level of stigma received. From a total of 11 participants interviewed, four main themes emerged: rejection, feeling down and afraid, sources of support, and professional vigilance.

Conclusion: The social stigma experienced by nurses comes from colleagues and society and impacts psychological distress. Support from families and colleagues strengthens nurses in facing social stigma. Nevertheless, nurses uphold the values to remain grateful and carry out professional responsibilities in taking care of patients. Nurses should be provided with psychological support and be prepared for disasters to provide excellent health services and reduce adverse mental health.

Keywords

coronavirus; COVID-19; Indonesia; nurses; social stigma

The world, including Indonesia, deals with a non-natural disaster in the form of an outbreak of Coronavirus Disease (COVID-19), an infectious disease caused by a type of newly discovered coronavirus. The genetic sequence of the new virus, called COVID-19, was officially announced by the World Health Organization (WHO) on 12 January 2020. The first status of COVID-19 was a global epidemic and

then upgraded to a pandemic status just within ten weeks after the first case was reported (WHO, 2020b). The disease outbreak has become a pandemic that can impact people's mental and psychosocial health conditions (Ministry of Health of Indonesia, 2020).

The first case in Indonesia had been officially announced on 2 March 2020 (Nuraini, 2020). The condition

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of the Indonesian public's unpreparedness for this pandemic was evident in the first week of the first cases publicly announced. There is growing anxiety in the community living around the first suspects confirmed with COVID-19 cases (Nuraini, 2020). The public feared the suspected and probable COVID-19 cases, which led to a negative stigma against them. This stigma took the form of exclusion and discrimination from the community. Health workers, such as nurses, who are part of COVID-19 disaster management's main pillars in health services, are also not free from the stigma. The stigma experienced by health workers was in the form of rejection by the community around the neighborhood or the nearby rented or boarding house. The most evident negative stigma reported was when the corpse of a dead nurse confirmed with COVID-19 was rejected by the community around the public cemetery in Central Java, Indonesia.

Health workers are most vulnerable to infection from patients who come to health care facilities because exposures from patients with COVID-19 are unavoidable (Tosepu, Effendy, & Ahmad, 2020; Wibowo, 2020). Besides, hospital care service flows for COVID-19 cases were still unclear in the pandemic's early days. The COVID-19 testing tools such as rapid tests were still limited, placing a higher risk of being exposed to health workers. The increasing number of health workers infected with COVID-19 is associated with the rising number of confirmed COVID-19 cases and patients' dishonesty with their previous travel history or symptoms (Tosepu et al., 2021; Wibowo, 2020).

Research on the health workers' mental health in handling COVID-19 in Singapore and India shows that one of the psychological distresses found was a social stigma (Chew et al., 2020). The experience shared by several health workers indicated that the stigma comes from the other health workers or friends. Health workers' mental health is essential in providing excellent health services, especially during a pandemic. Therefore, it is crucial to uncover the pictures of stigma to develop mental health support according to health workers' needs.

Social stigma in the health context is a negative relationship between a person or group of people with specific characteristics and diseases. In the pandemic context, this stigma means that people are labeled, stereotyped, discriminated against, treated separately, or experience loss of status because of their perceived relationship with the disease (WHO, 2020a).

Literature studies suggest that health workers are at significant risk of adverse mental health during the COVID-19 pandemic. The reasons include long working hours, risk of infection, lack of personal protective equipment, loneliness, physical exhaustion, and separation from family (Rajkumar, 2020). Another study focusing on mental health challenges during the COVID-19 pandemic found that mental health challenges, such as anxiety or fear of infection to depression, are in line with increased health workers' workload (Kar, Arafat, Kabir, Sharma, & Saxena, 2020).

One descriptive study in several health centers in India and Singapore found that 48 respondents (5.3%) experienced moderate to severe depression, 79 respondents (8.7%) mild to severe anxiety, 20 respondents (2.2%) very severe stress, and 34 respondents (3.8%) moderate to heavy levels of psychological stress (Chew et al., 2020). A possible contributing factor was social stigma, resulting in individuals having a higher tendency to express their psychological distress with physical symptoms (Chew et al., 2020). Literature studies emphasize the imbalance and mismatch between stigma mitigation, prevention, and containment of COVID-19. Those studies suggested short-term and long-term strategies for building empathy and social justice in current and future pandemics. Although the research in COVID-19 is relatively new, the stress from the stigma of COVID-19 may have similar mental health impacts with the previous research, including healthcare workers. Therefore, a strategy is needed to consider various health conditions and social identities to understand and reduce the stigma of COVID-19 (Logie & Turan, 2020).

At the beginning of the COVID-19 pandemic, few studies reveal the stigma experienced by nurses. Many studies have discussed the stigma among health workers but are still limited to survey studies. No research has explored the stigma experienced by nurses as health care providers who are at the same time experiencing the COVID-19 itself. This study aimed to uncover the pictures of the stigma against nurses taking care of clients with COVID-19 and experiencing as suspects or probable suspects or confirmed COVID-19 cases.

Methods

Study Design

This study was a mixed-method study using a sequential explanatory design-participant selection model established in two phases. The first phase was conducted with the quantitative methods, followed by the second phase of exploration with qualitative methods. The qualitative phase was emphasized and connected to the result of the first phase, with the intent is to purposefully select participants to best address the qualitative research questions (Creswell, 2018). The consideration for using mixed methods was to get a comprehensive and more detailed picture of the phenomena that occurred within the participants in the target population.

Participants and Study Setting

Quantitative strand

Respondents in this study were nurses taking care of COVID-19 patients in several private hospitals in Indonesia. The selection of respondents used the convenience sampling technique because it was difficult to reach the population in the pandemic situation, particularly at the beginning of the outbreak. The inclusion criteria were nurses taking care of COVID-19 patients and once experienced as probable suspect or confirmed COVID-19

cases. The number of participants who took part in quantitative research in this study was 118 respondents.

Qualitative strand

For qualitative data, selected participants were respondents with a stigma score of more than 21 nurses and willing to continue the interview process. After the researchers collected the quantitative data, a stigma score was established. The researchers identified 17 nurses who had more than a 21-stigma score. They were invited to participate in the second phase by email. 11 participants were interviewed.

Data Collection

Quantitative strand

The quantitative data were collected using a modified questionnaire from the Stigma Scale of the Explanatory Model Interview Catalog (EMIC Stigma Scale). This instrument was utilized after obtaining consent from the original author. The questionnaire was previously intended to measure the social stigma of stigmatized people for having leprosy and tuberculosis. The questionnaire was also translated into the Indonesian language (De Korte, Vellacott, Pongtiku, Rantetampang, & Van Brakel, 2018). There were 14 questions with four answer choices: yes, maybe, do not know, and no. Question number two was the only question with a reverse score (InfoNTD, 2020; Morgado et al., 2017). Each item was rated on a 4-point Likert scale, options being three = yes to zero = no. A total score of a stigma was computed by adding up individual items' scores. The maximum score is 42, and the minimum score is zero. The higher the score obtained by a respondent, the greater the indication of stigma. There is no stigma categorization of the total score (InfoNTD, 2020; Morgado et al., 2017). The EMIC stigma scale was confirmed to have good internal consistency and high item-total correlation (Chung & Lam, 2018). The research instrument was reliable, with a Cronbach's Alpha value of 0.88. The researcher collected quantitative data by compiling the survey into an online form using the Google platform and distributing a link by WhatsApp Messenger application to the nursing leaders in 13 private hospitals in Indonesia. The nursing leaders shared the survey link with their nursing staff. The quantitative data were collected in the first week of May 2020.

Qualitative strand

The qualitative data collection used an online semi-structured interview. Interview sessions were conducted in the third and fourth week of May 2020. The research instrument for obtaining qualitative data was semi-structured interview guidelines developed from the EMIC Stigma Scale to explore participants' stigma experiences. Two researchers with a nursing background conducted the interview using semi-structured interviews. The interview questions included (1) How was your experience as a nurse who is also a suspected or probable or confirmed COVID-19? (2) How did you experience working with other health

workers when you had experienced as suspected or probable or confirmed COVID-19? (3) How were the support of colleagues, family, and the people around you toward your profession and your experience? (4) Can you share the value that you get from this experience? The online interview was conducted by the WhatsApp voice call or Zoom application according to the participants' preference. The interviews took 45 to 60 minutes and were digitally audio-recorded to be transcribed verbatim in Indonesian.

Data Analysis

Quantitative strand

Quantitative data were summarized using descriptive statistics (mean, standard deviation, frequency) and processed in percentages based on each question's answers and each respondent's total stigma score. Data analysis was conducted using the IBM SPSS Statistics version 27.

Qualitative strand

The researchers performed a thematic analysis for the qualitative data. Data analysis processes included familiarizing with data, generating initial codes, searching for themes, reviewing themes, and defining and naming themes (Vaismoradi, Turunen, & Bondas, 2013). To establish this qualitative data's trustworthiness, the researchers employed member-checking by sending the transcripts to the participants to verify the data accuracy.

Ethical Consideration

This study obtained ethical clearance from the Institutional Review Board of the Mochtar Riady Institute for Nanotechnology (approval no. 2005005-04). In this light, the researchers gave the respondents the right to participate, and they could also stop participating during the research process. Permission to record the conversation was obtained after considering the participants' consent.

Results

Quantitative Results

Table 1 Distribution of respondents' characteristics by age and length of employment in their current hospital (N = 118)

Category	n	%
Age		
17 – 25 years	71	60.2
26 – 35 years	32	27.1
36 – 45 years	13	11.0
46 – 55 years	2	1.7
Length of work		
Less than one year	24	20.3
1 – 3 year	67	56.8
More than three year	27	22.9

The respondents' characteristics in this study were in the age range of 17-25 years old (60.2%), and 56.8% of the

participants have been working for one to three years at the current hospital (Table 1).

Most respondents, or around 72%, underwent both rapid tests for antibody and swab-polymerase chain reaction (PCR). In March 2020, 29.7% of respondents became suspected, and 6.8% were confirmed COVID-19 (Table 2).

Table 2 Distribution of respondents' characteristics based on COVID-19 test and their status related to COVID-19 from March to May 2020 (N = 118)

Category	n	%
COVID-19 test		
Rapid test (Antibody)	15	12.7
PCR (Swab)	18	15.3
Rapid test and PCR	85	72

Table 2 (Cont.)

Status of COVID-19		
<i>Suspected/ Probable cases</i>		
March	35	29.7
April	23	19.5
May	13	11
Not answer	47	39.8
<i>Confirmed cases</i>		
March	8	6.8
April	3	2.5
May	10	8.5
Never	97	82.2

The respondents' highest stigma score was 37, and the lowest score was zero. The mean score was 12.28 (SD ± 7.9). The distribution of the respondents who answered each item of the stigma questionnaire varies (Table 3).

Table 3 Distribution of respondents based on question items of the EMIC Stigma Scale (N = 118)

No	Question	Yes	Maybe	No	Do Not know
1	Do you choose so that other people do not know about the COVID-19 that you are experiencing?	29	25	62	2
2	Have you discussed this issue with close people, people you can easily talk to? Example: close friend, family	110	1	5	2
3	Do you think you will be underappreciated or less respected because of this health problem?	21	40	53	4
4	Have you been humiliated because of this health problem?	11	17	87	3
5	Do your neighbors, coworkers, or the community disrespect you because of your health problems?	17	24	69	8
6	Do you think that coming into contact with you will be bad for those around you even after being treated?	21	35	59	3
7	Do you feel that other people are avoiding you because of this problem?	22	34	59	3
8	Has anyone refused to visit your home because of this condition even after you have been treated?	15	26	66	11
9	If they know about your health problems, will the people in your community have less respect for your family? For example, neighbors, coworkers	12	36	64	6
10A	If you have children, is your illness causing social problems for your child?	1	3	20	1
10B	If you have children in the future, can your illness cause social problems for your child?	7	25	53	8
11A	If you are not married, does this disease make it difficult for you to get married?	3	18	57	12
11B	If you are married, is this a disease-causing problem in your marriage?	2	3	23	0
12	Do you feel that this disease can make it difficult for people in your family to get married? Example: children, grandchildren, or siblings	17	29	61	11
13	Have you been asked to stay away from work or social groups?	28	9	78	3
14	Did you decide to quit your job or stay away from community groups?	24	7	85	2

Qualitative Results

In the second phase, 11 out of 17 participants had more than 21 stigma scores and were willing to be interviewed. Most of the interviewed nurses were female (82%) and were between 20 and 40 years old. More than half of the participants (82%) have been working for one to three years at the current hospital. The purpose of the qualitative phase is to gain a deeper understanding of the stigma experienced by nurses taking care of clients with COVID-19 and at the same time experiencing as suspected or

probable or confirmed COVID-19 cases at the beginning of the pandemic in March to May 2020. Four major themes emerged from the qualitative data, including (1) rejection, (2) feeling down and fatigue, (3) sources of support, and (4) professional vigilance.

Rejection

Participants experienced rejection from the social environment. Participants stated that they got cross-infection from the workplace, and the experience was exacerbated by rejection from others. Participants

expressed feelings of being feared and avoided by colleagues and people in their neighborhood. Stigma in the form of rejection was obtained from colleagues and other officers in the hospital. Participants stated that they felt both verbal and nonverbal rejection when being suspected or probable COVID-19 cases. The experiences were described in the following statements:

- *“Yes, they said, you cannot come here”* (p10)
- *“Do not come close to me, or I will be positive too”* (p10)
- *“You do not come near us, get away from us”* (p7)
- *Participant 2 conveyed discrimination from friends who were quarantined because he was placed in a different room. “so, my friends were isolated, but I was isolated different from them”* (p2)

Several participants expressed rejection by other professions. There were hospital employees who were openly evasive and keeping their distance away.

- *“There are also other health workers who underestimated us; they wanted to go out like when we were in the same waiting room with us”* (p8)
- *“It feels like we are filthy, and that person keeps his distance, not entering the ICU”* (p9)

This social stigma was also found in the adverse treatment of other health workers.

- *“Yes, I feel rejected, my diagnosis has not been confirmed, it is still early, why are they so terrified”* (p3)
- *“We feel shunned even though we are fellow health workers”* (p8)
- *“(Hospital employee) when he met us, he avoided us”* (p8)

Most participants also experienced rejection from the boarding house owner in the community because most of the participants lived in a boarding or rent house.

- *“Suspicion arose from the boarding house owner. Yes, I informed them that I am taking care of the COVID-19 suspects. There is a stigma in the society; it looks like I will be expelled from the boarding house”* (p5)
- *“I could not go back to the boarding house because the owner was afraid that we would come home with the virus, afraid that other residents of the boarding house would be worried if, for example, they know that we are nurses caring for COVID patients”* (p11)

The rejection was also obtained from the local people, online taxi drivers; some were indirectly conveyed to their families.

- *“They (the local community) are afraid of me”* (p1)
- *“Stigma from them, wow there are positive people, you have to get out of this environment”* (p5)
- *“The taxi driver was shocked knowing I was a nurse. Then he pointed out the nurse should stay in isolation”* (p11)

- *“There was an incident where the community leader and my neighbor, not directly to me but my family, to my sister and my mother, said that I should not go home because I will spread the virus”* (p3)

Feeling Down and Afraid

The stigma experienced by nurses caused psychological distress, such as being down, sad, and fearful. Some of the participants chose to hide their status as nurses. These stigmatized nurses also think about the adverse effects that could happen to their families and loved ones. The participants expressed fear and sadness because they felt they were treated differently after becoming suspected or probable for COVID-19 cases.

- *“I am upset, even though I felt no symptoms, right”* (p1)
- *“I am also in a position to feel down right away. I Feel down. I am not accepted in this environment”* (p5)
- *“I feel despicable”* (p6)
- *“So sad, I am there to work, nothing else”* (p7)
- *“Feeling even more disappointed because when we were quarantined, there were also nursing colleagues and other health workers who avoided us”* (p8)
- *“It feels like we are filthy”* (p9 & p11)

In this study, participants stated that they were afraid and anxious to reveal their identity as nurses because they were considered in close contact with COVID-19 patients.

- *“It is because I do not want him to know my status, my job, so I have to lie”* (p1)
- *“I lose confidence too, feel afraid to use an online taxi, I am afraid to get questions”* (p1)
- *“Moreover, news began to appear that health workers were being kicked out from their boarding houses. I am cautious when I go outside. I am more afraid of the boarding house owner’s response”* (p2)
- *“Well, I was asked, where are you going? I do not dare to answer. If I said I was assigned to a COVID hospital, I could be kicked out, so I just said, Yeah Ma’am, I am leaving for home”* (p2)
- *“At the time, there was news that a nurse was kicked out from her boarding house, so I was afraid of being rejected by my new boarding house. I had the thought of wanting to lie and hide my status as a nurse. I am afraid of being rejected in a new environment”* (p9)
- *“Yes, there was a feeling of fear, fear of not being accepted; people do not know that I am a nurse”* (p9)
- *“I heard that the boarding house owner said that I shouldn’t stay there. I feel dizzy, wondering where to live and continue to quarantine in the hospital, but it means I would stay with others. I am afraid, and I have mixed feelings”* (p11)

Source of Supports

This study indicated that participants felt discriminated when exposed to COVID-19, and they needed support. The support was considered as a reinforcement and counter-

attack due to the stigma experienced. Participants felt affirmative relief from fellow health workers who gave encouragement and offered prayers. The participants' most valuable support was from family, parents, and siblings who openly accepted, protected, and offered prayers for them.

- "Yes, I got prayers of support; the prayers from parents are powerful" (p1)
- "Family support, they always support, come to give vitamins, give support like that" (p5)
- "From my family, my parents who are in the village, usually they call me once a week, but now, they call me every night" (p7)
- "Support from family, siblings, friends who are also on duty here" (p8)
- "I feel most strengthened from the family, from my mother" (p9)

Another support comes from other professions, such as doctors and the hospital's Human Resource Department (HRD).

- "So far, there is support from the HRD, so we have been given a vitamin package. Also, every few days we get fresh milk, there are also lunch boxes, all kinds of things" (p3)
- "The support from colleagues is excellent. Support from a cardiologist, he cares so much" (p5)
- "Our intensivist is the best. He is very understanding. He desperately asked so that nurses are quarantined here so he can see them" (p6)
- "We must support each other. Prayer is the most important one" (p1)

Professional Vigilance

In general, participants interpreted this experience as a valuable experience and made them find values in life, even though they experienced the negative impact of stigma. Some of the values obtained are described in terms of spiritual values, increased self-awareness, and a responsibility to serve patients. Spirituality in this study did not focus on the sole relation about God but was also interpreted as the wisdom obtained through unpleasant experiences, making a person alive again and leading to satisfaction in understanding life. Almost all the participants expressed gratitude for this experience and grew closer to God.

- "I realized that this COVID also made me closer to God" (p1)
- "As long as God still gives a chance, as long as God still gives a healthy condition, opportunities, just do our part" (p11)
- "I feel even more grateful" (p3)

They also expressed gratitude to understand self-care and appreciate little things as stated:

- "Because I am a nurse, maybe I am more grateful because I can care about my patient more. Not being careless" (p6)

- "I even think of appreciating small things which are invisible, never considered." (p2)
- "I am more grateful because we appreciate the importance of cleanliness, the importance of taking care of each other" (p10)

A health protocol for risk management increased the sense of security for health workers and reduced disease transmission. Participants stated that this experience made them more aware of the health protocol standards.

- "Because our caring and attention are honed, even more, our alertness is honed more, more than usual" (p3)
- "First, maybe it should be safe. Just stay safe, do hand washing, drink vitamins, do the social distance with friends, to take care of them. So yes, we still use the N95, and I also ask everyone to do the health protocols when we take care of patients" (p5)
- "Be more vigilant, be more vigilant, do hand washing and keep distance, keep wearing a mask everywhere" (p9)

Participants stated that they continued to serve patients professionally even though they had experienced the impact of stigma, once felt afraid and anxious, and now are still at risk of being re-exposed to the COVID-19.

- "Because we are nurses to care for others, so I think we will treat the patient with the same action. Just like before, before this COVID-19. We continue to treat patients with the determination as it has been before" (p8)

Participants also stated that they had more empathy and compassion because of their personal experience of stigma. They were aware that patients and families could also experience social stigma because they were considered to transmit disease.

- "I care my patient even better, no more careless" (p6)
- "The patient cannot be visited; I see the family in front of ICU hoping with anxiety, waiting for the patient, but they cannot go inside the room, but they still stay in front of the door. It makes me sad" (p2)
- "Because of this situation, we know that this is our struggle, where our job leads us, what challenges will we face, how to embrace those around us" (p7)

Discussion

The quantitative and qualitative results indicate that COVID-19 causes some nurses to experience stigma. This result is in line with the statement of WHO regarding the social stigma caused by COVID-19. Individuals tend to be afraid of something new, and fear is associated with other straightforwardly (WHO, 2020a). The stigma associated with COVID-19 varies from the transmission, examination or testing, pain level, comorbid disease levels affect, newly appearing symptoms, and treatment. An incomplete

explanation of the symptoms causes individuals suffering from this disease to experience segregated and labeled/stigmatized (Bhattacharya, Banerjee, & Rao, 2020). The stigma has several components, namely (1) differentiating and labeling differences, (2) associating human differences with negative attributions or stereotypes, (3) separating 'us' from 'them,' (4) experiencing loss of status and discrimination (Pescosolido & Martin, 2015).

The data show that in question items of 1, 3, 6, 7, 13, and 14, more than 20 respondents answered 'yes.' These question items are in line with the exposure to the dimensions related to stigma as a multidimensional thing. Some of these dimensions are associated with stigma, namely social distance, covering facts or disclosures, negative influences, and danger perceptions (Pescosolido & Martin, 2015). The answer 'yes' to question number one means the respondent chose not to let others know about the COVID-19 status; this is a disclosure dimension. The meaning of the disclosure dimension is to hide the COVID-19 examination results, in line with the understanding that an individual diagnosed with a disease will conceal his condition from the public (Ashby, 2016). This dimension focuses on the negative consequences of disclosing the status or results of the COVID-19 examination. The disclosure aspect may also be increased when asking the closest people and family not to reveal secrets to avoid them feeling embarrassed and hoping that they will still be accepted in society (COVID-19 Response Acceleration Task Force, 2020).

The third question is about the feeling of disrespect, which is most often experienced by patients of other diseases with high stigma scores, such as leprosy (Adhikari, Kaehler, Chapman, Raut, & Roche, 2014). COVID-19, as a new disease, also causes a decrease in self-esteem, even in health workers who are infected with COVID-19. The sixth question is related to the dimension of stigma based on fear of danger, such as stigma against patients with psychiatric illness or stigma on criminal behavior (Adhikari et al., 2014). Respondents who answered "yes" to this question item experienced internalized stigma (Pescosolido & Martin, 2015). Respondents stated that other people around them who met them would be adversely affected. COVID-19, as an airborne disease, is one of the facts that came to the respondents' minds for this question.

The seventh question is associated with the stigma dimension of social distance or maintaining an interpersonal distance that usually occurs in patients with psychiatric disorders (Ashby, 2016). This dimension's rationale depends on the party giving the stigma, whether to accept or refuse to interact with people who have certain diseases or disabilities. Question number 13 is quite similar to question number 14. Simultaneously, these two questions have differences in the words 'ask' or 'decide for themselves.' These items' dimensions are still related to social distance, which is discussed in the seventh question. So, questions number 7, 13, and 14, especially on the word 'avoiding' or 'social distancing,' will be further explored in

the context of the stigma caused by COVID-19 because social and physical distancing is part of health protocols for the prevention of this disease. For this reason, these items will be explained in more detail in the qualitative discussion of several participants.

From the results of the interview transcript analysis, four main themes emerged, including (1) rejection, (2) feeling down and afraid, (3) sources of support, and (4) professional vigilant. These negative response to stigma is consistent with the research, which states that exposure to this virus can negatively stigmatize labels, leading to negative responsive behavior (Ashby, 2016). The study shows that 140 from 2050 Indonesian nurses have felt humiliated by others because they work as the nurse of COVID-19 patients, and 135 nurses have been asked to leave their homes (Humasfik, 2020). The forms of rejection were the threat of eviction and avoidance by closing their doors when they see the nurse. The community also stays away from the nurse's family (Humasfik, 2020). The results in this study also follow the statement that health workers at the forefront who risk their lives have experienced stigma and are socially shunned because they are in contact with COVID-19 patients and are vulnerable to experiencing discrimination (Ashby, 2016). The participant's fear is the stigma's impact. Participants feel anxious because of the conversations with colleagues and thus grow the fear of themselves and others.

The stigma's impact can increase the risk of mental disorders. As stated by Adom and Adu Mensah (2020), people affected by stigma are continually fighting the stress they experience from anxiety, depression, and fear. Stigma is a reaction to disease and cannot be avoided. Through the values expressed by the participants, those experiences provide awareness that the real opponent is the virus and not the patient of COVID-19 (Earnshaw, 2020).

Based on those themes' interpretation, participants experienced social stigma from both the work environment and community. From the rejection experienced, psychological distress appears in the form of fear and anxiety. The results show that the participants receive support from their families and people around them, and this is a steady source of support in facing their crisis period. Later, even though they experience stigma, they still carry out professional responsibilities as health workers and get the value of life. Those values include being more vigilant and maintaining self-health, and even spirituality related matters, where participants could be grateful in bad situations.

The previous study revealed that stigma is an essential predictor of burnout and compassion fatigue in health workers, so the health workers need support to deal with the stigma (Ramaci, Barattucci, Ledda, & Rapisarda, 2020). In this study, nurses receive help from other health workers, such as doctors and staff. Nurses are the largest group in the health profession. Therefore, it is essential to raise awareness to face stigma from other professionals and meet negative behavior (Ashby, 2016).

This study's limitation includes the limited number of samples representing nurses from several private hospitals in Indonesia. This study does not analyze the participant's coping mechanisms and does not measure the level of anxiety or distress. There could also be an accidental assumption in the discussion when combining quantitative data sets and qualitative data without considering each data's type and depth. The existence of a presumption in combining the two methods is a weakness of mixed methods. This study tries to initiate the scope of stigma in the COVID-19 pandemic experienced by health workers. Although it only describes the stigma conditions experienced and does not statistically measure the variables' effect or relationship, this study is meaningful. Future studies should pay more focus on this topic.

Conclusion

Stigma is an issue that needs to be controlled by the health system because it is a crisis in the health sector and can impact health workers' mental health. There comes a need to provide psychological support and prepare an effective hospital disaster plan policy to improve health workers' safety and promote mental health. The psychological support can be given in mental health services accessible to nurses, implementation of mechanisms to assess nurses' mental wellness in real-time, establish a hotline staff for any type of needs or concerns, and any other forms. Future studies obtaining the presentation of psychological distress and coping with health workers are also needed. Health workers, especially nurses and doctors, need to be supported in carrying out their roles and responsibilities, especially during a pandemic, as the frontline of patient care.

Declaration of Conflicting Interest

The authors declare no conflict of interest.

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Authors Contribution

All authors have equal contributions in this study started from the proposal, data collection (quantitative and qualitative data), data analysis, final report, and development of the manuscript.

Data Availability Statement

The databases generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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