

Covid-19 Associated with Stigma among Nurses in the Frontline: A Phenomenological Study

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Abstract

Background: There is a scarcity of literature presenting the lived experience of nurses working in hospital and community settings in the Philippines during the COVID-19 pandemic. **Objective:** This paper aims to describe the lived experiences of COVID-19-related stigma among these nurses on the frontline. **Methods:** This study utilized a qualitative design using a transcendental phenomenological approach. Fourteen frontline nurses participated in the interview conducted during the first quarter of 2020. **Results:** Four overarching themes were unearthed from the participants' narratives, namely: (1) Social Stigma and Discrimination, (2) Self-Stigma, (3) Effects of COVID 19 stigma with the subtheme of (3.1) anxiety, (3.2) loneliness, and (3.3) fear, and (4) Resilience from experience. **Conclusion:** The study's findings provide insight into the situational experiences and the deleterious effects of stigma on nurses working on the frontline. **Recommendation:** Health institutions should provide a lens on these needs and implement supportive interventions to uplift the spirits of these nurses working on the frontline.

Keywords: Stigma, COVID-19, nurses, transcendental phenomenology, Philippines.



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INTRODUCTION

The COVID-19 pandemic dealt a substantial blow to the world's healthcare system, affecting millions worldwide. Given that healthcare providers are on the front lines of this problem, they are the ones who have faced challenges, including workplace discrimination (World Health Organization, 2020).

Nurses are a critical and significant factor in the fight against this pandemic disease as they act as the frontlines for both the patient's bedside care and the community for 24 hours. Nurses' multidimensional functions and responsibilities in the fight against this health problem are vital in healthcare and community settings. Particularly in terms of (1) public health education, screening, and support, (2) nosocomial infection prevention and surveillance, (3) health safety protocol implementation, (4) security of patients with identified underlying medical conditions, and (5) medical needs of both acute and critically ill individuals with COVID-19 (Alharbi et al., 2020). Nurses were considered critical components of any pandemic response team, especially COVID-19. Scholars agree that nursing is the essential health care profession in every country, across all areas.¹ They were considered the most significant health service providers when faced with a complex condition requiring hospitalization and even intensive critical care, such as COVID-19. Nurses assigned to communities, the majority of which are in rural areas impacted by the pandemic, have higher levels of issues in terms of mental health than those working in other healthcare settings, including nurses in most of the community quarantine centers for COVID-19.²

During a pandemic response, nurses faced various personal problems, including the risk of being infected and unknowingly spreading the disease to their family members, and psychological challenges, including stigma and limitations on their freedom within society due to the vulnerability of their role. Their choice between protecting their health and families and continuing care in COVID-19 facilities has created an ethical dilemma for them.² This stigma also extends to family members, making them feel even more neglected and putting them at risk of psychological problems.³ Studies have found

that nurses assigned to care for COVID-19 patients have been vulnerable to inappropriate psychological and clinical circumstances but have maintained and continued to provide nursing care to their patients.⁴

Consequently, nurses and other healthcare professionals who serve as frontline responders in disasters and pandemic crises have been shown to experience psychological issues, especially those working in high-pressure and high-risk circumstances.⁵ Nurses fear experiencing symptoms of COVID 19 disease with the thought of unknowingly transmitting it to their families and colleagues.

Moreover, in the De Los Santos & Labrague 'conducted in the Philippines, they found that the nurses' fear of COVID-19 was associated with their psychological distress. Similarly, a study by Satici et al.⁷ resulted in the same, in which the COVID-19 fear has a notable positive association with anxiety, depression, and stress. Although fear is thought to help encourage people to respond effectively to a given threat or stimulus, excessive and persistent fear may result in negative psychological responses such as stress, depression, and sleep disorders.⁸

There are various reports of social stigma due to the outbreak where one was labeled, stereotyped, and discriminated against because of perceived drivers of disease transmission.⁹ Stigma impacts the mental health of frontline employees and those who have recovered from the pandemic. The health crises have resulted in social stigma and discriminative behavior toward people who were thought to have had any contact with the disease. Bhattacharya et al.,¹⁰ stated some cases of frontline health workers that experienced social stigma in their community. Some have been forced to leave the neighborhood, refused access to their homes, and had their lives threatened.

Additionally, Ramaci et al. ⁹ provided evidence on the relationship between healthcare workers' stigma and job outcomes, discovering that stigmatization is linked to psychological and physical health consequences. The increased prevalence of self-reported physical symptoms was partly due to the psychological effect of the pandemic.¹¹ Other observational studies have found that

people who report discrimination are more likely to have poor physical health.¹²

Because of the increasing reports of physical and psychological distress among the frontline nurses, it was imperative to determine their stigma-related experiences during this pandemic. The literature revealed the existing COVID-19 stigma among healthcare workers on an international and national scale. Still, very few studies examined COVID-19-associated stigma among Filipino nurses in the community and hospital settings. This phenomenological study identified the lived experiences of COVID-19 associated stigma among frontline nurses in the hospital and community quarantine facilities in Ormoc City, Leyte.

OBJECTIVE

The study aimed to describe the lived experiences of COVID-19-associated stigma among frontline nurses in Ormoc City, Leyte

METHODS

Design

We adopted a transcendental phenomenological approach in this qualitative study. This research was designed to explore, describe, and analyze the lived experience of frontline nurses who experienced COVID-19-associated stigma. Furthermore, the researchers also aimed to categorize these experiences into themes that were useful in creating a vivid description of the COVID-19 stigma.

Sample size and sampling technique

The research participants include 14 frontline nurses assigned in the (CQF) community quarantine facility and from the selected hospitals in Ormoc City that accept COVID-19 patients. This sample size was within the acceptable range for phenomenological research.¹⁴ Participants were sampled until no new topics emerged from the data, indicating that we had reached data saturation. All respondents were frontline nurses who experienced COVID-19-associated stigma. Nurses were chosen since they had a significant role in delivering care for patients with probable or confirmed COVID-19 disease. They were more exposed to caring for patients as they act as the frontlines in the bedside and the community, making them the most appropriate respondents in the study. To

reduce the time spent screening relevant target participants and establish a trusting relationship more conveniently, the researchers used snowball sampling. Each participant was secured informed consent before conducting the interview.

The inclusion criteria were: (a) employed as Registered Nurses, (b) frontline nurses who were assigned to the CQF of Ormoc City, and (c) directly serving in the facility for at least three months since the onset of the COVID-19 outbreak within the country, (d) willing to participate throughout the study and (e) frontline nurses who experienced COVID-19 associated stigma. Participants were interested in the study and eager to conduct in-depth interviews.¹⁵ Excluded were nurses with no experience of COVID-19-related stigma, particularly those with no direct patient care.

The instrument for data collection

The instrument used in this study was a semi-structured questionnaire. We utilized open-ended and probing questions to explore the participants' views and expound on their stigma experiences. The researchers invited qualitative research experts to evaluate the validity of the guide questionnaire. Suggestions were integrated to improve the thought and syntax of the main and probing questions in the instrument. The researchers used a recorder during the discussion with the selected participants.

Data collection process

We implemented this study within the first quarter of 2021 in Ormoc City, Leyte. The study locale selected the first two hospitals to receive and care for COVID-19 cases. The researchers asked permission from authorities to conduct the study. Due to the threat of the virus, the researchers strictly observed health safety protocols (e.g., wearing of face mask and face shield and social distancing) as established by the Philippines' Inter-Agency Task Force for Emerging Infectious Diseases (IATF-EID) throughout the entire duration of this study for the safety of both the researchers and the participants.

Ethical consideration

The XXX University Ethical Review Board approved this study. We obtained an

informed consent form from individuals who agreed to participate in the study. They were thoroughly briefed about the study's purpose, methods, privileges, advantages, and risks before data collection began and their right to withdraw from the interview at any point. Confidentiality was applied using the first letters of their name instead of entirely spelled out in the transcribed response

Elements of methodological rigor

The rigor in conducting the qualitative study was strictly observed throughout the research process. The researchers adapted Lincoln and Guba's Framework to develop the trustworthiness of the qualitative inquiry. Four (4) criteria are suggested: credibility, dependability, confirmability, and transferability.

Throughout the inquiry, the researchers maintained a reflexive journal and wrote down important details and preconceived ideas about COVID-19 associated stigma – epoche. Maximum variation sampling, persistent observation, triangulation, reflexive journaling, peer review, and member-checking were adapted to ensure the study's credibility. To ensure dependability, the researchers maintained careful documentation and an audit trail. This includes the interview transcripts, methodologic and reflexive notes, topic guides, and drafts of the final findings.¹⁶ All audio recordings and transcripts gathered are secure in a password-protected flash drive.

Data analysis and investigator triangulation were adapted to ensure dependability and confirmability and reduce the possibility of biased decisions and idiosyncratic interpretations. The two researchers undertook the initial transcripts coding and met regularly to discuss the emerging categories.

In presenting the findings, the researchers provided thick and vivid descriptions of the study participants, events, and experiences observed during the inquiry. The researchers maintained proper documentation with quality outputs. We consulted academic qualitative research experts to ensure that the description and coding used in the analysis and interpretation were accurate

Data analysis

The researchers adopted Moustakas¹⁵ Transcendental Phenomenology as this study's research design. Thus, the data analysis used in this study was anchored in Moustakas' systematic procedure. The first step of the phenomenological reduction process is Epoche. We set aside all prejudgment as the study's conduct commences to see the phenomenon through a critical lens fully.

Epoche is an approach adopted by the researchers at the beginning of the study to put aside views on the COVID 19 associated stigma and concentrate on specific experiences reported by the participants.¹⁵ We prioritized listening and observing facts over reflectiveness when bracketing our previous experiences.

Horizonalization. Each researcher created a textual description of the experience of COVID-19-related stigma based on the participants' verbatim recorded interviews. We identified individual, non-repetitive, and non-overlapping significant verbatim statements shared by the frontline nurses who experienced COVID 19 associated stigma. The individual structural description comprehensively describes the experience's underlying causes, the themes, and aspects that account for "how" feelings and ideas about COVID-19-related stigma were expressed. After the filtering process, the remaining statements (horizons or textural meanings) were examined for the researchers to identify significant statements.

Clustering into Themes. The researchers further analyzed these significant statements to create themes or meaning units. Significant statements sharing similar meanings were clustered into a theme.

Composite Textural Descriptions of the Experiences. Next, the researchers created textual descriptions based on the participants' perceptions of the phenomenon. The textual descriptions presented the *what* of the phenomena, which aids readers in understanding a complete, possibly the best definition of the phenomenon. The researchers created individual textual descriptions using verbatim excerpts from the interview.

Composite Structural Descriptions of the Experiences. The researchers then interpreted and analyzed these descriptions to establish individual structural descriptions that examine the participants' narratives' mental, social, and cultural connections. Structural

descriptions focused on the background and *the how* of the phenomenon.¹⁵

The Essence of the Experience. Finally, the textual and structural descriptions of the experiences were explained in a composite description of the phenomenon using Moustakas' analytical approach known as "intuitive integration." The researchers analyzed the composite descriptions to create an objective "essence" derived from the individual textual descriptions of the participants and individual structural descriptions formulated based on the textural descriptions. The textural-structural synthesis provided a comprehensive, all-encompassing explanation of the phenomenon's essence.

RESULTS

This study aimed to describe the lived experience of COVID-19-related stigma among nurses working on the frontline.

Table 1. Description of Participants

| | Gender | Position | Age | Workplace |
|-------------|--------|----------------------|--------|-----------|
| Nurse J.A.B | Female | Dialysis Nurse | 24y/o | Hospital |
| Nurse K.D.C | Female | COVID Ward Nurse | 31 y/o | Hospital |
| Nurse J.P | Female | COVID Ward Nurse | 24 y/o | Hospital |
| Nurse J.F | Female | Dialysis Nurse | 26 y/o | Hospital |
| Nurse K.K | Male | COVID Ward Nurse | 28y/o | Hospital |
| Nurse Y.L | Female | COVID Ward Nurse | 28y/o | Hospital |
| Nurse L.P | Female | Emergency Room Nurse | 30y/o | Hospital |
| Nurse N.P | Female | Community Nurse | 36y/o | CQF |
| Nurse E.P | Female | Community Nurse | 45y/o | CQF |
| Nurse C.J. | Male | Community Nurse | 41 y/o | CQF |
| Nurse N.G | Female | Community Nurse | 43 y/o | CQF |
| Nurse S.P | Female | Community Nurse | 49y/o | CQF |
| Nurse V.C | Male | Community Nurse | 36 y/o | CQF |
| Nurse B.T. | Male | Community Nurse | 28 y/o | CQF |

Clustering into Themes

Four themes emerged from this analysis about how participants experienced COVID-associated stigma; (1) Social Stigma and Discrimination, (2) Self-Stigma, (3) Effects of COVID 19 stigma with the subtheme of (3.1) anxiety, (3.2) loneliness, and (3.3) fear, and (4) Resilience from Experience.

Theme 1: Social Stigma and Discrimination

According to the definition, discrimination is the unjust or biased treatment of persons and groups.¹⁷ Frontline nurses who care for patients with COVID-positive cases can experience discrimination. Based on the data collected, participants experienced some patients in the hospital,

Then the other patients suddenly fear us nurses who cared for a COVID-19 patient. (NURSE J.A.B)

Other nurses experience direct discrimination due to the nature of their work. These were experienced in public transport, convenient stores, and even searching for places to stay near their workplace.

We experienced difficulties commuting on public transport because other passengers feared us. (NURSE J.F), "The guard didn't let me in after looking for my ID that I am working as a nurse in a hospital with COVID-19 patients. (Nurse Y.L). " " There was a discrimination because of our uniform that time..."(Nurse S.P), and "There was this time that we were looking for a boarding house because we needed to stay nearer the hospital, but the owner declined, saying that they won't accept front liners in their place"(Nurse J.A.B)

Other nurses experienced that they were evaded by their patients and the people in their community due to the possibility that they were carriers of the COVID 19 virus. As frontliners of this pandemic, they are seen as the potential spreaders of viruses in their workplace and community. The participants verbalized:

"It's like they see us as the source of the disease and have the potential to infect them...(Nurse J.P.)", "They see me as someone who carries the virus...(Nurse Y.L.).", "It's like they see us as the source of the disease and have the potential to infect them...(Nurse J.P)", and "People are scared of me because I might infect them as well... (Nurse L.P)".

Social stigma is one of the themes that emerged from a careful selection of significant statements. Frontline nurses experience discrimination in various contexts. According to the study findings of Campo-Arias et al.,¹⁸, the nurses were perceived to be carriers of a disease, and they compromised the safety of others. Our results revealed that frontline nurses were denied entry, renting boarding houses, and accessing their basic needs.

This similar event was evident in a study by Sadang¹⁹and Labrague et al.,²⁰, which found that medical workers in the Philippines were evicted from their rented dormitories and apartments due to tenants' fear of being infected. Nurses were forced to look for new

areas to live in amid the pandemic. Our study also found out that frontline nurses experienced being avoided by people. Such a result implies a need to enhance public knowledge regarding the safety precautions that do not necessitate avoidance and discrimination against frontline nurses.

Theme 2: Self Stigma

The second theme identified is Self-stigma. In terms of mental health, there are two principal types of stigma: public stigma and self-stigma.²¹ Individuals who have been stigmatized may integrate perceived preconceptions and acquire negative attitudes about themselves. This process can produce self-stigma. With the data obtained, the participants were concerned that they might infect their family and friends and would not want to be talked about, so they decided to isolate themselves rather than be with them. Participant's statements such as:

"I don't want my family to acquire the disease from me, nor I would not want them to fear me. So that when the first wave of COVID came, I chose not to go home and look for a place where I could stay temporarily during the lockdown (Nurse J.F)", " I choose not to go home to my family. I was isolating myself, so there will be no issues. I will hear from our place (Nurse J.F)" and, "When they (friends) plan to go out, I choose not to go. I will control myself since I just came back from duty, and it is for the safety of all. I have to sacrifice, and I don't want them to pity me. (Nurse J.F)"

Another breadth brought by the careful selection of significant statements was the theme of self-stigma. Due to front-liners experiencing the impact of social stigma, it gave birth to another form: self-stigma. This finding was related to Shimotsu & Horikawa²² description of self-stigma. They said self-stigma occurs when people internalize these public attitudes and suffer numerous negative consequences.

Theme 3: Effects of COVID 19 Stigma

Subtheme 3.1: Anxiety. According to Pappa et al.,²³ anxiety is the feeling of apprehension and fear, characterized by physical symptoms such as palpitations, sweating, and feelings of stress. Our findings

revealed that nurses were anxious due to the pressing challenges and threats of COVID-19 they experience in their workplace. As the participants verbalized:

"I feel Anxious due to the new and challenging tasks we have not at work (Nurse Y.L)" and "I am anxious about the possibility of getting COVID-19 from my patients. We will immediately change with PPEs in the room. I am so anxious that the result of the patient that we received to care will come out positive (Nurse J.A.B)" Nurses are also anxious about some uncertainties as stated, *"I am anxious because of the possibility that might happen, something unexpected (Nurse L.P)."*

Subtheme 3.2: Loneliness. Loneliness is a distressing experience when a person perceives his social relationships as less in quantity, especially quality, than desired.²⁴ The participants revealed that they were sad about how people treated them, knowing that they worked on the frontline in the pandemic. Dealing with loneliness and being stigmatized alone also contributes to emotional negativism. This indicates that nurses are affected emotionally by the stigma brought about by COVID-19. Statements of the participants include:

"I was sad that I was alone in my boarding house since I could not go home to my family. I was isolating myself (Nurse J.F)", "I felt down since I am a frontline yet I am discriminated (Nurse Y.L)," and "Having the feeling of stigma in me, it makes me feel lonely... and dealing with it alone (Nurse K.D.C) "

Subtheme 3.3: Fear. The novelty of the COVID-19 and the exponential effect it has caused on life has made nurses fearful.⁶ Similarly, this was observed among the nurses in the study:

"I have this fear of acquiring the disease due to the high transmissibility (Nurse J.F)" and "FearFear that I might get infected, and the people are scared of me because I might infect them as well. (Nurse L.P)" They also fear when a positive case of COVID patient will be admitted in their area as stated, *"Fear, every time we will receive a positive patient (Nurse J.P)."*

Psychological and emotional effects were also evident in our study, categorized into

(3) subthemes. The first subtheme pertains to the anxiety felt by frontline nurses. Our participants reported different sources of anxiety, but most of them originated from their work roles. According to Labrague & De Los Santos,²⁵ since frontline nurses are directly involved in patient care, their risk of contracting COVID-19 is higher than the general population. This data showed that the anxiety experienced by these frontline nurses was related to the crisis they were in. Adding to this is the overall experience in caring for COVID-positive patients. Loneliness was also evident in most of our participants as they were subjected to self-isolation following the mandates of their respective institutions. Others also reported being "lonely" due to the discrimination they feel in their community. Fear was also one of the subthemes under the theme. Our findings showed that the fear they felt originated from exposure to COVID-positive patients. While fear helps motivate individuals to respond effectively to a given threat or stimuli, extreme and persistent fear may result in adverse psychological reactions such as stress, depression, and anxiety.

Theme 4: Resilience from Experience

Resilience is a biopsychosocial phenomenon encompassing personal, interpersonal, and community experiences.²⁶ This theme focuses on how experience affects resiliency, especially with stigma. Our participants from the community setting share a common denominator: they believe they can handle the stigma well because of their years of experience in the field. Most of our participants from the community setting have at least five years of experience as a nurse.

"My experience in the field made me realize that this is part of our job" (Nurse N.P.); "I don't feel anything for myself since I've been a nurse for so long that this kind of feeling is normal" (Nurse V.C). "This is nothing new for me (being discriminated), that's what they always say to us, and it's been like that since I started working (Nurse S.P).

Some participants consider the experience an opportunity to improve their practice as nurses, care providers, and health educators. The following significant statements imply that the participants display true

resiliency to fight against the stigma while maintaining an optimal level of working capability.

"I'm more motivated to educate them so that they won't feel that way around us (Nurse S.G.)"; and "I still take care of my patients even though they think that I am the source of the virus (Nurse B.T)."

After thoroughly classifying significant statements, the last theme was Resilience from Experience. This was one of the most important findings we could come up with. There are currently no studies discussing how an accumulation of experiences promotes resiliency. Although we have arrived at this uniquely identified theme, our research questionnaire was designed to extract narratives of 'what' and 'how' COVID-related stigma was experienced among frontline nurses.

Composite Textural-Structural Description of the COVID-19 related Stigma Experience

The phenomenon examined in this study entirely focuses on how the COVID-associated stigma was experienced across various contexts of nurses working on the frontline. After imaginative variation, structural themes were revealed based on the participants' textural descriptions. These are structures of time and space, relation to self, others, bodily concerns, and causality.

The first structure identified in the synthesis of the individual structural description was the structure of *time and space*. This structure focused on the "when" and "where" COVID stigma was experienced and further related it to "how" it was shared during specific times and places.

The experience of stigma surged in the same manner as the first wave of the pandemic. The stigma's precursor was the lack of factual information and the ever-changing protocols implemented. Their line of work as carers predisposes contact with the virus, which leads to being feared by the public. Additionally, the challenging and physically draining work situation they were in and augmented by the experience of social stigma exhausted these nurses to pity themselves, hence the development of self-stigma.

The structure of *relation to self* is another structure that could explain the experience of stigma among frontline nurses. It pertains to how the participants themselves can source the experience of stigma. Their values, beliefs, and attitude toward the stigma, how they initially perceive it, and how they absorb or react against it determine the experience. Most hospital frontline nurses felt anxious and fearful regarding COVID-19 stigma, which may be understandable because symptomatic patients are under their care. In contrast, community health nurses perceived the COVID stigma as a force that motivates them to provide better care for their patients and the public.

The structure of *relation to others* is contributory to the experience of stigma. Through this structure, the researchers focused on how the COVID-related stigma impacted the frontline nurses' relationships with others. Primarily, this structure aims to explain how COVID-19-related stigma can be sourced and how their relationship is affected by it. The structure of relation to others pertains to (1) Family, (2) Friends, (3) Co-workers, (4) Public, and (5) Significant others and Patient. These groups have a direct impact on how frontline nurses experience COVID-19 stigma. These sources contributed to stigma per se, while some served as an anchorage and inspiration to do better.

The bodily concern is another structure in the lived experience of frontline nurses experiencing COVID-related stigma. The high virulence and transmissibility of the virus and the lack of treatment are significant factors of the COVID-associated stigma. The vulnerability of their tired and overly exhausted bodies due to extended duty periods and the lack of PPEs is tantamount for these nurses to fear for themselves and their families.

The *causality* structure aimed to explain how the frontline nurses' perceptions of COVID-19 stigma influence their lived experience. Furthermore, it also focused on extracting the cause of what they have experienced to trace its whereabouts. Frontline nurses were significantly affected by being stigmatized due to the nature of their job. However, their caring qualities were not affected as they believe it is part of being a frontline nurse.

The Essence of the Experience

The essence of the experience is to describe what and how frontline nurses experienced COVID stigma. The essences of the stigma focus on the themes: Social Stigma, Self-Stigma, Psychological and Emotional effect of COVID stigma, and Resilience from Experience. As the first essence, social stigma is described as a form of stigma that comes from an external factor. Social stigma, in a sense, involves the structure of relationships with others.

The second essence revealed is the Self-Stigma. This is another form of stigma in which frontline nurses tend to stigmatize themselves due to a perceived threat of direct stigma from an external factor due to the preconceived fear and anxiety in their minds. Therefore, this essence involves the structures concerning self and others.

The third essence that emerged was the psychological and emotional effect of COVID stigma. Furthermore, we have classified these effects into three sub-themes; anxiety, loneliness, and fear. As frontline nurses are engaged on the battlefield against COVID-19, they can't help but feel anxious and fear the possibility of acquiring the disease. Loneliness is also an evident finding that frontline nurses often experience due to the stigma that originated both from an external (Social Stigma) and internal (Self-Stigma) source.

The last essence that emerged from the breadth of our composite textural-structural descriptions is resilience from experience. This is described as the capacity of frontline nurses to recover quickly from negative experiences brought about by the stigma. The resilience was developed over time through their individual experiences.

These four essences serve to define what COVID stigma is. Knowing what it looks like and how it was experienced is crucial in combatting the stigma and ultimately getting rid of it. The identified essences of the participants' experience transcend from initially experiencing what stigma is sourced from their surroundings: patients, co-workers, social circle, and society. This experience of social stigma extends the development of self-stigma, leading to negative consequences such as fear, anxiety, and loneliness. Nevertheless, it is evident in the narratives of these nurses how

they can surpass adversities through their strength and resilience

Conclusion

The frontline nurses are confronted with physical threats of the COVID-19 and are also experiencing psychosocial challenges on the bouts of stigma in public health emergencies. There is a need to give attention to these issues to design and implement interventions not to compromise patient care delivery. For instance, leaders in the health system in both hospital and community settings should consider supportive initiatives to mitigate the worsening of stigma and distress and improve the well-being of these frontline nurses. Alternatively, social support may be promoted by nursing organizations and health advocates to likewise create a concerned environment for these care providers. Health organizations must consider the undesirable ripple effect of a demoralized and stigmatized health worker. It is also an unsupportive work environment to their work performance and ultimately to patient safety

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