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# COVID-19 Health Protocol Training on the Competence of Village Community Leaders

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**ABSTRACT**

Indonesia is a country with a fairly high rate of COVID-19 transmission. There are various efforts made by the government to control the transmission of COVID-19. These efforts still require support and countermeasures such as maximizing the involvement of community leaders. This study aims to identify the competence of community leaders which includes knowledge, skills and attitudes and then analyze the effect of COVID-19 health protocol training on the competence of community leaders. This research is a quantitative study with a quasi-experimental design with a one group pre-test-post-test design. There was no comparison group (control) but the first observation (pre-test) was carried out before giving the intervention and a post-test was carried out. The intervention carried out was training on COVID-19 health protocols. The population in this study were all community leaders who live in the village of Gheo Goma and the sampling in this study used a purposive sampling technique. The instruments used in this study were questionnaires and the SOP for the COVID-19 health protocol. Data analysis used dependent t-test (paired t-test). The results of the analysis showed that the p value of the knowledge variable was 0.0851, the attitude variable was 0.415 and the skill variable was 0.234 ( $>0.05$ ). There is no difference in the competence of community leaders in preventing or managing non-natural disasters Covid-19 before and after being given COVID-19 health protocol training.

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## INTRODUCTION

Corona Virus Disease 2019 (COVID-19) has become a major global health problem. WHO (World Health Organization) has declared COVID-19 as a public health emergency that is troubling the world or also known as the Public Health Emergency of International Concern (KKMMD/PHEIC) 1. In addition, WHO also declared COVID-19 as a pandemic. The determination of the status of the pandemic is based on the widespread spread of transmission of cases that have infected 114 countries around the world, where previously the COVID-19 case was first detected in the city of Wuhan, People's Republic of China (Gugus Tugas COVID-19 RI, 2020)

Globally, data from the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University and Medicine (JHU) reported 163,714,589 confirmed cases and 3,392,575 deaths. Meanwhile, Indonesia ranks 18th with 1,748,230 confirmed cases and 48,477 deaths<sup>3</sup>. East Nusa Tenggara (NTT) Province is one of the provinces with a high number of confirmed COVID-19 cases in Indonesia. According to data from the task force for the acceleration of handling COVID-19 in NTT Province, the number of confirmed cases reached 16,068 cases and 448 cases died. Meanwhile, the COVID-19 case in Ende Regency, which was recorded as one of the regencies with a high number of confirmed cases and deaths, recorded 845 confirmed cases (Gugus Tugas COVID-19 NTT, 2021)

Indonesia has so far made many policies as an effort to control COVID-19. The policy is in the form of the formation of a task force for the acceleration of handling COVID-19 and Large-Scale Social Restrictions (PSBB) in the context of accelerating the handling of COVID-19 (Keppres, 2020). These government policies need to be supported and need to be supported by taking integrated countermeasures including the involvement of all components of society, such as community leaders, one of which is *satnnya*.

The still high attention of the village community towards the existence of community leaders is a huge opportunity and potential to change people's lifestyles, including implementing the COVID-19 health protocol. Community leaders have sufficient knowledge about COVID-19 which shapes their attitudes and behavior to be alert to the rapid spread of the virus and its effects. Community leaders have proactive behavior to invite the community to make efforts to prevent and overcome the impact of the pandemic, as well as provide examples of preventive actions through clean and healthy living behaviors and driving activities (Rosidin et al, 2020). The purpose of the research is to identify the competence of community leaders which includes knowledge, skills and attitudes and then analyze the effect of COVID-19 health protocol training on the competence of community leaders.

## RESEARCH METHOD

This research is a quantitative study with a quasi-expreminent design with a one group pre-test-post-test design. There was no comparison group (control) but the first observation (pre-test) was carried out before giving the intervention and a post-test was carried out. The intervention carried out was training on COVID-19 health protocols for community leaders using lecture, discussion, and practice methods. The training was conducted for 16 hours. The population in this study are all community leaders who live in the village of Gheo Goma with various forms of character. While the sample in the study was obtained from a predetermined population that met the inclusion criteria such as age at least 13 years, domiciled in the village of Gheo Goma, cooperative and willing to participate in the study (informed consent). Sampling in this study used a purposive sampling technique, namely the researcher took subjects who met the criteria in the study.

The instruments used in this study were questionnaires and the SOP for the COVID-19 health protocol. The questionnaire consists of 15 statements related to the COVID-19 health protocol. The questionnaire was made by the researcher himself so that it will be tested for validity and reliability. Validity and reliability tests were carried out on 30 respondents. Each question in the instrument used is said to be valid if  $r_{\text{count}} > r_{\text{table}}$ . Meanwhile, it is said to be reliable if Cronbach's Alpha value is  $> 0.60$ .

In this study, validity and reliability tests were carried out on 30 respondents consisting of 15 statements with answers 4 (Strongly Agree) 3 (Agree) 2 (Disagree) and 1 (Strongly Disagree). The assessment criteria in this study are good category worth 1 (68%-100%), moderate category 2 (34%-

67%) and less valuable category 3 (0%-33%). From the results of validity testing, it can be seen that  $r$  count  $>$   $r$  table so that all questionnaire questions are declared valid. While the results of the reliability test showed an alpha of 0.762, thus each question item that was declared valid was considered reliable because it had an alpha value greater than the value of  $r$  table (0.361).

The results of the normality test showed that the Shapiro-Wilk score on the pre-test measurement was 0.097 and the post-test measurement score was 0.054. While the pre-test measurement score in the control group was 0.058 and the post-test measurement score in the control group was 0.306. The results of the normality test showed that the pre- and post-test data in the intervention group, pre-test and post-test data in the control group had data that were normally distributed ( $p > 0.05$ ). The data were normally distributed in the pre-test and post-test measurements in the intervention group and the pre-test in the group was the result of eliminating data outliers or data that had extreme high or low extreme values. While the test results above indicate that the test has a significance of 0.271 or  $p > 0.05$ , it can be said that the variance of two or more groups of population data in this study is the same (homogeneous).

Data collection and collection procedures consist of preparation and administration stages, sample selection stages and data collection stages before intervention and then intervention, and data collection after intervention and data processing stages. The process of data processing through the process of editing, coding, scoring, processing and cleaning. 15 While the data analysis techniques used were univariate analysis and bivariate analysis using a t-test dependent (paired t-test) with the help of SPSS software version 16. Research ethics include Right to self-determination, Right to privacy and dignity, Right to anonymity and confidentiality, Right to fair treatment and Right to protect for discomfort and pain.

## RESULT AND DISCUSSION

### Results

#### a. Characteristics of Respondents

Characteristics of respondents include age, gender, education, respondent's occupation, and the respondent's employment status, years of service and the province of origin of the respondent.

**Table 1.** Distribution Of Respondents By Age, Gender, Education, Marital And Employment Status.

Variable	F	%
<b>Age (Years)</b>		
<20	1	2,9
20-40	13	37,1
40-60	20	57,1
>60	1	2,9
Total	35	100,0
<b>Sex</b>		
Male	13	37,1
Female	22	62,9
Total	35	100,0
<b>Education</b>		
Primary school	3	8,6
Junior high school	7	20,0
Senior high school	19	54,3
Higher education	6	17,1
Total	35	100,0

<b>Marital status</b>		
Marry	32	91,4
Not married	3	8,6
Total	35	100,0
<b>Employment status</b>		
There isn't any	32	91,4
Civil servant	2	5,7
Honorary	1	2,9
Total	35	100,0

Source: Primary data 2022

Based on table 1 above, it shows that the distribution of respondents based on age is 40 to 60 years, namely 20 respondents (57.1%). As for gender, the majority of respondents were female as many as 22 respondents (62.9%). Based on the level of education, the distribution of respondents mostly has a high school education level, which is 19 respondents (54.3%), the distribution of respondents based on marital status is the majority unmarried, which is 32 respondents (91.4%) and the distribution of respondents based on employment status shows that the majority of respondents are not married. have an employment status of 32 respondents (91.4%).

**Table 2.** Distribution Of Respondents Based On Knowledge, Attitudes And Skills.

Variable	Pre Test		Post Test	
	F	%	F	%
<b>Knowledge</b>				
Not enough	0	0,0	0	0,0
Enough	2	5,7	1	2,9
Well	33	94,3	34	97,1
Total	35	100,0	35	100,0
<b>Attitude</b>				
Not enough	0	0	0	0
Enough	2	5,7	2	5,7
Well	33	94,3	33	94,3
Total	35	100,0	35	100,0
<b>Skills</b>				
Not enough	0	0	0	0,0
Enough	2	5,7	1	2,9
Well	33	94,3	34	97,1
Total	35	100,0	35	100,0

Source: Primary data 2022

Based on table 2 above, it shows that the frequency distribution of the respondent's knowledge variable before being given an intervention shows the majority of good categories, namely 33 respondents (94.3%) and knowledge after the intervention is in the good category as well as 34 respondents (97.1%). The attitude variable of the respondents before and after the intervention showed the same category, which was both in the good category of 33 respondents (94.3%). Meanwhile, the skill variable of the respondents before the intervention showed the majority of good categories, namely 33 respondents (94.3%) and the skills after the intervention were in the good category as well as 34 respondents (97.1%).

b. Difference of Knowledge, Attitudes and Skills of Respondents Pre and Post Covid-19 Health Protocol Training

The knowledge, attitudes and skills of respondents before and after the Covid-19 health protocol training were tested using the dependent sample t-test (Paired t test) with the results as illustrated in the table below.

**Table 3.** Knowledge, attitudes and skills of respondents before and after Covid-19 protocol training

Variable	Mean	N	SD	SE	P Value
<b>Knowledge</b>					
Pre test	16,29	35	1,792	,303	0,085
Post Test	17,20	35	2,069	,350	
<b>Attitude</b>					
Pre test	16,60	35	2,089	,353	0,415
Post Test	17,06	35	2,086	,353	
<b>Skills</b>					
Pre test	16,23	35	1,750	,296	0,234
Post Test	16,74	35	2,119	,358	

\* Meaning to  $\alpha = 0,05$

The results of the analysis above show that the p value for the knowledge variable is 0.0851 and the p value for the attitude variable is 0.415. While the p value for the skill variable is 0.234, so it can be concluded that there is no significant difference between the knowledge, attitudes and skills of respondents before and after being given an intervention in the form of Covid-19 protocol training ( $> 0.05$ ).

c. Differences in Competence of Respondents Pre and Post Covid-19 Health Protocol Training

Knowledge and skills after being given the intervention have been tested using the Independent T-test and get the results as illustrated in Table 4 below.

**Table 4.** Differences in Competence of Pre and Post Test Respondents

Variable	Mean	N	SD	SE	P Value
<b>Community Leader Competence</b>					
Pre Test	49,11	35	4,516	,763	0,156
Post Test	51,00	35	5,568	,941	

\* Meaning to  $\alpha = 0,05$

The results of the statistical test dependent t test (paired t test) obtained the p value of community leaders' competence of 0.156. So it can be concluded that there is no significant difference between competencies before and after being given treatment in the form of Covid-19 health protocol training or  $H_a$  was rejected.

## Discussions

### Characteristics of Respondents

Distribution of respondents based on age, namely 40 to 60 years, namely 20 respondents (57.1%). As for gender, the majority of respondents were female as many as 22 respondents (62.9%). Based on the level of education, the distribution of respondents mostly has a high school education level, which is 19 respondents (54.3%), the distribution of respondents based on marital status is the

majority unmarried, which is 32 respondents (91.4%) and the distribution of respondents based on employment status shows that the majority of respondents are not married. have an employment status of 32 respondents (91.4%). There are several factors that influence the level of community capacity in dealing with landslides, namely age (0.00), gender (0.00), education level (0.00), income (0.00), type of house (0.00), and experience dealing with disaster events (0.027) (Setiawan, 2014)

The factor of total income and education level has a positive constant value, which means, the higher the level of education and income, the higher the level of capacity. The constant in the house type variable is negative, which means that residents with permanent housing types have a higher capacity level than residents with non-permanent or semi-permanent housing types (Setiawan, 2014). Another study stated that there was a positive correlation between family income and life insurance measures ( $r = 0.154$ ;  $\text{sign} < 0.01$ ) and property insurance ( $r = 0.232$ ;  $\text{sign} < 0.01$ ). The findings of the field study also show that insurance service providers generally do not want to provide loans or insurance to residents who live in the study location due to the history of floods that often hit this area. Second, there is a positive correlation between the level of education with the act of dividing the task ( $r = 0.190$ ;  $\text{sign} < 0.01$ ) and the act of preparing various emergency equipment ( $r = 0.167$ ;  $\text{sign} < 0.01$ ). This means that residents who have higher education (junior high school, high school, and bachelor's degree) tend to take preparedness actions by dividing tasks for each family member and preparing various emergency equipment. The study findings show that education affects the community in taking preparedness actions. Third, there is a positive correlation between the age of the population and the act of preparing land/houses elsewhere ( $r = 0.162$ ;  $\text{sign} < 0.01$ ) and preparing life insurance ( $r = 0.163$ ;  $\text{sign} < 0.01$ ). This means that residents who have a relatively mature age tend to take preparedness actions by preparing land/houses in other places and insuring their lives. The findings of the study of the effect of age are the length of time they have lived in the study location which encourages them to prepare a new location that is safer and free from disasters (Nizar, 2013). Distribution of Respondents Based on Knowledge, Attitudes and Skills Before and After the Covid 19 Health Protocol Training Intervention was given.

The frequency distribution of respondents' knowledge of variables before the intervention was given showed the majority of good categories, namely 33 respondents (94.3%) and knowledge after the intervention was in the good category as many as 34 respondents (97.1%). The attitude variable of the respondents before and after the intervention showed the same category, which was both in the good category of 33 respondents (94.3%). While the skill variable of the respondents before the intervention showed the majority of good categories, namely 33 respondents (94.3%) and the skills after the intervention were in the good category as well as 34 respondents (97.1%). Pengetahuan Responden Sebelum dan Setelah Diberikan Intervensi Pelatihan Protokol Kesehatan Covid 19.

The results of the analysis show that the p value of the knowledge variable is 0.0851 or there is no significant difference between the respondents' knowledge before and after being given an intervention in the form of Covid-19 protocol training ( $> 0.05$ ). The results of research conducted by Juliandi concluded that the variable that has a relationship with community preparedness in dealing with a disease outbreak is knowledge (Radhi et al., 2019). Knowledge is the result of knowing, which occurs after people sense a certain object. Sensing occurs through the five human senses, but mostly through a process, namely the learning process and requires assistance, for example the help of someone who has more control over something, the help of tools such as books and so on. Research conducted by Radhi et al stated that there was a relationship between knowledge and nurse preparedness to face malaria outbreaks (Radhi et al., 2019). While the results of Erika et al's research stated that there was a relationship between knowledge and the risk of contracting Covid-19 in the

people of North Sulawesi with a p value (0.000). Good, positive knowledge from the community in dealing with the Covid-19 pandemic can make people take concrete actions to reduce the risk of contracting Covid-19 (Sembiring & Nena Meo, 2020).

Factors affecting community disaster preparedness consist of 1) knowledge of disaster preparedness, 2) attitudes towards disaster preparedness, 3) policies and guidelines, 4) plans for disaster emergencies, 5) disaster warning systems, and 6) resource mobilization. (Hakim Husen et al., 2020). Communities in general have local knowledge that is passed down from generation to generation in anticipating landslide events with various coping strategies, both structural (physical) and non-structural (non-physical) (Setiawan, 2014).

Lindell and Whitney (2000) show that there is a positive correlation between knowledge of the sources of hazards encountered and the actions taken regarding these hazards. That is, the individual who knows the source of the danger he faces is at risk to himself, then he will take preventive action to avoid the risk of the danger. Pearson correlation analysis was conducted to determine whether there is a relationship between knowledge of disaster sources and preventive actions taken by individuals or communities. The results of the analysis did not show a correlation between the two ( $r = -.094$ ;  $\text{sign} > 0.05$ ). This shows that respondents who know the source of the cause of flooding, do not necessarily take preventive actions to reduce the risk of flood disasters (Krishna et al., 2014). Paton (2003) modeled the determination of a person's preparedness for natural hazards starting from a person's perception to the cognitive processes that underlie behavior change and become a person's habit over time. A person's preparedness process in this model is divided into 3 phases, namely the motivation phase, the desire formation phase, and the phase of change from desire to preparation (Krishna et al., 2014).

Knowledge is one of the factors that influence a person's behavior and beliefs, besides that cognitive abilities shape a person's way of thinking, including the ability to understand the factors that influence illness and personal health practices. The higher a person's knowledge about the meaning of health and the benefits of health facilities, the greater the desire to use health facilities (Radhi et al., 2019).

#### **Attitudes of Respondents Before and After Being Given the Covid 19 Health Protocol Training Intervention.**

The results of the analysis show that the p value of the attitude variable is 0.415 or there is no significant difference between the attitudes of respondents before and after being given an intervention in the form of Covid-19 protocol training ( $> 0.05$ ). Attitude is an individual's closed response to a particular stimulus or object that involves aspects of opinion and emotion. Attitude can be said as a syndrome or a collection of symptoms in response to a stimulus or object. Attitude also refers to an individual's response to something, and that response involves thoughts, feelings, concerns and other psychological symptoms. Attitude is an individual's readiness or willingness to act and is not the implementation of a particular motive. Attitude is not yet an action or activity, but it is a predisposition to a behavior (Rosidin et al., 2020).

Attitude is also defined as a person's view or determination of an object which will be followed by action after there is a stimulus to act. A positive or accepting attitude will make a person carry out activities or actions as required, enjoy, passionate in carrying out, think creatively and innovatively and have a sense of responsibility. A person's attitude will have a direct effect on behavior, depending on what conditions, time and situation (Radhi et al., 2019). Research conducted by Hermawati concluded that a positive attitude tends to cause people to be more responsive to dengue outbreaks. Research conducted by Radhi et al stated that there was a relationship between

attitude and nurse preparedness in dealing with malaria outbreaks (Radhi et al., 2019). While the results of Erika et al's research stated that there was a relationship between attitude and the risk of contracting Covid-19 in the people of North Sulawesi with a p value (0.000). A positive attitude from the community in dealing with the Covid-19 pandemic can make people take concrete actions to reduce the risk of contracting Covid-19 (Sembiring & Nena Meo, 2020)

### **Respondents' Skills Before and After Being Given a Covid 19 Health Protocol Training Intervention.**

The results of the analysis show that the p value of the skill variable is 0.234 or there is no significant difference between the knowledge, attitudes and skills of respondents before and after being given an intervention in the form of Covid-19 protocol training ( $> 0.05$ ). Lack of community skills for preparedness in dealing with disasters, namely due to lack of human resource capacity, skills or skills are skills that must be possessed by someone to do their work in their respective fields of duty (Hakim Husen et al., 2020).

The community is required to have adequate disaster management skills. People skills are very important in the event of a disaster and disaster victims (Ibrahim et al., 2020). Skills include Covid 19 health protocol behaviors such as consistent use of masks, refraining from leaving the house unless necessary, always washing hands with soap under running water, always providing disinfectant, taking a shower as soon as possible after leaving the house, not making physical contact, keeping a distance, limiting the number of passengers in the vehicle, maintaining the immune system through adequate nutritional intake and regular exercise. Skills also include periodically seeking information related to COVID-19 case updates (Utami, 2020).

### **Competence of Respondents Before and After Being Given a Covid 19 Health Protocol Training Intervention.**

The results of the statistical test showed that the p value of the competence of community leaders was 0.156 or there was no significant difference between the competence of the respondents before and after being given treatment in the form of Covid-19 health protocol training or  $H_0$  was rejected. Some aspects of competence are skills, individuals who have something in completing the tasks assigned to them (Azimmi & Zaitul, 2020).

Factors that affect a person's competence in disaster management include cognitive abilities, attitudes (affective), and psychomotor (skills). Capacity building and skills can be done through related training, training that is carried out continuously will make a person skilled, so that the skills possessed related to disaster management can be used if needed at any time (Hakim Husen et al., 2020).

The purpose of community-based Covid 19 disaster management is to increase public awareness and preparedness, strengthen the ability to deal with Covid 19, especially in collaboration with various parties, develop disaster organizations adapted to local conditions, increase public knowledge about disasters (Ibrahim et al., 2020). Community leaders have a very strategic role in increasing the active role of the community in handling the Covid disaster. Community leaders are people who have a big role in a community group and have power, namely the ability to influence other people or groups according to their wishes.

The role of community leaders, among others, is as a social controller, guardian and enforcer of values and norms that apply in society. In addition, community leaders also play a role in solving various problems that occur. Community leaders have an obligation to provide support, guidance,

motivation and direction to the community. Community leaders also act as support providers. The support of community leaders is divided into emotional support, appreciation support, instrumental support and informative support. Emotional support is indicated by expressions of empathy, concern and concern. Appreciation support is indicated by expressions of respect and encouragement to move forward. Instrumental support is indicated by providing direct assistance according to community needs. Informative support is indicated by providing advice, instructions, suggestions and feedback (Rosidin et al., 2020). The knowledge, attitudes, and actions of community leaders in the context of preventing Covid-19 describe their behavior. This behavior then encourages them to carry out their role in society in prevention efforts. One form of that role is to provide support related to prevention and control efforts (Rosidin et al., 2020).

## CONCLUSION

Based on the results of the analysis, the Covid-19 health protocol training has no effect on the Covid-19 health protocol training on the competence of community leaders in preventing or managing Covid-19.

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Based on the results of the analysis, the Covid-19 health protocol training has no effect on the Covid-19 health protocol training on the competence of community leaders in preventing or managing Covid-19.

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