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Preventive Measures and Handling of COVID-19 and Emerging Disease in the Border Areas of West Kalimantan Province Entikong District and Jagoi Babang District

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Abstract

One of the country's entry points is the National Border Post (PLBN), which is the main key in preventing the entry of the COVID-19 pandemic into Indonesia because many people come and go from various places so that the country's entrance in border areas becomes one of the places at risk of spread. COVID-19 virus such as in Entikong District and Jagoi Babang District. This research was conducted to determine the description of knowledge, attitudes, prevention efforts, health service facilities and health promotions in the Entikong and Jagoi Babang border areas, determine the influence of prevention efforts on the incidence of COVID-19, determine the influence of health service facilities and health promotions on the incidence of COVID-19 and find out the reality of implementing 3T. This research uses a mix method research design, namely a research step that combines two forms of research approaches, namely qualitative and quantitative. The sampling technique used purposive sampling with a total of 156 respondents who were divided into two groups, namely the case group and the control group. The following is a description of the research results, namely: 1) The case group in the Entikong border area has the highest presentation of low knowledge, poor attitude presentation, poor presentation of prevention efforts, and poor health facility presentation compared to the Jagoi Babang border area and the two regions combined, 2) There is a significant influence in efforts to prevent the incidence of COVID - 19, 3) There is a significant influence of health service facilities and health promotions in preventing the incidence of COVID - 19, 4) There are factors that encourage and hinder someone from carrying out a COVID - 19 test in the area borders, 5) There are obstacles in implementing the handling of COVID - 19 in border areas, and 6) There are problems in implementing handling of COVID - 19 in border areas..

Keywords: *COVID-19, Handling, Preventive Measures, The Border Areas*

1. INTRODUCTION

Health can be influenced by several factors, namely: heredity, health services, behavior and environment. Health development aims to increase awareness and willingness to live a healthy life for each population in order to realize a more optimal health status. By doing so, the community is expected to be able to participate more actively in maintaining and improving their health status so that the community is able to become a subject in health development (Budiyanto, 1992). Conversely, the community can also be a subject in spreading viruses that can cause disease. The number of people in one place can increase the opportunity for the spread of viruses, such as COVID - 19.

COVID-19 can be transmitted from one individual to another through coughing/sneezing droplets. In addition, people can also be infected by touching surfaces that have been contaminated with the covid-19 virus and then touching the face such as eyes, nose, and mouth). Through the application of physical distancing such as staying away from gatherings or crowds, avoiding mass meetings, and maintaining distance from other people can reduce the risk of being infected with COVID-19 (Islam et al., 2020). One of the important things in controlling COVID-19 is the implementation of COVID-19 handling protocols. The protocol is the main "weapon" for field officers who are in border areas or entrances to Indonesian territory. Without a clear protocol, the spread of COVID-19 entering Indonesia will be very difficult to control. Through the issuance of COVID-19 handling protocols at the entrance to Indonesian

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territory (Airports, Ports, and PLBN), the government hopes that all crossers must follow the SOP at official doors (Airports, Ports, and PLBN).

In terms of borders and entry points, it appears that Indonesia has been neglectful. Between January and February 2020, several countries announced the first cases of COVID-19 in their countries and prepared to "fight" against the virus. Other countries have also begun to tighten human traffic at their borders. Some countries neighboring Iran (Afghanistan, Iraq, Turkey, Pakistan), for example, even closed their borders. Meanwhile, during the same period, the Indonesian government claimed that no COVID-19 cases had been found in Indonesia, and there were no measures to tighten borders or restrict flights from abroad. The ban on flights from all of China only took effect on February 5, 2020, although previously it had also banned migrants from Hubei Province (Djalante et al., 2020). Even though at that time, in Indonesia's neighboring countries such as Malaysia and Singapore, COVID-19 cases had been found. Instead of tightening borders or limiting human traffic at the entrance to Indonesia, towards the end of February 2020 the government plans to pour 298.5 billion in incentives for the tourism sector to boost foreign tourists entering Indonesia. This plan is certainly inversely proportional to other countries that are racing to tighten the entrance to their countries. However, this plan could not go smoothly because on March 2, 2020 President Joko Widodo announced the first COVID-19 case to occur in Indonesia (Nasution, 2020).

The country's entrances, in this case ports, airports, and Cross Border Posts (PLBN) are the key to preventing the entry of the COVID-19 pandemic into Indonesia because of the large number of people coming and going from various places so that the country's entrance is one of the places at risk in spreading the COVID-19 virus. The current era is equipped with transportation that is so modern and massive that it allows the rapid movement of human mobilization every time, even for mobilization between countries. No wonder the spread of COVID-19 happened so quickly, spreading from the Asian continent to all other continents. Therefore, the function of borders or entrances during a pandemic is not only limited to a control function that regulates the traffic of people and goods, but also controls the spread of COVID-19. The challenge lies in the fact that the existing protocol lacks clear Standard Operating Procedures (SOPs) for categorizing official cross-border routes. Moreover, there exist unofficial cross-border routes, often exploited for illegal activities, commonly referred to as 'rat routes' or traditional routes.

In fact, the traditional route is widely used by border communities who go back and forth every day to barter goods, buy staples, work in plantations or fields in neighboring countries. They usually leave in the morning and return home in the afternoon. Based on observations found in the field, the facts show that the uneven implementation of the COVID-19 pandemic protocol on all crossing routes has led to suboptimal results in efforts to deal with the pandemic. As happened in Pineleng Subdistrict, during the implementation of restrictions on community activities (PPKM), it was found that man people were not disciplined in implementing PPKM, for example, some left the house without wearing a mask, did not maintain distance, and made celebrations that caused crowds (Entjaurau et al., 2021). This has weakened the enforcement of health protocols. Therefore, the "rat" crossing route was closed in an effort to prevent weakening the enforcement of the COVID - 19 pandemic protocol.

The Governor of West Kalimantan has issued West Kalimantan Governor Decree Number 250 of 2021 concerning the Establishment of a Special Task Force for Handling COVID-19 at the West Kalimantan Border specifically at the Border on March 19, 2021 and began working as an effort to control COVID-19, especially for Indonesian migrant workers arriving at the border. This is a follow-up to the presence of 69 COVID - 19 positive Indonesian migrant workers (PMI) out of 108 Indonesian migrant workers deported by the Malaysian Government through the Entikong Cross Border Post (PLBN), Sanggau Regency, West Kalimantan (Kalbar) (Cipta & Arief, 2021).

West Kalimantan itself has five border crossings, namely Sambas Regency, Bengkayang Regency, Sanggau Regency, Sintang Regency and Kapuas Hulu Regency. Data from the West Kalimantan Province Covid-19 task force as of January 1, 2022 are as follows:

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Table 1. Covid 19 data

STATUS	SAMBAS	BENGKAYANG	SANGGAU	SINTANG	KAPUAS HULU
Positive	3226	2817	2444	3071	752
In Treatment	1	1	0	0	0
Recover	3191	2803	2412	2876	737
Passed Away	34	13	32	195	15

The border area that is very close to Malaysia is Entikong Sub-district. Entikong Sub-district has an area of 506.89 Km2 or about 3.94% of the total area of Sanggau Regency. The population of Entikong sub-district is 18,166 people, with a male population of 9,542 people and a female population of 8,624 people (Sanggau, 2018). Despite the sizable population of Entikong Sub-district, some crucial infrastructures, such as healthcare, are still significantly limited. There is only one health center to serve the entire population of Entikong Sub-district. In addition, the people of Entikong region are also dependent on neighboring countries in terms of fulfilling their basic needs. They tend to buy sugar, oil, gas and rice from Malaysia because of the cheaper price and quality (Djuyandi et al., 2023). Besides Entikong Sub-district, there is another border area close to Malaysia, namely Jagoi Babang Sub-district.

Jagoi Babang Village, Jagoi Babang Sub-district, Bengkayang Regency is one of the country's border points in West Kalimantan Province. PLBN is a post office as well as a place to control the entry and exit of people and goods at the border of Indonesia and Malaysia. Jagoi Babang District is located in the northeast of Bengkayang Regency, the border gate is located in Jagoi Babang District which faces the Sirikin district which is the state of Serawak, Malaysia (Kurniadi et al., 2017). The total population in Jagoi Babang District is 11,717 people, consisting of a male population of 6,415 people and a female population of 5,302 people. The Jagoi Babang border area is a border area that has considerable interaction with neighboring countries, both in terms of trade, labor movement, and kinship relations. Hence, in pandemic conditions, this area becomes quite a dilemma. Where it is strategic for the back and forth of various human interactions, but on the other hand, it is the most vulnerable area for the entry of COVID-19.

Traditional borders do have a relatively more "fluid" spatial function than formal borders. Precisely because it is more "fluid", cross-border closure efforts are the final choice to facilitate pandemic control. The choice to close traditional crossings is done in order to break the COVID - 19 pandemic chain, which if the crossing remains open, it will increase the potential for people to be exposed to COVID - 19 and it will be more difficult to break the chain (Yuniarti, 2019). However, this closure has a more severe impact on survival. The consequences of this closure render the economic vitality of border communities highly vulnerable. This is related to the importance of cross-border activities carried out by people on the border with neighboring countries in fulfilling their needs, especially those bound by kinship relationships.

In relation to fulfilling the needs of border communities, it is also necessary to consider making efforts to improve the existing infrastructure at the border. The development of good infrastructure, including health support infrastructure, is very much needed by border communities given their vulnerable position to infectious diseases that enter from border crossings. Another concern is the lack of personnel on duty in border areas, especially in traditional routes. The availability of sufficient personnel is important in enforcing COVID-19 handling protocols in border areas.

There have been many studies conducted on the role of local governments in preventing and dealing with COVID-19, one of which is a study conducted by Ginanjar (2020) with the aim of assessing the strategies that have been implemented by the central and local governments in handling COVID-19. This study revealed that due to decentralization in the health sector, health service standards can vary depending on the commitment and fiscal capacity of the region. Because of this, there can be inequalities in health services between regions, so a review of the granting of regional authority over medical services is needed. Although local governments have been given the authority to manage health services, the central government should always ensure that every citizen has their basic health services fulfilled. Border areas should be a major concern to prioritize strengthening public health through strengthening

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and handling pandemics. Handling the pandemic is also prioritized to support the needs of those who are isolated in the midst of a pandemic.

As a border area frequented by many people, it should be given protection from the COVID-19 virus. That way, the spread of the COVID-19 virus at the border does not spread quickly. For this reason, it is necessary to know what has been done to prevent and deal with COVID-19 in the border area. Based on this, the researcher is interested in conducting research with the title "Prevention and Handling Measures for Covid-19 and Emerging Disease in the Border Areas of West Kalimantan Province (Entikong District and Jagoi Babang District). The objectives contained in this study are First to analyze the effectiveness of current preventive measures implemented in Entikong and Jagoi Babang districts to mitigate the spread of COVID-19 and emerging diseases. This Purpose analyze the factors that influence the incidence of COVID-19 in border communities and to analyze the implementation of the KKMMD policy through the COVID-19 pandemic study.Second to propose recommendations for improving preventive measures and handling of COVID-19 and emerging diseases in the border areas.

2. METHOD

2.1. Research Type

This research is a mixed methods research, which is a research step by combining two forms of approaches in research, namely qualitative and quantitative. Mixed research is a research approach that combines qualitative research with quantitative research (Creswell, 2010). Meanwhile, according to Sugiyono (2011), mix methods is a research method by combining two research methods at once, qualitative and quantitative in a research activity, so that more comprehensive, valid, reliable, and objective data will be obtained. The mix methods approach is needed to find problems in the field that will provide new understanding for each Covid-19 prevention and control activity program in the government area of Entikong District, Sanggau Regency as an option to solve the problem.

This study used a stepwise mixed technique. According to Creswell (2010), this is a strategy where the researcher combines data found from one method with another. This strategy is obtained with an observational analytic epidemiological research design using a program evaluation study design and qualitative which basically tries to observe, understand the preventive measures that have been taken by the local government in carrying out effective handling in preventing and accelerating the handling of Covid-19 in the border area of West Kalimantan, especially Entikong District.

In addition, data collection was also carried out qualitatively using a phenomenological approach (Merriam, 2002). According to Kuswarno (2007), the phenomenological approach was carried out to see the meaning of the informants' experiences, especially those related to Testing, Tracing, Treatment in the border area during the COVID-19 pandemic.

2.2. Research Respondents

The population in this study are people who have been infected with the COVID - 19 virus in border areas, in West Kalimantan Province in 5 districts, namely Bengkayang Regency, and Sintang Regency. According to data from the West Kalimantan Provincial Health Office, the number of cases in the 5 regions is 18,923 with the following details:

Table 2. Population Size of COVID-19 Cases in Border Areas

Disctrics	**Number of Cases**
Bengkayang	5889
Sintang	4355
Total	**18923**

The sampling technique in this study was selected by purposive sampling. Purposive sampling is a sample selection technique with certain considerations (Sugiyono, 2011). In this case, this study has several considerations in selecting the required samples, namely case and control samples.

Based on calculations, the number of samples in this study was 156 people in 2 border areas of Bengkayang and Sanggau Regencies, consisting of Case and Control samples, as follows:

a. Case Sample
   1) Based on calculations using the application, the sample results are 52 residing in the border area of Sanggau and Bengkayang Regencies.
   2) Aged 21-65 years and >65 years, because some people infected with covid-19 from secondary data obtained from the Bengkayang Regency and Sanggau Regency Health offices are aged 21-65 years and >65 years.
b. Control Sample
   1) People who have never been infected with covid-19 and some of the neighbors of cases numbered 104.
   2) Subjects willing to participate in the study.
c. Research Informants
   Informants selected to be respondents or informants are those categorized as: (1) Survivors and non-survivors; (2) Health Officers in Border Areas; (3) Apparatus in charge of Government organs located in border areas; and (4) informal figures such as religious and traditional leaders.

2.3. Data Collection

In this study, researchers employed both quantitative and qualitative approaches. With these two approaches, two types of data were obtained, namely primary data and secondary data. According to Riadi (2016), primary data is data obtained from the source and collected by the first person directly, while secondary data is data obtained indirectly from research subjects such as internet sites or references that are the same as the subject under study. Primary data was obtained by interview using a questionnaire sheet to obtain data on the knowledge of the head of the family and data on the attitude of the head of the family. Meanwhile, secondary data was obtained by collecting data from the puskesmas, agency, or sub-district office, the village head's office in the form of location, address and number of family heads.

The process in this research began with research preparation by looking for an appropriate quationare to measure Knowledge, Attitude, and Provision of Health Service Facilities in Jagoi Babang and Entikong**.** When all scales are appropriate, then proceed with conducting the research. The quetionare is given to subjects who meet the criteria. The research implementation phase began in a month, with questionnaire distributed online using Google Forms. Each respondent received a quetionnare and personal data that each respondent could fill in. The scores obtained are from the subject's answers. The questionnaire in this study contains 20 statements with two answer choices, namely true and false. Respondents can choose one of the two answer options by giving a check mark (√) on one of the answer options. There are several topics in the questionnaire, namely:

a. Respondent Characteristics, containing respondent's personal data
b. Statements regarding the level of public knowledge of the incidence of COVID – 19
c. Statement regarding the level of attitude towards the incidence of COVID – 19
d. Statements regarding health facilities and sources of information
e. Statements regarding COVID - 19 prevention efforts.

The next stage is processing the data that has been obtained, consisting of personal data. In addition, the data collection technique in this study was to interview informants in depth with an interview guide which was conducted with a duration ranging from 45-60 minutes.

2.4. Data Analysis

The data that has been obtained is processed in several ways, such as: editing, scoring, coding, and tabulating. Editing is checking the data for completeness, clarity of meaning of answers, consistency and errors between answers on the questionnaire. Scoring is the distribution of scores to answers that require scores. Coding is giving a sign or code to facilitate data processing or converting data from sentence or letter form into number or number data. Tabulating is grouping data into tables according to

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characteristics to facilitate data identification. After the data has been processed, then the data is analyzed according to the type of data.

Quantitative data were analyzed using both univariate and bivariate analysis. Univariate analysis, Analyzing the existing variables descriptively which has ordinal scale data by calculating the frequency distribution in tabular form which includes knowledge, attitudes, prevention facilities, and covid-19 prevention efforts. Meanwhile, bivariate analysis was carried out to test the relationship between the independent variable and the dependent variable with the chi square ($\chi 2$) statistical test, to determine the significant relationship between each independent variable and the dependent variable. The chi-square test is used when the research data consist of frequencies in the form of categories, either nominal or ordinal. This test is also used to determine the significance of two or more variables.

Meanwhile, qualitative data was analyzed using the theory from the opinion of Merriam (2002) and Sugiyono (2011), that qualitative data analysis techniques include: 1) interview data from respondents, 2) all interview results are transcribed, 3) look for and find patterns in each interview text, 4) reduce data, 5) classify by coding data (coding), 6) formulate data coding results (axial coding) and 7) conclusion, drawing / verification.

3. RESULTS

3.1. Quantitative

3.1.1. Respondent Characteristics Gender

The percentage of males in the case group in the Entikong border area was the highest, namely 70%, compared to the Jagoi Babang area and the combination of the two areas, namely 40% and 54%. This is in line with research conducted by Putri et al. (2021), where men have the same risk as women of being infected with COVID-19 at the research site in West Sumatra, p-value = 0.485 (p> 0.05). This is the same as research conducted by Rinaldi (2021), which said that there is a correlation between gender and the incidence of COVID-19 in Bogor City and the significance value is 0.000 < 0.05, that men have a greater chance of contracting COVID-19 than women. This is due to a reduction in the number of B cells in men as they get older, which results in a lack of antibody supply which can be a weakness in a person's ability to fight the SARS-CoV-2 virus (Al-Bari et al., 2021). Additionally, based on BPS survey data, it indicates that women are more adept at implementing health protocols. Furthermore, according to Wiranti et al. (2020), women are also better at implementing policies and are more compliant with existing rules or regulations.

3.1.2. Age

The age sample related to COVID-19 is adjusted to WHO provisions, namely 20-50 years old which is the age of high mobility, while under 20 years old is categorized as medium, and above 50 years old is categorized as low. The percentage aged 20-50 (high mobility) in the case group in the Entikong border area is the highest, namely 78%, compared to the Jagoi Babang area and the combination of the two areas, namely 63% and 70%.

The results of the analysis of the relationship between age and the incidence of COVID-19 showed that the age group ≤60 years was 171 people (57.2%) while the age group >60 years was 2 people (57.1%) who tested positive for COVID-19. The statistical test shows p-value = 1,000 (p>0.05), meaning that there is no real relationship between age and the incidence of COVID-19. It was also obtained from research conducted by Ruapertiwi (2021), at the Putri Hijau Kesdam I/Bukit Barisan Level II Hospital, Medan, North Sumatra, 2020, which showed that there was no relationship between patient determinants based on host factors, namely age, on the incidence of COVID-19 with a p-value = 0.097 (p>0.005) dominated by the age group, namely 41-85 years with a total of 200 respondents, there were 102 patients with positive examination results for COVID-19.

Age is a factor that can influence behavior. Based on research conducted by Supriyadi et al. (2021), which shows that age is related to behavior in implementing health protocols. According to the CDC in 2020, the older a person is, the higher the risk of experiencing severe symptoms when infected with

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COVID-19, so that the older you are, the more you pay attention to your personal health, one of which is by implementing health protocols (Simanjuntak et al., 2020).

3.2. Univariate Analysis

3.2.1. Age

Samples with age related to COVID-19 are adjusted to WHO provisions, namely age 20-50 years is the age of high mobility, while under 20 years is categorized as medium, and above 50 years is categorized as low. The percentage aged 20-50 (high mobility) in the case group in the Entikong border area is the highest, namely 78%, compared to the Jagoi Babang area and the combination of the two areas, namely 63% and 70%. More details can be seen in Figure 1.

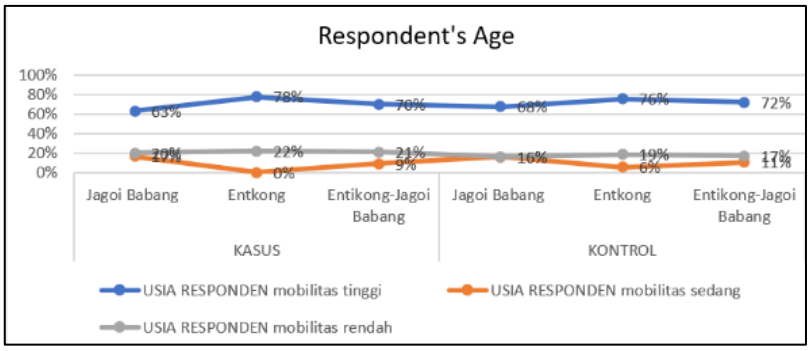

Figure 1. Age of Respondents

3.2.2. Gender

The gender percentage in the case group in the Entikong border area was the highest, namely 70%, compared to the Jagoibabang area and the combination of the two areas, namely 40% and 54.40%. More details can be seen in Figure 2.

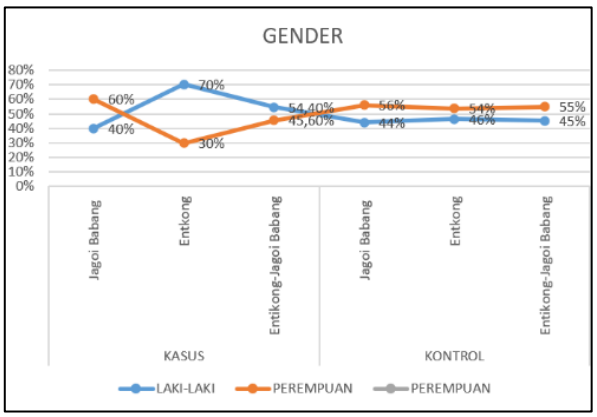

Figure 2. Gender of Respondents

3.2.3. Knowledge Overview

The percentage of low knowledge in the case group in the Entikong border area was the highest, namely 78%, compared to the Jagoi Babang area and the combination of the two areas, which recorded 50% and 63%. More details can be seen in Figure 3.

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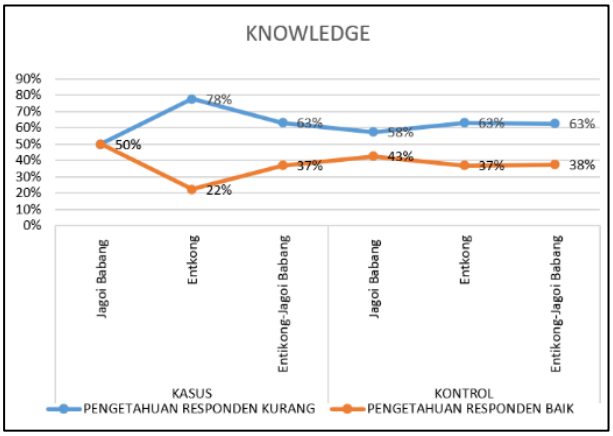

Figure 3. Overview of Knowledge

3.2.4. Attitude Overview

The percentage of attitudes of disapproval in the group of cases in the Entikong border area was the highest, namely 63%, compared to the Jagoi Babang area and the combination of the two areas, namely 43% and 53%. More details can be seen in Figure 4.

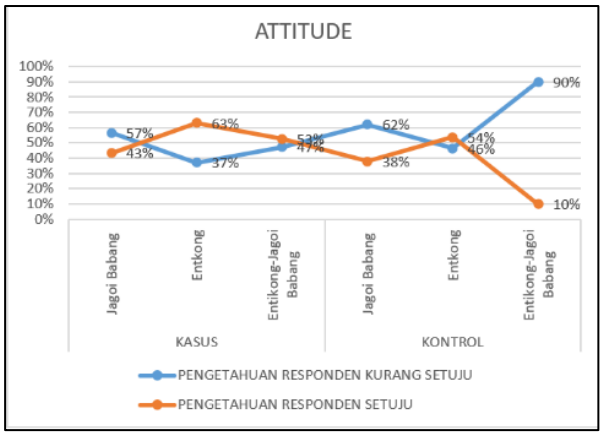

Figure 4. Attitude Description

3.2.5. Overview of Provision of Health Service Facilities

The percentage of poor health service facilities in the case group in the Entikong border area was the highest, namely 59%, compared to the Jagoibabang area and the combination of the two areas, namely 50% and 53%. More details can be seen in Figure 5.

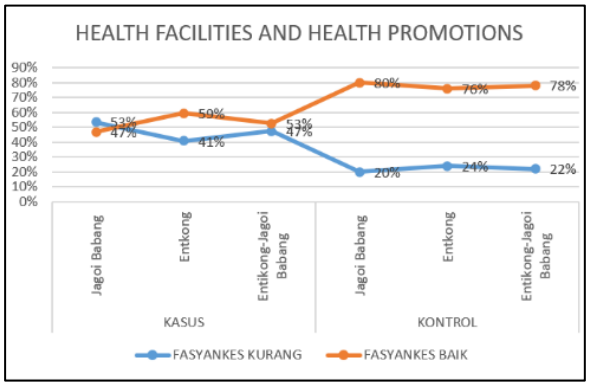

Figure 5. Overview of Health Service Facilities

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3.3. Bivariate Analysis

In the relationship/bivariate analysis of each independent variable and cross-tested with the research dependent variable based on the case group and control group. To find the magnitude of the existing relationship, the chi square test is carried out and the association relationship is through OR (Odds Ratio)

3.3.1. Entikong Border Area

Based on table 1, it shows that there is a significant influence of prevention efforts on the incidence of COVID-19 with a p value: 0.042 < α (0.05), OR: 2.8, meaning that residents with poor prevention efforts are at 2.8 times greater risk. exposed to COVID-19. Comparison of prevention efforts in the Jagoi Babang area and these two areas.

Table 3. Results of Bivariate Analysis of the Relationship between Knowledge, Attitudes, Prevention Efforts and Health Service Facilities and the Incident of COVID-19 in the Entikong - Sanggau Border Area

No	Variable	Case	Control	Total	P Value
1	Knowledge				
	Not enough	21 78%	34 63%	55 68%	0,214
	Good	6 22%	20 37%	26 32%	
2	Attitude				
	Disagree	10 37%	25 46%	35 43%	0,482
	Agree	17 63%	29 54%	46 57%	
3	Prevention				
	Not Enough	21 78%	30 56%	51 63%	0,042**
	Good	6 22%	24 44%	30 37%	
4	Yankes Facilities				
	Not Enough	11 41%	13 24%	24 30%	0,132
	Good	16 59%	41 76%	57 70%	
5	Respondent's Age				
	High Mobility	21 77,80%	41 75,90%	62 76,50%	
	Medium Mobility	0 0%	3 6%	3 4%	0,880
	low Mobility	6 22%	10 19%	16 20%	
6	Gender				
	Man	19 70%	25 46%	44 54%	0,817
	Women	8 30%	29 54%	37 46%	
	Total	27 **100%**	54 **100%**	81 **100%**	

3.3.2. Jagoi Babang Border Area

Based on table 2, it shows that the proportion of service facilities lacking in the case group is 53% higher than in the control group, namely 20%. However, on the other hand, good service in the case group was lower, namely 47%, compared to 80% in the control group. The results of statistical analysis

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show a significant influence of health facilities and health promotion in preventing the incidence of COVID-19 with a p value: 0.030 < α (0.05), OR: 2.8, meaning that residents with poor prevention efforts are 2.8 times more likely to be at risk. greater exposure to COVID-19 compared to prevention efforts in the Jagoi Babang area and these two areas.

Table 4. Results of Bivariate Analysis of the Relationship between Knowledge, Attitudes, Prevention Efforts and Health Service Facilities with the Incident of COVID-19 in the Jagoi Babang - Bengkayang Border Area

No	Variable	Case	Control	Total	P Value	Odd Ratio
1	Knowledge					
	Not enough	21 78%	34 63%	55 68%	0,353	0,617
	Good	6 22%	20 37%	26 32%		
2	Attitude					
	Disagree	17 57%	31 62%	48 60%	0,646	0,801
	Agree	13 43%	19 38%	32 40%		
3	Prevention					
	Not Enough	21 70%	39 78%	60 75%	0,437	0,658
	Good	9 30%	11 22%	20 25%		
4	Yankes Facilities					
	Not Enough	16 53%	10 20%	26 33%	0,030**	4,570
	Good	14 47%	40 80%	54 68%		
5	Respondent's Age					
	High Mobility	19 63%	34 68%	53 66%	0,880	0,000
	Medium Mobility	5 17%	8 16%	13 16%		
	low Mobility	6 20%	8 16%	14 18%		
6	Gender					
	Man	12 40%	22 44%	34 43%	0,034	4,204
	Women	18 60%	28 56%	46 58%		
	Total	27	54	81		

3.3.3. Jagoi Babang - Entikong Border Area

Based on table 3, it shows that the proportion of service facilities lacking in the case group is 47% higher than in the control group, namely 22%. However, on the other hand, good service in the case group was lower, namely 53%, compared to 78% in the control group.

The results of statistical analysis show a significant influence of health facilities and health promotion on the incidence of COVID-19 with a p value: 0.001 < α (0.05), OR: 10.967, meaning that inadequate services have a 10.967 times greater risk of exposure to COVID-19.

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Table 5. Results of Bivariate Analysis of the Relationship between Knowledge, Attitudes of Prevention Efforts and Health Service Facilities and the Incident of Covid-19 in the Jagoi Babang and Entikong Border Areas

No	Variable	Case	Control	Total	P Value	Odd Ratio
1	Knowledge					
	Not enough	36 63%	65 63%	101 63%	1	1,029
	Good	21 36,80%	39 37,50%	60 37,30%		
2	Attitude					
	Disagree	27 47,40%	56 53,80%	83 51,60%	0,15	0,619
	Agree	30 53%	48 46%	78 48%		
3	Prevention					
	Not Enough	42 74%	69 66%	111 69%	0,377	1,42
	Good	15 26%	35 34%	50 31%		
4	Yankes Facilities					
	Not Enough	27 47%	23 22%	50 31%	0,001**	10,967
	Good	30 53%	81 78%	111 69%		
5	Respondent's Age					
	High Mobility	40 70%	75 72%	115 71%	0,812	
	Medium Mobility	5 9%	11 11%	16 10%		
	low Mobility	12 21%	18 17%	30 19%		
6	Gender					
	Man	31 54%	47 45%	78 48%	0,323	1,446
	Women	26 46%	57 55%	83 52%		
	Total	**81 100%**	**80 100%**	**161 100%**		

3.4. Qualitative

3.4.1. Social Construction of Testing, Tracing, Treatment in Border Areas

The World Health Organization (WHO) released that Coronavirus Disease (COVID-19) first occurred in Wuhan, Hubei Province, China at the end of December 2019 to the beginning of January 2020. At the end of March 2020 COVID-19 had spread to 193 countries (World Health Organization, 2020). On that basis, COVID-19 was designated by WHO as a pandemic (World Health Organization, 2020). Indonesia, including West Kalimantan Province, which also includes its own border areas, was also declared to have entered the COVID-19 pandemic period in the same month, namely March 2020 (Kompas.com, 2020).

To "fight" COVID-19, there is only one "effective" way, namely to mobilize all power and efforts - especially governance - together and then attack continuously without stopping or known as the total football strategy, or in other words discipline , unity and consistency are the main keys in fighting

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COVID-19. Meanwhile, the governance in question is vaccination as a sharp spearhead in the fight against COVID-19, which is strengthened by the 3M protocol, and accompanied by 3T (Covid-19, 2021).

3 T (Test, Tracing and Treatment) is one of the second protocols besides 3 M, its implementation is not as easy as 3 M, because its implementation must involve other parties. This approach is designed by identifying COVID-19 cases by checking health through several types of tests for confirmed detection of COVID-19, then tracing people who spend time and are in close contact with them and may be infected, then approach self-isolation, so that if infected they can preventing transmission to other people (Rajan et al., 2020).

Because COVID-19 is a relatively new disease experienced by people in border areas and preventive measures in the form of 3 T can also be considered as a new process in order to prevent/control the spread of the disease, in this case it can be said to be a moment of externalization and internalization in the case of implementation. The 3 T's are difficult to differentiate. Therefore, in this discussion, objective and subjective reality are not presented separately, and the reality that emerges is assessed as a fact which can then be said to be a relatively new stock of knowledge constructed by the informant.

3.4.2. The Reality of Implementing COVID-19 Tests at the Border

It is important to carry out tests to avoid the potential for transmitting the virus that causes COVID-19 to other people. Apart from that, it is important to carry out tests so that someone who is confirmed can receive treatment quickly. Generally, there are three types of COVID-19 tests that are often used to detect whether someone is infected with the SARS-CoV-2 virus or not, including antigen tests (Antigen Swab), molecular tests (RNA/PCR Swab), and breath exhalation tests (Test Genose) (Covid-19, 2021). Not only can testing catch potentially asymptomatic cases, it can also detect cases before symptoms develop, and help slow the spread. A person needs to be tested if they experience symptoms of COVID-19 and/or have a history of contact with a patient confirmed positive for COVID-19. Apart from that, tests need to be carried out regularly on vulnerable groups such as health workers, people with low immune system/autoimmune, who have accompanying conditions such as kidney problems or heart problems.

Furthermore, regarding the reality of the factors that motivate informants to participate or take the COVID-19 test, you can see the following table.

Table 6. Objective and Subjective Realities about Driving Factors for Taking a COVID-19 Test

Driving Factors for Taking a Test	Informants and Status	Origin
○ Have been in close contact with the Survivor ○ Government Recommendations (Puskesmas)	(J) Confirmed Positive	Community
○ Self-awareness after symptoms of fever	(M) Confirmed Positive	Company Employees
○ After there is a positive confirmed cluster in the office	Entikong BNPP employee, Confirmed Positive	State Apparatus
○ Driven by the Office ○ Self-Awareness Due to symptoms (can't smell or taste)	(MK) Confirmed Positive	Company Employees
○ Encouraged by the Community Health Center (Puskesmas)	(P) Confirmed Positive	State Apparatus

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Apart from identifying the reality in the form of factors that encourage informants not to refuse the test, other realities also identified several factors that become obstacles so that informants refuse or delay taking the test. The factors in question are:

a. Currently suffering from another disease.
b. Already elderly (elderly).
c. Negative information circulating on social media causes informants to be afraid to take the test.
d. The informant feels that he has no symptoms.

3.4.3. The Reality of Implementing COVID-19 Tracing at the Border

Contact tracing is a process for identifying, assessing and managing people who have had close contact with confirmed/probable cases to prevent further transmission. This activity is important because confirmed cases can transmit the disease from 2 days before to 14 days after the onset of symptoms (Covid-19, 2021).

Contact tracing is carried out with the aim of breaking the chain of transmission and finding sufferers early in order to reduce the death rate and more severe morbidity. The benefits of contact tracing are (a) identification: identifying the time and place of people who had close contact with patients suffering from COVID-19; (b) information: informing people who may have been exposed to COVID-19; (c) isolation: isolating people infected with COVID-19 to prevent further spread (Covid-19, 2021).

Regarding the reality of implementing COVID-19 Tracing in border areas, several obstacles in its implementation are:

a. The authorities in the area (Puskesmas) are late in receiving information about patients experiencing COVID-19.
   [Lessons from the Semanget Village case]... the information from Muhammad Alkadri Regional Hospital was slow, why people were already buried, count how many hours it took from Pontianak to get here [Semanget Village],... In the afternoon it was buried, only then did the information come out, which is also the problem..., M (Interview July 2022).
b. The public's closed attitude in providing information to health workers.
   [Lessons from Semanget Village] .... That's when tracing began after the burial. At the meeting there were around 68 people who were put up for SWAB, and of those 68 people there were more than 30 people who were confirmed positive. Their close family members were also from the group of mothers who before being put in the coffin wiped their faces. Also, the problem is that people in the village don't know that this father has been confirmed to have Covid, but actually his close family and children know that this father is infected with Covid. We had already asked his family whether when they were transferred from Antonius to the city hospital, they had received a positive result letter or not, and the family said they had not, even though in the attachment sent by the city hospital there was already a PCR result letter from Antonius Hospital (M, Interview July 2022).
c. The PCR lab is not available at the border so the data sent outside for PCR seems to be neglected.
   [Learning from the case of Suluh Tembawang Village, 40 PCR samples have not yet been answered] ... found people who went through the rat road in Suluh Tembawang Village [with Malaysia], examined [using] anti-Gen, 18 people confirmed 2, the rest admitted to having symptoms, then samples PCR was sent to Pontianak, sent to UNTAN, we reported it, but it just disappeared, there was no follow-up information.

3.4.4. The Reality of Treatment for COVID-19 Survivors at the Border

Treatment or follow-up aims to provide care to patients who are confirmed positive for COVID-19. This treatment must be carried out by the community, by means of isolation which aims to reduce the risk of spread and severity of the disease. If a positive patient has no symptoms, he or she must self-isolate in a facility provided by the government or can self-isolate at home under supervision from the local health center. Meanwhile, positive patients with symptoms are required to isolate in a hospital designated by the government. Self-isolation is carried out to ensure that people around us do not become infected and to make it easier for health workers to monitor the health of people who are isolated

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(Covid-19, 2021). Related to this, the reality of follow-up (Treatment) for COVID-19 survivors at the border can be seen in the following table.

Table 7. The reality of treatment for COVID-19 survivors at the border

Reality of Treatment	Characteristics	Description
Self-Isolation	No symptoms, close contact with survivors	(Informan H), Klaster Desa Semanget
Self-Isolation	No symptoms, close contact with survivors	(Informan P), Klaster BPNB Entikong
Self-Isolation	No symptoms, close contact with survivors	(Informan J), Klaster Desa Semanget
Self-Isolation	Symptoms, after visiting Pontianak	(Informan RM), Klaster BPNB Entikong
Self-Isolation	Symptomatic	(Informan MK), Klaster PT. BPK
Self-Isolation, Isolation to Hospital	Symptomatic	(Informan M), Klaster PT. BPK

The reality of treatment shows that there are still cases of patients who are symptomatic but are self-isolating at home. Furthermore, from the informants' explanations through in-depth interviews, several things were identified which illustrate the state of facilities and availability of human resources to carry out treatment in border areas, including isolation places in border areas which are considered to be inadequate. The temporary isolation place uses the old Puskesmas building, with inadequate facilities. Therefore, in the Entikong border area, if a patient is found who is exposed and requires treatment, then the person concerned is isolated in the capital city of Sanggau Regency or in Pontianak (ESS and M, Interview June 2022).

Meanwhile, significant others identified as playing a role in shaping the 3 T social construction in communities in the Entikong border area are presented in the following table.

Table 8. The Role of Significant Others in 3T Social Construction

Significant Other	**Role**
public health Office Community Health Center	○ Socialize and implement 3T
Religious leaders	○ Providing support to the government by socializing the importance of 3T starting from the diocese, parish, station and church
Village Apparatus	○ Socialize the importance of Testing
Batih Family	○ Providing shelter, food and providing psychological support to survivors during self-isolation
Perusahaan	○ Providing a place for self-isolation and supplying food to staff exposed to COVID-19

4. DISCUSSION

This research was conducted for various purposes. The research objectives that have been mentioned can be answered with the results attached to the research results. First, to analyze the extent of knowledge, attitudes, prevention efforts and health service facility providers. The first objective has been answered with the results of quantitative data processing (can be seen in diagram 3 to diagram 6). The results of the data processing show that the percentage of low knowledge in the case group in the Entikong border area is the highest, namely 78%, the percentage of disapproving attitudes in the case group in the Entikong border area is the highest, namely 63%, the percentage of prevention efforts is poor in the case group in the area. Entikong is the highest, namely 78%, and the percentage of poor health service facilities and health promotions in the group of cases in the Entikong border area is the

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highest, namely 59%. Meanwhile, in Jagoi Babang District, the case group had a low percentage of knowledge, namely 50%, a percentage of disapproving attitudes, namely 57%, a percentage of poor prevention efforts, namely 70% and a poor percentage of health service facilities and health promotion, namely 53%.

The difference in the percentage of low knowledge in the case group between the two regions is 28%, so it can be seen that the Jagoi Babang area has a lower percentage of low knowledge than the Entikong area. Meanwhile, the difference in the percentage of disapproving attitudes in the case group between the two regions is 6%, so it can be seen that the Jagoi Babang area has a lower percentage of disapproving attitudes than the Entikong area. Furthermore, the difference in the percentage of poor prevention efforts between the two regions is 8%, so it can be seen that the Jagoi Babang area has a lower percentage of poor prevention efforts than the Entikong area. Finally, the difference in the percentage of poor health service facilities and health promotions between the two regions is 6%, so it can be seen that the Jagoi Babang area has a lower percentage of poor health services and health promotions than the Entikong area.

The second objective is to determine whether prevention efforts influence the incidence of COVID-19. The second objective has been answered through qualitative processing which shows that there is an influence of prevention efforts on the incidence of COVID-19 (can be seen in table 3). This is also in line with answering the hypothesis in the research. In hypothesis 1, Ha is accepted, this is in accordance with the results in table 1 which shows that there is an influence of prevention efforts on the incidence of COVID-19. In accordance with the theory presented by R & Alimansur (2020), that with efforts to prevent the transmission of COVID-19, 19 can slow the spread of the COVID-19 virus. This can happen because by taking preventive measures, it will be more difficult for the virus to spread between one person and another because the preventive measures taken include social distancing, using a mask when outside the house, washing hands and clean yourself after traveling. With these efforts, it is hoped that COVID-19 can slow down its spread because there have been efforts to protect ourselves from COVID-19.

Next, third, to find out whether or not there is an influence of health services and health promotion facilities on the incidence of COVID-19. The third objective has been answered, it is known that there is an influence of health care facilities and health promotion on the incidence of COVID-19 (can be seen in table 4). In hypothesis 2, Ha is accepted, indicating that there is an influence of health facilities and health promotion on the incidence of COVID-19. This is in accordance with the opinion expressed by Pangoempia et al. (2021), that health facilities such as community health centers have a very important role during the COVID-19 pandemic, namely carrying out prevention, detection and response in preventing and controlling COVID-19. This is because the health facilities closest to the community in border areas are Public health center. With the existence of community health centers in border areas, it is hoped that this can help prevent and control COVID-19. Apart from that, community health centers are also expected to be able to help treat patients who are positive for COVID-19.

The last objective has also been answered in the qualitative data results. The fourth objective is to get a picture of the reality of implementing the 3 Ts, namely Testing, Tracing, Treatment in the Border Area of Entikong District and Jagoi Babang District. In the qualitative results, it is stated that there is a driving factor for someone to take a COVID-19 test, namely self-awareness after experiencing symptoms. Self-awareness is an important thing for society to have, with self-awareness a person will do something without needing pressure or certain conditions (Kusuma & Nurcahayati, 2021). Self-awareness to carry out a test after experiencing symptoms is a good step for the community to take in dealing with COVID-19. People who carry out tests with self-awareness can indirectly help in dealing with COVID-19 because if the results are positive, immediate treatment can be administered, and the spread of the virus is expected to slow down as the patient undergoes isolation.

The implementation of tracing of people who had close contact with people confirmed for COVID-19 at the border experienced several obstacles, one of which was the public's closed attitude in providing information if they or they were infected with COVID-19 to health workers. This attitude emerged because of the negative stigma from society towards positive COVID-19 patients (Covid-19, 2021). It is estimated that the negative stigma that positive patients receive can result in patients receiving certain

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labels or labels from society. The labeling given can disrupt the patient's life even though the patient is negative for COVID-19. COVID-19 patients can experience bad treatment because of this stigma, for example being a topic of conversation, being ostracized, and so on. This is in line with the results of research conducted by Priandono et al. (2022), stigma can come from the community, such as neighbors, in the form of being a topic of discussion for neighbors and being shunned from the surrounding environment. Apart from that, they also become the center of attention and receive different treatment from their neighbors, to the point that some neighbors don't want to be around the house of someone who is positively infected with COVID-19. Because of these things, people tend to be closed in providing information if they are infected with COVID-19. 19 to health workers.

Finally, based on the results of qualitative data, it is known that there are problems in implementing treatment, namely that there are still cases of patients with symptoms who are only self-isolating at home. This is because the isolation places are still inadequate. Isolation places are needed to maximize healing for COVID-19 positive patients. Apart from that, isolation is also very useful in reducing the density of suspected COVID-19 in the community, thereby reducing the potential for COVID-19 transmission (Mona, 2020). Logically, by isolating, patients who are positive for COVID-19 have limited access to other people, so that the spread of the virus can be controlled. Apart from that, by isolating in an adequate place, patients also receive treatment so they can recover. For this reason, according to the interview results, if a patient is found to be infected with COVID-19 and requires proper treatment, the patient will be isolated in the capital city of Sanggau Regency or in Pontianak because the facilities in Entikong District are inadequate. Knowledge is really needed, so that people can understand that they need to isolate. The importance of isolation is sometimes hampered by poor knowledge. Low knowledge is a barrier in dealing with COVID-19.

It can be seen that the percentage of low knowledge in the case group in the Entikong border area is the highest, namely 78%. When compared with Jagoi Babang District, the Jagoi Babang area has a lower percentage, namely 50%. The knowledge in question pertains to information about the COVID-19 virus. According to Mona (2020), knowledge of COVID-19 can be interpreted as the result of the patient's knowledge about the disease, understanding the disease, how to prevent it, treat it and its complications. There are several things that cause a lack of knowledge about COVID-19, namely the low level of education in the Entikong District community. It is known from the Entikong Village website that most people only have education up to elementary school level (Desa Entikong, 2023). Meanwhile, the education most commonly pursued by the people of Jagoi Babang District is the same as that of the people of Entikong District, namely up to elementary school level (Niko, 2016). The fact that people have low levels of education can affect the knowledge they can obtain. The low level of knowledge they have can also influence their awareness of implementing the COVID-19 health protocol. Both of these things are in accordance with the theory presented by Anggreni & Safitri (2020), that someone with higher education tends to get exposure to more information, quickly and exactly where this influences their behavior. So someone with a low level of education gets the opposite, namely not getting more, faster and more accurate information that can influence behavior.

Apart from knowledge, things that can influence behavior are attitudes (Wiranti et al., 2020). The results of this research data show that the highest percentage of disapproval is also found in the Entikong border area, namely 63%. Meanwhile, in the Jagoi Babang border area, the percentage of disapproval is lower compared to the Entikong border area, namely 57%. This attitude of not agreeing is a negative attitude. The results of this research are in line with research conducted by Wiranti et al. (2020), that the factor that influences society in complying with health protocols in preventing COVID-19 is attitude. This factor can influence it because, if the public's attitude is open and obedient to recommendations to implement health protocols, then it is estimated that the community will comply with these recommendations. On the other hand, if there is an attitude of rejection and indifference towards recommendations to implement health protocols, then with any effort it is estimated that the public will not want to comply with these recommendations because from the start they have rejected and were indifferent. According to Wahyuni et al. (2021), attitude is a person's response resulting from thinking about an object. To find out about the object, someone needs information or knowledge about it. By knowing knowledge about an object, a person will get detailed information about things they don't know

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and this is predicted to influence a person's attitude towards an object compared to before knowing information about the subject. This is also confirmed by the opinion of Wawan (2010), that someone who has good knowledge will have good behavior too. Good knowledge brings good behavior because with good knowledge, a person will find out things they don't know well about something and it could be that what they know is a good thing about that object. After knowing it, a person's attitude can change for the better because he already knows good things about the object.

The percentage of poor prevention efforts in the case group in the Entikong border area was also the highest, namely 78%. Meanwhile, the Jagoi Babang border area has a lower percentage of poor prevention efforts than the Entikong border area, namely 70%. This is caused by the low level of public knowledge regarding COVID-19. This is in line with the opinion of Notoadmojo (2014), someone with good knowledge can influence someone in implementing efforts to prevent COVID-19. With the knowledge they have, awareness of implementing prevention efforts is higher because a person already knows the consequences he will get if he does not make efforts to prevent COVID-19. This is in accordance with the results of research from Sari & Budiono (2021), that respondents who have good knowledge also have good behavior towards preventing the transmission of COVID-19. Vice versa, respondents who have less knowledge have bad behavior towards preventing the transmission of COVID-19. A person's lack of knowledge makes them feel correct, as they may not yet possess good knowledge about something, and what they know initially is considered correct, even though it may not necessarily be so. Therefore, with information that is not necessarily true, a person feels he is right and this is thought to influence his attitude. We know that people who always feel right always feel they are better than anyone else, so they are reluctant to accept other information that does not match their previous knowledge. Therefore, this causes him to adopt bad attitudes such as rejecting correct information about an object.

From the research results, it is known that the percentage of poor health service facilities in the case group in the Entikong border area is also the highest, namely 59%. Meanwhile, when compared with the Jagoi Babang area, the percentage of poor health service facilities is lower than the Entikong area, namely 53%. Health service facilities are the front line for the community in facing the problem of COVID-19. This is in accordance with the opinion of the Kemenkes (2020), that health service facilities such as community health centers are the spearhead for providing health services to the community in their working areas in dealing with COVID-19. If The existing health facilities are not good, so it can be estimated that the response to COVID-19 in this area will also not be optimal. This happens because the community health center is the closest health facility to border communities. Community Health Centers are the spearhead of handling COVID-19, and have a central role. The completeness of facilities and quality of service at community health centers influences the acceleration of handling COVID-19. If the facilities are not good then efforts to overcome COVID-19 will be less than optimal because not all health problems related to COVID-19 can be resolved due to poor facilities.

The research findings highlight the critical role of public knowledge and health service facilities in mitigating the spread of COVID-19 in border areas. In particular, the study reveals a strong correlation between poor prevention efforts and low levels of public knowledge. Individuals with limited understanding of COVID-19 are more likely to exhibit negative behaviors towards prevention, such as rejecting accurate information and disregarding recommended practices. This phenomenon can be attributed to the human tendency to cling to existing beliefs, even when confronted with contradictory evidence.Furthermore, the research underscores the importance of well-equipped and effective health service facilities in border regions. These facilities serve as the frontline defense against the virus, providing essential healthcare services to communities. The quality and availability of such facilities directly impact the effectiveness of COVID-19 response efforts. When health service facilities are inadequate, it becomes challenging to address the full spectrum of health issues related to the pandemic, leading to suboptimal outcomes.

The implications of these findings for public policy and prevention strategies in border areas are significant. To enhance public knowledge and promote preventive behaviors, policymakers should invest in targeted education and communication campaigns. These initiatives should be tailored to the specific needs and cultural contexts of border communities, ensuring that information is accessible,

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understandable, and relevant. Additionally, it is imperative to prioritize the improvement of health service facilities in border regions. This includes investing in infrastructure, equipment, and human resources to ensure that these facilities are equipped to meet the healthcare needs of the population and respond effectively to public health emergencies like COVID-19. By addressing these factors, policymakers can significantly strengthen the capacity of border areas to prevent and mitigate the spread of infectious diseases.

The research findings offer valuable insights into the factors influencing the effectiveness of COVID-19 prevention efforts in border areas. The study underscores the critical role of public knowledge and health service facilities in mitigating the spread of the virus. Specifically, the research demonstrates that individuals with limited understanding of COVID-19 are more likely to exhibit negative behaviors towards prevention, such as rejecting accurate information and disregarding recommended practices. Additionally, the study highlights the importance of well-equipped and effective health service facilities in border regions, as these facilities serve as the frontline defense against the virus. The implications of these findings for the development of science and health policy are significant. In terms of science, the research contributes to a growing body of knowledge on the determinants of health behavior and the effectiveness of public health interventions. The findings suggest that future studies should explore the underlying psychological and social factors that influence individuals' responses to health threats and develop strategies to address these factors. Furthermore, the research emphasizes the need for continued investment in research to improve our understanding of COVID-19 and develop more effective prevention and treatment measures.

From a policy perspective, the findings call for a multi-faceted approach to addressing the challenges of COVID-19 in border areas. Policymakers should prioritize the development of comprehensive public health campaigns that target both knowledge gaps and behavioral factors. These campaigns should be tailored to the specific needs and cultural contexts of border communities, ensuring that information is accessible, understandable, and relevant. Additionally, the research highlights the importance of investing in the improvement of health service facilities in border regions. This includes ensuring adequate funding, infrastructure, equipment, and human resources to enable these facilities to provide effective healthcare services and respond to public health emergencies. By addressing these factors, policymakers can significantly enhance the capacity of border areas to prevent and mitigate the spread of infectious diseases and protect the health and well-being of their populations.

5. RECOMMENDATION

The various findings that have been obtained in this research can be used as recommendations for reviewing public policies for local governments in handling COVID-19 in border areas. Some of these recommendations include:

a. Government support is needed to formulate and enforce regulations in a structured and massive manner in order to prevent and deal with the COVID-19 outbreak. In addition, the government together with religious and traditional leaders in both regions are expected to be able to maximize the dissemination of information about COVID-19 in efforts to prevent and handle COVID – 19.
b. Special attention is needed from the government regarding the availability and suitability of health facilities and infrastructure at the border, such as isolation areas, laboratories for analyzing test results and human resources or 3T implementing officers at the border.
c. The government as a leader in carrying out prevention and supervision in border areas should implement certain standards by implementing health protection such as:
    1) Improving Medical Treatment Facilities and Infrastructure with compliance and management to avoid diseases being transmitted through the main border gates or to areas that have rat routes.
    2) Increasing regional capacity to prevent and detect early the emergence of diseases that could cause a public health emergency as a whole.
    3) Strengthen supervision and management of cases from the country's entry points, both through official and unofficial channels.
    4) Increasing human resources available in the regions, especially in border areas

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5) Strengthening communication and coordination between sectors in the Regional Government Government to enhance the handling and prevention of COVID-19.

6. CONCLUSIONS

Based on the results of research on Actions to Prevent and Handle COVID-19 and Emerging Diseases in the Border Areas of West Kalimantan Province (Entikong District and Jagoi Babang District) the following conclusions can be drawn:

a. Characteristics of the respondents who participated in this research were 156 people who were in the border area of Bengkayang and Sanggau Regencies. Respondents were divided into two groups, namely the case group and the control group. The case group consisted of 52 people aged 21-65 years and >65 years who had been infected with COVID-19. Meanwhile, the control group consisted of 104 people who had never been infected with COVID-19 and were willing to take part in the research.
b. In the group of cases in the Entikong border area, the percentage of males is highest, namely 70%, compared to the Jagoi Babang border area, which is 40% and the two areas combined, namely 54%. Meanwhile, the percentage of high mobility age (20-50) in the case group in the Entikong border area was the highest, namely 78%, compared to the Jagoi Babang border area, which was 63% and the combination of the two regions, which was 70%.
c. In the group of cases in the Entikong border area, the percentage of low knowledge is highest, namely 78%, compared to the Jagoi Babang border area, which is 50% and the combination of the two areas, namely 63%
d. In the group of cases in the Entikong border area, the percentage of disapproval was highest, namely 63%, compared to the Jagoi Babang border area, which was 43% and the combination of the two areas, namely 53%.
e. The group of cases in the Entikong border area has the highest percentage of poor prevention efforts, namely 78%, compared to the Jagoi Babang border area, which is 70% and the combination of the two areas, namely 74%.
f. The case group in the Entikong border area has the highest percentage of poor health facilities, namely 59%, compared to the Jagoi Babang border area, which is 50% and the combination of the two areas, namely 53%.
g. The results of statistical analysis show that there is a significant influence on prevention efforts on the incidence of COVID-19 with a p value of $0.042 < 0.05$.
h. The results of statistical analysis show that there is a significant influence on health facilities and health promotions in preventing the incidence of COVID-19 with a p value of $0.030 < 0.05$.
i. The reality of implementing the COVID-19 test at the border is that it is known that there are several factors motivating someone to carry out the test, namely having had close contact with survivors, self-awareness because they are experiencing symptoms of fever and cannot smell and taste, the existence of a confirmed positive cluster in the office, is encouraged by the office and encouraged by the community health center. Meanwhile, there are also several inhibiting factors that make someone refuse to take a test, namely suffering from another disease, being elderly, hearing negative information that makes them afraid to take the test and feeling like they are asymptomatic.
j. Based on the results of the interview, it is known that the reality of implementing COVID-19 tracing at the border has several obstacles, including the authorities at the Community Health Center being late in receiving information about patients experiencing COVID-19, the public's closed attitude in providing information to health workers and the PCR laboratory. which is not available at the border so that the data sent out for PCR seems to have been neglected.
k. Based on the results of interviews, it is known that the reality of implementing COVID-19 treatment shows that there are still cases of patients who are symptomatic but are self-isolating at home. Apart from that, several things were identified which illustrate the condition of facilities and availability of human resources to carry out treatment in border areas, including isolation places in border areas which are considered to be inadequate.

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l. The research findings emphasize the crucial roles of public knowledge and well-equipped health service facilities in mitigating the spread of COVID-19 in border areas. Enhancing public education and investing in healthcare infrastructure are essential for effective disease prevention and control.

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