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Vol: 7 Number 2, April 2022
Page: 284-296

The Factors of Social Strengths and Weakness Faced to A Construction Process of Social Support of Tuberculosis's Sufferer

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Abstract. *This study examines any determinant factor of social strengths and weakness that face to a* construction process of social support for patients of tuberculosis sufferers, with qualitative methods and case study designs, phenomenology, analytic, comparative, and explorative. The result is that social power factors to face them include:(1) local cultural wisdom values, (2) social norms owned family and community, (3) potential types of social support, (4) potential social relationships in family and community behavior, (5) potential lifestyle changes, (6) positive perceptions of families and communities, (7) health or medical information and socialization, (8) positive social impacts of TB disease, (9) DOTS or TOSS policies or programs. While the social weakness factors are (1) the potential for shifting and neglecting the values of local cultural wisdom, (2) the potential for neglecting the socio-cultural norms of family and society, (3) the potential for neglecting social support, (4) the potential for estrangement in social relations (kinship, brotherhood, friendship) in family and community social behavior, (5) status quo lifestyle behavior, (6) potential negative perceptions of TB SPP, family, and society, (7) potential for stereotypes, stigma-labeling, (8) potential social discrimination and conflict, (9) the potential for social oppression of sufferers, (10) information gaps and health/medical socialization, (11) the negative impact of TB disease, (12) inequality in the implementation of DOTS/TOSS.

Keywords: *Strengths; Weaknesses; Construction; Social Support; Tuberculosis Sufferers*

Abstrak. Penelitian ini mengkaji model konstruksi dukungan sosial penderita penyakit tuberculosis, dengan metode kualitatif dan desain *case study*, fenomenologi, analitik, comparative, eksploratif. Hasilnya bahwa faktor kekuatan sosial dalam konstruksi dukungan sosial penderita penyakit tuberculosis meliputi (1) nilai-nilai kearifan budaya lokal, (2) norma-norma sosial keluarga dan masyarakat, (3) potensi jenis dukungan sosial, (4) potensi hubungan sosial perilaku keluarga dan masyarakat, (5) potensi perubahan gaya hidup, (6) persepsi positif keluarga dan masyarakat, (7) informasi dan sosialisasi kesehatan/medis, (8) dampak sosial penyakit Tb secara positif, (9) kebijakan/ program DOTS atau TOSS. Sedangkan factor kelemahan sosial adalah (1) potensi pergeseran dan pengabaian nilai-nilai kearifan budaya lokal, (2) potensi pengabaian norma-norma sosial budaya keluarga dan masyarakat, (3) potensi pengabaian dukungan sosial, (4) potensi kerenggangan hubungan sosial (kekeluargaan/ kekerabatan, persaudaraan, persahabatan) dalam perilaku sosial keluarga dan masyarakat, (5) perilaku gaya hidup statusquo, (6) potensi persepsi negatif SPP Tb, keluarga, dan masyarakat, (7) potensi stereotype, stigma-labelling, (8) potensi diskriminasi sosial dan konflik, (9) potensi opresi sosial subyek penderita, (10) kesenjangan informasi dan sosialisasi kesehatan/medis, (11) dampak negatif penyakit Tb, (12) ketimpangan implementasi kebijakan/ program DOTS/ TOSS.

Kata Kunci: *Kekuatan; Kelemahan; Konstruksi Sosial; Dukungan Sosial; Penderita Penyakit Tuberculosis*

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Vol: 7 Number 2, April 2022
Page: 284-296

INTRODUCTION

One of the most fundamental and popular problems in the health aspect is 'disease'. Observers of health problems or experts such as (Conrad & Kern 1992), Diederiks *et al.*, (Notoatmojo & Sarwono, 1985; Sarwono, 2006) and other ones agree that disease is not only a cultural product but also a social construction. In this regard, Geest argues that in different societies disease is expressed differently, explained differently, and constructed differently (Soejoeti, 2016). Furthermore, one type of disease that has not only caused health problems but has also become a social problem widely is "tuberculosis disease" (also known as tuberculosis or pulmonary tuberculosis). According to International Health Institutions (WHO, 2017) and National Health Institutions (Ministry of Health owned Indonesia, Kemenkes, 2018), TB disease is equivalent and included in the ten types of deadly diseases in the world such as AIDS/HIV, cancer, malaria, and degenerative diseases such as heart disease and diabetes which have characteristics, potencies, and levels. the ability to attack the organs of the human body lethally. TB disease has become a global or international health problem because it has lethal properties if it attacks human organs (especially the lungs). The problem phenomenon according to WHO, every second there is one person infected with tuberculosis in the world: one third of the world's population has been infected with tuberculosis germs; about 33% of the total TB cases in the world are found in Asian countries. In 2013, it was estimated that there were 8.6 million TB cases, of which 1.1 million people (13%) were HIV-positive (WHO, 2014).

Tuberculosis (TB) is one of the leading causes of death due to infection in the world, besides malaria, and with its dangerous nature, it has actually become a world health problem and has attracted a lot of attention from the international community because in addition to affecting people's work productivity, it is also the main cause of death for many people in various parts of the world. country. WHO reports, half a percent of the world's population is stricken with tuberculosis, of which most (75%) are in developing countries, including Indonesia. It is estimated that 539,000 new cases of TB are found every year with 101,000 deaths (WHO, 2014).

Tuberculosis (TB) is still a major health problem in the world, which causes health problems for millions of people every year and it is estimated that TB cases in the world reach around 10.4 million cases consisting of men around 5.9 million cases and women around 3. 5 million cases (WHO, 2017). In this context, Indonesia has contributed a third of the TB burden in the world (WHO, 2017). Indonesia is one of the countries that has the largest burden of tuberculosis among 8 countries, namely India (27%), China (9%), Indonesia (8%), Philippines (6%), Pakistan (5%),

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Vol: 7 Number 2, April 2022
Page: 284-296

Nigeria (4%), Bangladesh (4%) and South Africa (3%). According to the 2018 WHO report, globally, new cases of tuberculosis were 6.4 million, equivalent to 64% of the incidence of tuberculosis (10.0 million). Tuberculosis remains the 10th leading cause of death in the world and global tuberculosis deaths are estimated at 1.3 million patients (WHO, 2018). A country that is not free from Tuberculosis (TBC) then the mortality rate due to Mycobacterium tuberculosis is getting higher. Therefore, TB is still an infectious disease that is a concern and an important public health problem in the world (Amin, 2006). Especially in Indonesia, it is still one of the countries that are included in the group with the highest burden of TB problems (high burden countries). This has also been confirmed by the WHO report that Indonesia is included in the 30 high burden countries that have a burden of TB, MDR-TB and HIV-TB (WHO, 2017).

According to Kemenkes (the Ministry of Health owned Indonesia Government), at year 2017 there were 446,732 cases, and increased to 566,623 cases in 2018 at all provinces. In each province, men generally have a higher number of tuberculosis cases, namely 1.3 times than women (Kemenkes RI, 2019). Furthermore, in terms of age groups, TB disease attacks all age groups from toddlers to elderly people. In other words, TB sufferers exist at all levels or age levels. During the last four years (2014-2018), for example, TB disease or TB sufferers were evenly distributed in all age groups even though the proportion of cases was different or varied. In 2018, the most tuberculosis cases were in the 45-54 years age group, namely 14.2%, then 13.8% at the age 25-34 years and 13.4% for the 35–44-year age group. The Ministry of Health conducted a sweeping of cases in hospitals (Mapping Up) to reduce under-reporting of tuberculosis cases, and the data from the search included an unknown age group (NA) which resulted in a shift in the proportion of tuberculosis cases by age group from 2014-2017 with 2018. Thus, Indonesia is still one of the countries that are included in the group with the highest burden of TB problems (high burden countries) (Directorat Jenderal P2P, Kemenkas, 2019).

Specifically, in South Sulawesi, there were 13,659 TB cases, consisting of 12,965 TB cases (7,180 smear positive TB cases), 97 MDR TB cases and 597 child TB cases, smear positive TB cases (South Sulawesi Provincial Health Office, 2018). South Sulawesi still has 84.0% of cases of CDR (Case detection ratio) or ranks second highest after DKI Jakarta. In addition, it is still classified as an area with the second highest CNR (Case notification ratio) number after DKI Jakarta for all tuberculosis cases per 100,000 population (Kemenkes RI, 2019). All of these data clearly indicate that South Sulawesi is still a breeding ground for tuberculosis. The high prevalence of the population with TB indicates that the prevention of TB requires an extra social

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Vol: 7 Number 2, April 2022
Page: 284-296

approach beyond the medical-only approach. Although the Government in particular the Indonesia Ministry of Health has adopted the WHO recommendation regarding the implementation of the Directly Observed Treatment Short-course (DOTS) strategy since 1995 as an approach in tackling TB (Depkes RI, 2012) and stipulates PERMENKES Nomor 67 Tahun 2014 Tentang Penanggulangan Tuberculosis (a rule made by ministry of health decision in order to tuberculosis management at Indonesia), which this rule be basic to launching a program called TOSS (*Temukan Obati Sampai Sembuh* TB (namely to find any tuberculosis sufferer case, then give medicine treatment until they heal it). This program expected Indonesia will be free from this disease before 2050. But its problem, these policies and programs are not adequate because they are more dominant in terms of medical treatment support alone, and far from touching aspects of the need for social support as a whole. Therefore, the prevention of tuberculosis and the healing of its sufferers really need the presence and synergy of medical and non-medical approaches, especially social support.

In South Sulawesi, the potentials regarding aspects or forms of social support for tuberculosis sufferers actually already exist in family and community life both in rural and urban areas, because most families and communities are still bound by their social structure, namely values, norms and values, norms, customs, traditions and beliefs (religion), as well as patterns of social relations and social solidarity based on the texture and tenure of culture and local wisdom values which are potential social modalities and social strengths to provide social support in order to management of TB disease and the totality of the patient's healing process. Its phenomenon of the problem is that, in its development, the potential for social power tends to weaken along with the shifting and stretching of the actualization of socio-cultural values and norms in family and community life. Social feelings are no longer fully based on the values of local cultural wisdom and collective social awareness but tend to shift to individualism attitudes and behavior. Local humans and society in South Sulawesi with their environmental and socio-cultural characteristics are being faced with a shift in social strength to social weakness, especially in actualizing a social support approach for overcoming health problems, especially the problem of tuberculosis. This shift triggers a decrease in the quality of social interaction relationships and social support for subjects with tuberculosis (SPP Tb), which has an impact on the healing process of the patient's disease.

RESEARCH METHODS

This research is based on or is based on the constructivism paradigm, which is an interpretive, logical, and aesthetic paradigm in

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Vol: 7 Number 2, April 2022
Page: 284-296

studying a problem (Bodgan & Taylor, 2009), including aspects of sociology and health, theoretical conceptions, policies, and factual phenomena of construction of social support approaches (social support). support) to the disease and subjects with tuberculosis (SPP Tb). The constructivism paradigm used in examining the factual phenomena of the construction of social support in its consequences is methodological, ontological, epistemological, and axiological. The approach method with research specifications is a combination of analytical descriptive - inferential - componential (Merriam, 2002 in Seidman, 2006). This type of qualitative descriptive research. Case study research design, phenomenology. Sources of data in the form of primary and secondary data. The research unit of analysis is the assessment, attitude, action, and behavior of social support from close people around the subject of tuberculosis (SPP Tb) patients in providing social support (informational, emotional, instrumental, and rewarding). The research location is Gowa Regency. The main informants of the study were 25 people consisting of 5 people from SPP Tb, 18 main and supporting informants consisting of 9 close family members (spouse, close relatives, parents) representing the social structure of the family, 4 neighbors and 5 friends/ friends/colleagues from SPP TB who represent the social structure of work and society.

Data collection techniques with literature study (documentation), observation, interviews. The research instrument is the writer/researcher himself as a direct participant, who is supported by observation sheets and interview guide sheets, and uses several stationery equipment, digital cameras, cellular phones/smartphones, laptops, and others. Data analysis used a qualitative descriptive approach, which was to describe the findings of the research using the existing theoretical bases, as well as through Snow bowling and discourses analyses. The data analysis process is carried out through stages, namely identification according to the research objective group, processing and interpreting the data, then abstracting, reducing, and checking the validity of the data. The stages of data analysis in qualitative research are data reduction, data display, and conclusions or verification (Miles & Huberman, 2000; Creswell, 2010; Moleong, 2012).

DISCUSSION

Performance of Social Support for Tuberculosis Patients

The results showed that generally the core informants (SPP Tb) and close people around, especially the main and supporting informants (family as like wife, close relatives, parents, close neighbors, friends/coworkers) as family and the community of social agents in this study give and receive each other, respond to and support each other in the implementation

ISSN: p-2540-8763 / e-2615-4374
DOI: 10.26618/jed.v%vi%i.6735
Vol: 7 Number 2, April 2022
Page: 284-296

of informational, emotional, instrumental and reward social support. First, SPP TB generally acknowledges receiving informational support in the form of directions, advice, explanations, and knowledge information related to how to treat health conditions and deal with disease, attitudes towards treatment and healing of disease. On the other hand, in general, the main and supporting informants also acknowledged that they provided the direction or advice needed by SPP Tb. Second, in general, SPP TB admits that they receive emotional support, especially in the form of empathy, care, concern, affection, and a good attitude. On the other hand, in general, the main and supporting informants also admitted that they provided the type and form of support to SPP Tb. Third, both SPP Tb and close people in the vicinity (key and supporting informants) both acknowledged that they had provided instrumental support, especially in the type and form of fulfilling the needs for medicines from UPK and food, but for limited material and financial needs and still paying attention to socio-cultural norms.

Fourth, in general, SPP Tb admits that they receive appreciation support, especially in the form of good treatment and attitude, approaching actions and behaviors, not avoiding, appreciating, and providing support. On the other hand, in general, the main informants and supporters also acknowledged that they gave awards in the form of praise and flattery in addition to other types of assessments to SPP TB for their achievements in surviving various physical and psychological burdens due to their illness. The overall phenomenon of the research results accordance with the opinions of experts such as (Cohen & Syme 1985, Hendropuspito, 1989), House (Smet, 1994) and Wills & Fegan (David Berry S & Landry, 1997), Sheridan and Radmacher 1992 in (Haditono, 2001), Jacobson 1986 in (Landis, 1989) regarding the types of social support or social support such as informational support, emotional support, instrumental support, and reward support.

Construction of Social Support for Tuberculosis Patients

The construction of social support currently involves direct social relationships between people with tuberculosis (SPP Tb) and those close to them. Therefore, in this context, the construction of social support can be viewed from two perspectives, namely the perspective of SPP TB and the perspective of social actors and agents of the people close to them (family and community).

1. Construction of social support from the SPP Tb perspective

Generally, SPP Tb in this study constructs 8 (eight) main aspects in relation to its position as central social actors who receive social support (informational, emotional, instrumental, reward). The eight main aspects are: First, SPP TB constructs a social paradigm and belief that social support is a medicine, or

ISSN: p-2540-8763 / e-2615-4374
DOI: 10.26618/jed.v%vi%i.6735
Vol: 7 Number 2, April 2022
Page: 284-296

an integral part of the treatment and healing process for their disease suffering. Second, SPP Tb constructs the level of importance that social support is already a primary need for himself and his illness, both expected from himself and from others, especially those close to him. Third, SPP TB constructs its own social conditions and needs for social support (informational, emotional, instrumental, appreciation), with certain similarities and differences between the SPP TB. Fourth, SPP TB constructs sources of social support from close people around them, especially family (life partners, close relatives), parents, near neighbors, friends, and health/medical personnel. In this context, the Tb SPP circles also construct similarities and differences in elimination, dichotomy, clusters and classifications or groupings of family and community social agents who are considered to have the most role and influence in certain social support, even giving birth to the construction of "central social figures" from the public social agents of the family and society.

Fifth, SPP TB constructs similarities and differences in characteristics, types, and forms as well as certain indicators of social support received from close people around them (especially family, close relatives, parents, near neighbors, friends, and health workers or medical). Sixth, SPP Tb constructs similarities and differences in assessments of attitudes, actions, and social behavior as well as the approach methods used by those close to them in providing social support (informational, emotional, instrumental, reward). Seventh, SPP Tb constructs similarities and differences in attitudes, actions and social behavior as well as the approach method in responding to social support (informational, emotional, instrumental, appreciation) from those close to them. Eighth, SPP TB constructs the same and different perceptions regarding the presence and absence of internal and external conflicts, social discrimination, labels, stigma, social stereotypes, and social oppression from others.

2. Construction of social support from the close people in around perspective

The social agents of family and community in the research generally construct 12 (twelve) main aspects in relation to their position as providing social support (informational, emotional, instrumental, appreciation) to SPP Tb. The twelve main aspects are: First, They constructing the same paradigm or social belief that social support is a medicine, or an integral part of the treatment and healing process for the disease suffered by SPP TB; Second, They constructing the same assessment that social support is already a primary need for Tb SPP; Third, They constructing judgments, social feelings and the same awareness and social responsibility that they feel the need to get involved and take a direct or indirect role to meet the primary needs of social support for Tb SPP; Fourth,

ISSN: p-2540-8763 / e-2615-4374
DOI: 10.26618/jed.v%vi%i.6735
Vol: 7 Number 2, April 2022
Page: 284-296

They constructing the same and different assessments regarding the social conditions ones of SPP TB; Fifth, They construct the same and different assessments regarding the attitudes, actions and social behavior (STP) of SPP Tb towards the conditions of their respective social support; Sixth, They construct attitudes, actions and social behavior (STP) in meeting the needs of social support of each SPP Tb;

Seventh, They constructed any method or approach, innovation, creativity and social competence in overcoming problems and meeting the needs of social support (informational, emotional, instrumental, reward) of each SPP Tb; Eighth, They constructing the application of the values of local cultural wisdom (NKBL) and socio-cultural norms (NSB) that are the same and different in the provision and fulfillment of social support needs of each SPP Tb; Ninth, They constructing the performance of social and cultural relations of kinship, friendship that are the same and different in providing and fulfilling the social support needs of each Tb SPP; Tenth, They constructing the same and different assessments, attitudes, responses, actions and social behavior towards social support from other people to each Tb SPP; Eleventh, They constructing the same and different perceptions, attitudes, actions and social behavior regarding the presence or absence of internal and external conflicts, social discrimination, stamps/labels, stigma, stereotypes, social oppression of SPP TB from the people around them; Twelfth, They construct the factors that influence (supporters and barriers, strengths and weaknesses) social support.

The two perspectives of the construction of social support (the perspective of SPP Tb and the perspective of the social agents of those close to them (such as family, parents, neighbors, friends) are in accordance with the main thesis of the theory of social construction of reality by (Berger and Luckmann 1990) regarding the dialectical nature of the relationship between human individuals and society. In this case, society is seen as a product of humans, and on the other hand humans are seen as the product or product of society. The social construction created by SPP Tb and the close people in around to it is dialectical, which according to Berger (Bungin, 2008) goes through a three-stage process known as a "moment". The dialectical process in the social construction implies that SPP Tb individuals create society (family and community social actors from close people around SPP Tb), and society creates individuals through three stages of events, namely externalization, objectivation, and internalization. *First,* Externalization is the initial stage for individuals with SPP TB as well as individuals from close people around (such as individual family, individual relatives, individual parents, individual neighbors, individual friends/coworkers)

ISSN: p-2540-8763 / e-2615-4374
DOI: 10.26618/jed.v%vi%i.6735
Vol: 7 Number 2, April 2022
Page: 284-296

together expressing themselves openly, interacting/talking/communicating/telling stories, actualizing social support roles. *Second*, objectivation is a further stage of externalization, where these individuals are in their social reality interacting/ talking/ communicating/ telling, facing each other and interpreting, showing each other their attitudes and actions and social behavior, some are in a position to provide support and some receive support, all of which form subjective-objective social reality as a habit that is carried out repeatedly so as to produce a surplus of values, knowledge and experience, especially in terms of giving and receiving material and non-material, physical support/assistance and psychic. *Third*, Internalization is a stage or process of socialization of the objectivation process. In this case, the surplus value, knowledge, and experience gained by individuals (SPP Tb, family, relatives, parents, neighbors, friends/friends/coworkers) from the interaction and self-objectification are internalized (absorbed, implanted) and treated/practiced. in the process of daily social support relationships. This practice is referred to as a reality that is constructed equally and differently by these individuals. Therefore, according to (Eriyanto 2009) that everyone who has certain experiences, preferences, education, and certain social or social environments will interpret the social reality with their respective constructions.

Factors of Social Strengths and Weaknesses in the Construction of Social Support for Tuberculosis Patients

Based on the results of research and analysis, there are a number of social strength factors in the construction of social support for SPP Tb, namely (1) factors of local cultural wisdom values, (2) family and community social norms, (3) potential types of social support, (4) social relations between family and community behavior, (5) lifestyle changes, (6) positive family and community perceptions, (7) health or medical information and socialization, (8) positive social impact of TB disease, (9) DOTS or TOSS policy and program factors. While the social weakness factors are (1) the shift factor and neglect of local cultural wisdom values, (2) the neglect factor for family and community socio-cultural norms, (3) the neglect factor for social support, (4) Factors of estrangement in social relations (family/kinship, brotherhood, friendship) in family and community social behavior, (5) Status quo lifestyle behavior factors, (6) Negative perception factors for sufferer or patients of tuberculosis, family, and society, (7) Stereotype, stigma, labelling, (8) Social discrimination and conflict, (9) Social oppression, (10) Information gaps and health/medical socialization, (11) Negative impact for TB disease, (12) Potential inequality in policy implementation/ DOTS/TOSS program.

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Vol: 7 Number 2, April 2022
Page: 284-296

The findings of the research on the social power factor in the social support construction for Tb sufferer are in accordance with Waters' opinion (DeLamater and Hyde, 1998) regarding the three social power factors in social construction, namely language, culture, and consistency. Similarly, the opinion of Schwarzer & Leppin (Smet, 1994) regarding the social facts of SPP TB as perceived support and those close to them as received support in the process of constructing social support for tuberculosis sufferers. The construction of social support created by SPP TB and those close people to them according to (Sheridan & Radmacher, 1992) in (Taylor & Scadding, 2009) can be viewed as an interpersonal transaction involving aspects of information, emotional attention, assessment, and instrumental assistance. Similarly, the opinion of Gottlieb and Saroson (Smet, (1994) and (Taylor & Scadding, 2009) regarding the presence of individuals or other people who are meaningful in providing various types, nature and forms as well as the characteristics of real assistance in the form of information, advice, suggestions, instructions for action and behavior, materials, medicines, medical expenses, attention, care, empathy, compassion, motivation and enthusiasm, positive assessment / appreciation and others which all have emotional benefits or behavioral effects as well as problem solving for the recipient.

The presence of close people around SPP TB such as family (especially wife, parents, close relatives), neighbors, friends/ coworkers with social paradigms/beliefs, motivation, social feelings, awareness, their respective social roles and responsibilities, perceptions, assessments, attitudes, actions and social behavior in providing informational, emotional, instrumental and rewarding social support to SPP TB according to (Kaplan and Saddock, 1998, Baron and Byrne, 2000) regarding activities and actions real social support as well as the process of interaction and communication between the party providing support and the party receiving social support, especially in terms of the position of SPP TB as a patient with a disease and the provision of religious advice. The presence of close people around SPP Tb in providing social support, especially emotional support in overcoming SPP Tb's anxiety over the problems and burden of illness he suffers according to the opinion of (Heller et al1986), in (Soekanto, 2014) regarding the existence of a social support component in the form of an assessment that heightened rewards, and interpersonal transactions associated with anxiety.

To looking further, the direct involvement of close people around such as family, neighbors, friends/coworkers in providing various types and forms of social support to SPP TB takes place informally (non-formally), spontaneously, according to each other's free

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DOI: 10.26618/jed.v%vi%i.6735
Vol: 7 Number 2, April 2022
Page: 284-296

will, not role playing and engineering, not bound by time, according to daily habits, according to socio-cultural norms, according to the degree of closeness of social relationships (kinship, brotherhood, friendship), based on feelings of empathy and moral responsibility, according to human values, or in short taking place as it is or naturally. The finding of social facts regarding social support from close people is in accordance with the opinion of Rook and (Dootey 1985, Rook K, 1992; Smet, 1994), (Koentjoroningrat 2002) and (Wangmuba 2009), in (Yesmil and Adang, 2013) regarding sources of social support that are natural, not artificial, and spontaneous, and free from psychological burdens and labels, according to socio-cultural norms, long rooted and close social relations. received by someone SPP TB non-formally through the interaction of social support.

The findings of the research on social weakness show that first, the TB SPP and close people in around of SPP Tb admit that there are still certain elements and groups of people who tend to perceive TB disease as bad and negative; (2) SPP TB circles admit that sometimes they still hear and receive directly discriminatory treatment, labels, stigmas and certain stereotypes from certain other people around them; Third, generally close people around (family: especially spouse/wife, parents, relatives/close relatives), near neighbors, friends/coworkers admit that they have never done anything and firmly reject the practice of social discrimination, marginalization, labeling, stigma and any stereotype against SPP Tb. These three things show that SPP TB still has the potential to face pressure, social discrimination, marginalization, labeling, stigma, and stereotypes as well as social oppression in the surrounding environment. And it also means that SPP TB still has the potential to experience internal and external conflicts, prone to feelings of anxiety and inferiority as well as mental stress. Thanks to social support from close people around (family, relatives, parents), neighbors, friends/coworkers, all these negative potentials can be controlled and resolved.

Close people around especially family, play a big, important, and strategic role in keeping SPP Tb from possible stressors from the surrounding environment. This is in accordance with (Argyle's, 1991) opinion regarding the role of the family system as an antidote (buffering effect) to preventing negative effects or stressor effects in the form of negative labeling and social discrimination against TB SPP by other people in the surrounding environment. The family is always ready to help SPP TB when needed because of the feeling of being loved and loving. In essence, family members are the important people to provide instrumental, emotional and togetherness support in dealing with stressful life events.

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DOI: 10.26618/jed.v%vi%i.6735
Vol: 7 Number 2, April 2022
Page: 284-296

CONCLUSION

Factors of social strength in the construction of social support for SPP Tb are (1) factors of local cultural wisdom values, (2) factors of family and community social norms, (3) potential types of social support, (4) factors of family behavior social relations and society, (5) lifestyle change factors, (6) positive family and community perception factors, (7) health/medical information and socialization factors, (8) positive social impact factors for TB disease, (9) policy/program factors DOTS or TOSS. While the social weakness factors are (1) the shifting and neglect of local cultural wisdom values, (2) the neglect for family and community socio-cultural norms, (3) the neglect for social support, (4) the estrangement in social relations (kinship). / Kinship, brotherhood, friendship) in family and community social behavior, (5) Status quo lifestyle behavior, (6) Negative perception for TB SPP, family, and society, (7) Stereotype, stigma-labeling, (8) Social discrimination and conflict, (9) social oppression for sufferers, (10) information gaps and health/medical socialization, (11) Negative impact for TB disease, (12) Potential inequality in the implementation of DOTS/ TOSS policies/ programs.

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