LAPORAN KEMAJUAN PENELITIAN MULTI TAHUN

ID Proposal: 91a75503-5b52-44bd-9056-83a83bfd327f
Laporan Kemajuan Penelitian: tahun ke-1 dari 2 tahun

1. IDENTITAS PENELITIAN

A. JUDUL PENELITIAN

MODEL PENGEMBANGAN PUSAT KRISIS BERBASIS MASYARAKAT UNTUK PENANGANAN TUBERCULOSIS DI SURABAYA

B. BIDANG, TEMA, TOPIK, DAN RUMPUN BIDANG ILMU

Bidang Fokus RIRN / Bidang Unggulan Perguruan Tinggi	Tema	Topik (jika ada)	Rumpun Bidang Ilmu
Kesehatan dan Kesejahteraan	-	kesehatan masyarakat	Ilmu Keperawatan

C. KATEGORI, SKEMA, SBK, TARGET TKT DAN LAMA PENELITIAN

Kategori (Kompetitif Nasional/ Desentralisasi/ Penugasan)	Skema Penelitian	Strata (Dasar/ Terapan/ Pengembangan)	SBK (Dasar, Terapan, Pengembangan)	Target Akhir TKT	Lama Penelitian (Tahun)
Penelitian Desentralisasi	Penelitian Dasar Unggulan Perguruan Tinggi	SBK Riset Dasar	SBK Riset Dasar	3	2

2. IDENTITAS PENGUSUL

Nama, Peran	Perguruan Tinggi/ Institusi	Program Studi/ Bagian	Bidang Tugas	ID Sinta	H-Index
MUNDAKIR Ketua Pengusul	Universitas Muhammadiyah Surabaya	Ilmu Keperawatan		5989021	0
ASRI S.Kep, M.N.S. Anggota Pengusul 1	Universitas Muhammadiyah Surabaya	Ilmu Keperawatan		6081226	1

3. MITRA KERJASAMA PENELITIAN (JIKA ADA)

Pelaksanaan penelitian dapat melibatkan mitra kerjasama, yaitu mitra kerjasama dalam melaksanakan penelitian, mitra sebagai calon pengguna hasil penelitian, atau mitra investor

Mitra	Nama Mitra

4. LUARAN DAN TARGET CAPAIAN

Luaran Wajib

Tahun Luaran	Jenis Luaran	Status target capaian (*accepted, published, terdaftar atau granted, atau status lainnya*)	Keterangan (*url dan nama jurnal, penerbit, url paten, keterangan sejenis lainnya*)
1	Publikasi Ilmiah Jurnal Internasional	accepted/published	

Luaran Tambahan

Tahun Luaran	Jenis Luaran	Status target capaian (*accepted, published, terdaftar atau granted, atau status lainnya*)	Keterangan (*url dan nama jurnal, penerbit, url paten, keterangan sejenis lainnya*)
1	Prosiding dalam pertemuan ilmiah Internasional	sudah terbit/sudah dilaksanakan	INC UNAIR

5. ANGGARAN

Rencana anggaran biaya penelitian mengacu pada PMK yang berlaku dengan besaran minimum dan maksimum sebagaimana diatur pada buku Panduan Penelitian dan Pengabdian kepada Masyarakat Edisi 12.

Total RAB 2 Tahun Rp. 222,635,000

Tahun 1 Total Rp. 123,890,000

Jenis Pembelanjaan	Item	Satuan	Vol.	Biaya Satuan	Total
Analisis Data	HR Pengolah Data	P (penelitian)	1	1,500,000	1,500,000
Analisis Data	Transport Lokal	OK (kali)	7	100,000	700,000
Bahan	Barang Persediaan	Unit	4	325,000	1,300,000
Bahan	Bahan Penelitian (Habis Pakai)	Unit	60	129,500	7,770,000
Bahan	ATK	Paket	80	192,500	15,400,000
Pelaporan, Luaran Wajib, dan Luaran Tambahan	Biaya seminar internasional	Paket	1	2,500,000	2,500,000
Pelaporan, Luaran Wajib, dan Luaran Tambahan	Publikasi artikel di Jurnal Internasional	Paket	1	35,000,000	35,000,000
Pelaporan, Luaran Wajib, dan Luaran Tambahan	Biaya konsumsi rapat	OH	3	30,000	90,000
Pengumpulan Data	HR Pembantu Peneliti	OJ	3	2,250,000	6,750,000
Pengumpulan Data	HR Petugas Survei	OH/OR	10	8,000	80,000
Pengumpulan Data	FGD persiapan penelitian	Paket	80	350,000	28,000,000
Pengumpulan Data	Transport	OK (kali)	98	100,000	9,800,000
Pengumpulan Data	HR Pembantu Lapangan	OH	180	80,000	14,400,000
Sewa Peralatan	Peralatan penelitian	Unit	2	300,000	600,000

Tahun 2 Total Rp. 98,745,000

Jenis Pembelanjaan	Item	Satuan	Vol.	Biaya Satuan	Total
Analisis Data	HR Pengolah Data	P (penelitian)	1	1,500,000	1,500,000
Analisis Data	Transport Lokal	OK (kali)	11	1,000,000	11,000,000
Bahan	Bahan Penelitian (Habis Pakai)	Unit	20	93,750	1,875,000
Bahan	ATK	Paket	80	23,000	1,840,000
Pelaporan, Luaran Wajib, dan Luaran Tambahan	Biaya Publikasi artikel di Jurnal Nasional	Paket	1	5,000,000	5,000,000
Pelaporan, Luaran Wajib, dan Luaran Tambahan	Publikasi artikel di Jurnal Internasional	Paket	1	35,000,000	35,000,000
Pelaporan, Luaran Wajib, dan Luaran Tambahan	Biaya penyusunan buku termasuk book chapter	Paket	100	100,000	10,000,000
Pengumpulan Data	HR Pembantu Peneliti	OJ	3	2,250,000	6,750,000
Pengumpulan Data	Biaya konsumsi	OH	50	50,000	2,500,000
Pengumpulan Data	Transport	OK (kali)	60	100,000	6,000,000
Pengumpulan Data	HR Pembantu Lapangan	OH	180	80,000	14,400,000
Pengumpulan Data	HR Petugas Survei	OH/OR	360	8,000	2,880,000

6. KEMAJUAN PENELITIAN

A. RINGKASAN: Tuliskan secara ringkas latar belakang penelitian, tujuan dan tahapan metode penelitian, luaran yang ditargetkan, serta uraian TKT penelitian.

Surabaya dengan jumlah penduduk sebanyak 2.848.583 jiwa ditemukan kasus suspek Tuberculosis (TB) sebanyak 16.616 jiwa dan dengan BTA + sebanyak 2.330 jiwa. Berdasarkan data dinkes kota Surabaya 2015 prevalensi penyakit TB tertinggi di Kecamatan Tandes yaitu ditemukan sebanyak 551 jiwa dengan suspek TB dan 114 jiwa ditemukan dengan BTA+. Angka kejadian Tuberculosis (TB) menunjukkan adanya peningkatan dari tahun ke tahun. Jumlah kasus TB baru di Surabaya tahun 2016 sejumlah 5.428 pasien dan jumlah kasus TB baru pada tahun 2017 sejumlah 6.488 pasien . kasus TB di Jatim yang terdeteksi dibandingkan jumlah kasus nasional meningkat dari 40 persen di tahun 2016, menjadi 46 persen di tahun 2017 dan 49 persen di tahun 2018.

Tujuan Penelitian ini 1) Mendapatkan gambaran penanganan Tuberculosi (TB) masyarakat di surabaya). 2) mengeksplorasi bentuk penenganan TB Berbasis Masyarakat di Surabaya .

Tahap pra pengembangan model yang terdiri dari langkah pertama hingga ke tiga menggunakan pendekatan kualitatif telah dilaksanakan di tahun pertama peneliti dengan melakukan observasi lapangan tentang pemahaman dan pelaksanaan Manajemen TB, wawancara dengan pihak kecamatan, dinas kesehatan, petugas puskesmas, kader, kelurahan, PMO, penderita tentang pemahaman dan pelaksanaan Manajemen TB, dilanjutkan dengan focus group discussion (FGD). Jumlah partisipan dalam penelitian ini adalah 50 orang yang terdiri dari pihak Kecamatan 3 orang , Dinas Kesehatan Kota Surabaya 1 orang, Puskesmas 6 orang, Kader Kesehatan 15 orang, Satgas TB 6 orang, PMO 10 orang dan penderita TB di wilayah Kecamatan Kenjeran, Tandes dan Pabean Cantikan Surabaya 15 orang. Teknik pengambilan sampel adalah Purposive sampling. Data

kualitatif dalam tahap pra pengembangan model dianalisis dengan menggunakan thematic analysis

Luaran pada penelitian adalah Rencana target Tahun I dari penelitian ini adalah Prosiding Internasional Conference dan Jurnal Internasional bereputasi

Target TKT tahun pertama adalah 2.

Hasil penelitian mendapatkan 3 tema utama dan subtheme sebagai berikut: 1. Manajemen TB Komunitas dengan sub tema a. tingkat kewaspadaan (i. Kemudahan proses adminitrasi, ii. Efek samping, iii. Kepatuhan); b. Pelayanan (i. Fasilitas kesehatan, ii. Dukungan sosial); c. Pendidikan (i. Stigma dan mitos, ii. Kesadaran akan bahaya TB); 2. Perspektif Tenaga kesehatan dengan sub tema a. Faktor individu (i. Keterlambatan diagnosis, ii. Beban finansial); b. Pelatihan tenaga kesehatan (i. Perbanyak pelatihan, ii. Kekurangan tenaga dan sumberdaya); 3. Perspektif kader TB dengan sub tema a. Altruism sebagai faktor motivasional, b. kekurangan kader muda, c. Identifikasi kebutuhan akan peningkatan keahlian dan pelatihan.

B. KATA KUNCI: Tuliskan maksimal 5 kata kunci.

tuberkulosis; pusat krisis berbasis masyarakat; kualitatif

Pengisian poin C sampai dengan poin H mengikuti template berikut dan tidak dibatasi jumlah kata atau halaman namun disarankan seringkas mungkin. Dilarang menghapus/memodifikasi template ataupun menghapus penjelasan di setiap poin.

C. HASIL PELAKSANAAN PENELITIAN: Tuliskan secara ringkas hasil pelaksanaan penelitian yang telah dicapai sesuai tahun pelaksanaan penelitian. Penyajian dapat berupa data, hasil analisis, dan capaian luaran (wajib dan atau tambahan). Seluruh hasil atau capaian yang dilaporkan harus berkaitan dengan tahapan pelaksanaan penelitian sebagaimana direncanakan pada proposal. Penyajian data dapat berupa gambar, tabel, grafik, dan sejenisnya, serta analisis didukung dengan sumber pustaka primer yang relevan dan terkini.

LAPORAN KEMAJUAN PENELITIAN

1. IDENTITAS PENELITIAN(diisikan sesuai dengan proposal)

A. JUDUL PENELITIAN

MODEL PENGEMBANGAN PUSAT KRISIS BERBASIS MASYARAKAT UNTUK PENANGANAN TUBERCULOSIS DI SURABAYA

B. BIDANG, TEMA, TOPIK, DAN RUMPUN BIDANG ILMU

Bidang Fokus RIRN/ Bidang Unggulan Perguruan Tinggi	Tema	Topik (jika ada)	Rumpun Bidang Ilmu
Kesehatan dan Kesejahteraan	……	kesehatan masyarakat	Ilmu Keperawatan

C. KATEGORI, SKEMA, SBK, TARGET TKT DAN LAMA PENELITIAN

Kategori (Kompetitif Nasional/ Desentralisasi / Penugasan	Skema Penelitian	Strata (Dasar/ Terapan/ Pengembangan)	SBK (Dasar/ Terapan/ Pengembangan)	Target Akhir TKT	Lama Penelitian (Tahun)
Penelitian Desentralisasi	Penelitian Dasar Unggulan Perguruan Tinggi	SBK Riset Dasar	SBK Riset Dasar	3	2

2. IDENTITAS PENGUSUL

Nama, Peran	Perguruan Tinggi/ Institusi	Program Studi/ Bagian	Bidang Tugas	ID Sinta	H-Index
MUNDAKIR Ketua Pengusul	Universitas Muhammadiyah Surabaya	Ilmu Keperawatan		5989021	0
ASRI S.Kep, M.N.S. Anggota Pengusul 1	Universitas Muhammadiyah Surabaya	Ilmu Keperawatan		6081226	1
Dst. ……	……	……	……	……	……

3. MITRA KERJASAMA PENELITIAN (JIKA ADA)

Mitra	Nama Mitra
……	……

4. LUARAN DAN TARGET CAPAIAN

Luaran Wajib

Tahun Luaran	Jenis Luaran	Status Target Capaian (accepted, published, terdaftar atau granted, atau status lainnya)	Keterangan (url dan nama jurnal, penerbit, url paten, keterangan sejenis lainnya)
2019	Publikasi Ilmiah Jurnal Internasional	accepted/published	……

Luaran Tambahan

Tahun Luaran	Jenis Luaran	Status Target Capaian (accepted, published, terdaftar atau granted, atau status lainnya)	Keterangan (url dan nama jurnal, penerbit, url paten, keterangan sejenis lainnya)
2019	Prosiding dalam pertemuan ilmiah Internasional	sudah terbit/sudah dilaksanakan	ICHT 2019

5. KEMAJUAN PENELITIAN

Ringkasan penelitian berisi latar belakang penelitian, tujuan dan tahapan metode penelitian, luaran yang ditargetkan, serta uraian TKT penelitian yang diusulkan.

A. RINGKASAN

LATAR BELAKANG
1.2 Latar Belakang Masalah

World Health Organitation (WHO) menyatakan bahwa *Tuberkulosis* (TB) merupakan masalah kedaruratan global bagi kemanusiaan dan masih menjadi permasalahan penting diberbagai Negara belahan dunia. Di Indonesia, walaupun strategi DOTS telah terbukti sangat efektif untuk pengendalian TB, tetapi beban penyakit TB di masyarakat masih sangat tinggi. Hal ini karena penerapan strategi DOTS dan progam-progam penanganan TB dalam penerapanya masih memiliki tantangan dan masalah di masyarakat. Kendala utamanya adalah kegagalan untuk memobilisasi semua kapasitas masyarakat, melibatkan anggota masyarakat untuk berpartisipasi, dan ketidakjelasan bentuk kontribusi dan siapa yang harus terlibat dalam kegiatan Program Penanganan TB yang mempengaruhi keberlanjutan dan efektivitas progam (Depkes RI 2012).

Beberapa upaya yang dilakukan pemerintah untuk menanganani TB sampai menghilangkan angka kejadian TB melalui berbagai macam kebijakan dan berbagai program belum mampu menjawab permasalahan yang ada. Sebuah program perlu diadakan melalui pemberdayaan dan pengembangan masyarakat yang dilakukan secara berkelanjutan disertai upaya pemantauan dari petugas kesehatan setempat. Tingkat keberhasilan dan efektivitas program-program tersebut terutama tergantung pada kesiapan kapasitas masyarakat untuk menerima dan menerapkan progam-progam tersebut. (Taman dan Lloyd, 2004).

Di indonesia progam utama dalam penanganan kasus TB yaitu dengan menggunakan strategi DOTS (*Directly Observed Treatment Shortcourse*). Fokus utama DOTS adalah penemuan dan penyembuhan pasien. Strategi ini akan memutuskan penularan TB, dengan demikian juga akan menurunkan angka kejadian TB di masyarakat. Namun pada penerapannya Fasilitas Pelayanan Kesehatan tidak semuanya menanganani pasien TB dengan sistem DOTS. Implementasi dan akselerasi DOTS di Fasilitas Pelayanan Kesehatan selain Puskesmas di Indonesia tahun 2010 menunjukkan bahwa hanya 30% rumah sakit telah menerapkan strategi DOTS. Untuk praktik swasta, strategi DOTS belum diimplementasikan secara sistematik (Stranas TB 2011).

Propinsi jawa timur merupakan salah satu propinsi di Indonesia yang masih mengalami masalah dalam penanggulangan penyakit tuberkulosis dengan prevalensi 110 per 100.000 penduduk. Di Surabaya dengan jumlah penduduk sebanyak 2.848.583 jiwa ditemukan kasus suspek TB sebanyak 16.616 jiwa dan dengan BTA + sebanyak 2.330 jiwa. Berdasarkan data Dinkes kota Surabaya 2015 prevalensi penyakit TB tertinggi di Kecamatan Tandes yaitu ditemukan sebanyak 551 jiwa dengan suspek TB dan 114 jiwa ditemukan dengan BTA +. (Dinkes Kota Surabaya 2015). Pada tahun 2016 Ditemukan sebanyak 109 TB jiwa TB baru dengan keseluruhan jumlah penderita TB adalah 170 dengan angka Sukses Rate sejumlah 88,64% (Dinkes Kota Surabaya 2016). Angka ini termasuk dari tiga besar kejadian TB di Kota Surabaya.

Pemberdayaan Masyarakat dalam Penanggulangan Krisis Kesehatan merupakan upaya untuk menumbuhkembangkan kemampuan masyarakat agar secara mandiri memiliki pengetahuan dan ketrampilan di bidang kesehatan. Upaya pemberdayaan ini merupakan upaya

yang sangat penting. Dalam UU Nomor 24 Tahun 2007 tentang Penanggulangan Bencana dinyatakan bahwa setiap orang berkewajiban menjaga kehidupan sosial masyarakat yang harmonis, memelihara keseimbangan, keserasian, keselarasan, dan kelestarian fungsi lingkungan hidup; melakukan kegiatan penanggulangan bencana; dan memberikan informasi yang benar kepada publik tentang penanggulangan bencana.

Upaya pemberdayaan masyarakat harus dimulai dari pengenalan masalah dan potensi spesifik daerah, oleh karenanya diperlukan pendelegasian wewenang lebih besar kepada daerah. Kesiapan daerah dalam menerima dan menjalankan kewenangannya sangat dipengaruhi oleh tingkat kapasitas daerah yang meliputi perangkat organisasi dan sumber daya manusianya, serta kemampuan fiskal. Tujuan pemberdayaan masyarakat adalah memampukan masyarakat mengurangi ancaman, menurunkan kerentanan dan meningkatkan kemampuannya menyelesaikan krisis kesehatan.

1.2 Tujuan Khusus

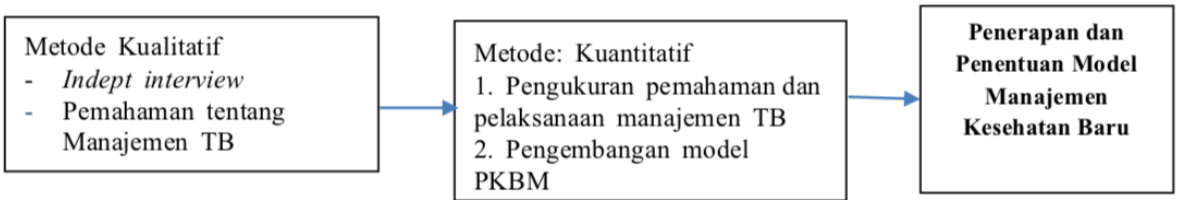
Tahun Ke – 1

Menyusun model pengembangan penanganan Tuberculosis (TB) dengan mengggunakan model Pusat Krisis Berbasis Masyarakat (PKBM).

METODE PENELITIAN

4.1 Rancangan Penelitian

Metode penelitian yang akan digunakan dalam penelitian ini adalah mixed methods, yaitu metode gabungan antara kualitatif dengan kuantitatif (Creswell, 2008). Metode kualitatif akan digunakan untuk mendapatkan informasi tentang pemahaman dan pelaksanaan manajemen TB di Kecamatan Pabean Cantikan, Tandes, Kenjeran Surabaya. Sedangkan metode kuantitatif digunakan untuk mengumpulkan data terkait pengaruh model PKBM dalam meningkatkan pemahaman dan pelaksanaan Manajemen TB melalui rancangan eksperimental dengan membandingkan keadaan sebelum dan sesudah perlakuan. Secara detail desain dijelaskan dalam gambar 4.1 sebagai berikut:



Gambar 4.1. Rancangan Penelitian *Exploratory Mixed-Method*

4.2 Tahapan Penelitian

Penelitian menggunakan menggunakan langkah-langkah siklus riset dan pengembangan. Borg & Gall (1983) menyebutkan bahwa terdapat sepuluh (10) langkah dalam penerapan the R&D cycle, yaitu (1) penelitian dan pengumpulan informasi (2) perencanaan-*planning*, (3) pengembangan model (4) uji coba model-*preliminary field testing*, (5) revisi model, (6) uji coba lapangan satu, (7) revisi model hasil uji lapangan- 8) uji lapangan model operasional- (9) revisi akhir model (10) desiminasi dan implementasi. Dari 10 langkah the R&D cycle, akan dikelompokan menjadi tiga tahap, yaitu: (1) pra pengembangan model, (2) pengembangan model, (3) penerapan model.

Dari 10 langkah the R&D cycle, telah dikelompokan menjadi tiga tahap yaitu tahap pra pengembangan model, pengembangan model dan penerapan model. Tahap pra pengembangan model yang terdiri dari langkah pertama hingga ke tiga telah dilaksanakan di tahun pertama peneliti dengan melakukan observasi lapangan tentang pemahaman dan pelaksanaan Manajemen TB, wawancara dengan pihak kecamatan, dinas kesehatan, petugas puskesmas, kader, kelurahan, PMO, penderita tentang pemahaman dan pelaksanaan Manajemen TB, dilanjutkan dengan *focus group discussion (FGD).*

Sedangkan langkah empat hingga ke sepuluh dilaksanakan pada tahun kedua sebagai langkah pengembangan dan penerapan model. Secara rinci terlihat di gambar berikut ini:

TAHUN PERTAMA

Tahap 1- Pra pengembangan model (Tahap 1-3)
Tujuan penelitian:
1. Memperoleh informasi tentang gambaran pemahaman Manajemen penanganan TB
2. Memperoleh informasi tentang gambaran pelaksanaan Manajemen penanganan TB

Tahap Kegiatan:
1. Pengkajian literatur/ teoritik
2. Pengumpulan data
   - pengurusan ijin penelitian
   - surve/ observasi lapangan dan daya dukung lingkungan
   - wawancara dengan Partisipan tentang pemahaman dan Pelaksanaan Manajemen penanganan TB
   - focus group discussion dengan Partisipan tentang pemahaman dan Pelaksanaan Manajemen penanganan TB
   - Pengukuran Pemahaman dan Pelaksanaan Manajemen penanganan TB

TAHUN KEDUA

Tahap 2- Pengembangan model (Tahap 4-7)
Tujuan penelitian:
1. Mengembangkan kerangka kerja hipotetik dan model PKBM
2. Mengembangkan model PKBM

Tahap Kegiatan:
4. Pengembangan model:
   - sosialisasi kepada seluruh masyarakat kecamatan di Surabaya
   - workshop pada masyarakat
   - penyusunan Plan of Action (PoA) tentang rencana penerapan model
5. Uji coba awal danperbaikan awal
6. Uji lapangan tahap 1
7. Perbaikan operasional

Tahap 3- Penerapan model (Tahap 8-10)
Tujuan penelitian:
1. Memperoleh data empiris tentang efektifitas PKBM

Tahap Kegiatan:
8. Uji coba lapangan 2
9. Hasil pengamatan uji coba lapangan dan perbaikan hasil akhir
10. Penerapan model dan desiminasi

Gambar 4.2. Rencana Pelaksanaan Penelitian Tahun Pertama dan Kedua

Penelitian dilakukan di Tiga Kecamatan dengan angka kejadian TB paling tinggi yaitu: Pabean Cantikan, Tandes, Kenjeran Surabaya. Penelitian dilaksanakan selama 3 tahap, yaitu: (1) ***pra pengembangan model*** melalui studi survey, studi dokumentasi, wawancara, dan focus group discussion (FGD) bersama Pihak Kecamatan, Dinas Kesehatan Kota Surabaya, Puskesmas, Kader Kesehatan, Satgas TB, PMO dan penderita TB, (2) ***pengembangan model*** , diawali dengan training bagi Pihak Kecamatan, Dinas Kesehatan Kota Surabaya, Puskesmas, Kader Kesehatan, Satgas TB, PMO dan penderita TB dengan durasi training selama empat hari penuh. Jadwal training dikoordinasikan dengan Warga, kemudian dilanjutkan dengan pengembangan model dengan evaluasi formatif melalui uji coba terbatas pada salah satu Kecamatan, (3) ***penerapan model*** dengan membuktikan keefektifan model pada program kecamatan lain.

3.4 Populasi, Sampel, Teknik Pengambilan Sampel, dan Besar Sampel

Jumlah partisipan dalam penelitian ini adalah 50 orang yang terdiri dari pihak Kecamatan 3 orang , Dinas Kesehatan Kota Surabaya 1 orang, Puskesmas 6 orang, Kader Kesehatan 15 orang, Satgas TB 6 orang, PMO 10 orang dan penderita TB di wilayah Kecamatan Kenjeran, Tandes dan Pabean Cantikan Surabaya 15 orang. Teknik pengambilan sampel adalah *Purposive sampling*.

3.4.1 Variabel Penelitian

Variabel dalam penelitian ini terdiri dari dua variabel yaitu variabel bebas dan variabel tergantung. Variabel bebas penelitian ini adalah model PKBM, sedangkan variabel tergantungnya adalah pemahaman dan pelaksanaan penanganan TB .

3.4.2 Instrumen Penelitian

Instrumen yang akan digunakan dalam pengumpulan data adalah daftar cek masalah, jurnal kegiatan harian, dan instrument validasi model. Daftar cek masalah, jurnal legiatan harian, dan lembar wawancara yang digunakan untuk penggalian informasi data lapangan tentang implementasi Manajemen TB. Instrumen validasi model digunakan untuk mengukur kelayakan model pada tahap 1, dimana instrument ini mengukur komponen model yang meliputi penggunaan istilah, sistematika model, rumusan asumsi model, kejelasan struktur model, keterbacaan model, dan kesesuaian komponen antar model.

3.8 Teknik Pengumpulan Data

Pengumpulan data dilakukan dengan survey/observasi lapangan dan telah mendapatkan gambaran situasi tentang penanganan Tuberculosis (TB) yang dilakukan secara nyata. Selain dengan dengan observasi, dilakukan juga wawancara dan *focus group discussion* (FGD) kepada Pihak Kecamatan, Dinas Kesehatan Kota Surabaya, Puskesmas, Kader Kesehatan, Satgas TB, PMO dan penderita TB di wilayah Kecamatan Kenjeran, Tandes dan Pabean Cantikan Surabaya.

3.9 Teknik Analisis Data

Data kualitatif dalam tahap pra pengembangan model dianalisis dengan menggunakan *thematic analysis* menggunakan enam tahap menurut Braun and Clarke (2006). Pada tahap penerapan

model di tahun kedua teknik analisa data yang digunakan persentase dan uji perbedaan dua rata-rata atau uji t-test. Teknik uji perbedaan rata dan uji t-test digunakan untuk menguji kefektifan model .

3.10 Peta Penelitian

Penelitian ini sejalan dengan rencana induk penelitian Universitas Muhammadiyah Surabaya yang berorientasi pada peningkatan kesadaran multikultural, toleransi dan menciptakan masyarakat sipil yang beradab serta menghasilkan inovasi yang dapat dimanfaatkan khususnya oleh masyarakat kampus.

2019	1. Pra pengembangan model tentang penerapan Manajemen TB 2. Pengembangan model pembelajaran berbasis PKBM yang melibatkan Pihak Kecamatan, Dinas Kesehatan Kota Surabaya, Puskesmas, Kader Kesehatan, Satgas TB, PMO dan penderita TB
2020	Pengembangan dan penerapan Manajemen TB melalui model PKBM di Kecamatan Pabean Cantikan, Tandes, Kenjeran.

3.11 Luaran Penelitian Luaran penelitian ini adalah:

1. Modul Pusat Krisis Berbasis Masyarakat (PKBM) untuk TB
2. Publikasi jurnal ilmiah internasional dan nasional terakeditasi
3. Prosiding konferensi ilmiah internasional

3.12 Indikator Capaian Tahunan

1. Tahun I indikator yang diharapkan adalah pemetaan data tentang penerapan manajemen TB

2. Tahun II indikator yang digunakan adalah jurnal ilmiah internasional bereputasi dan terdapat modul modul Pusat Krisis Berbasis Masyarakat untuk penanganan TB di Surabaya

Hasil penelitian berisi kemajuan pelaksanaan penelitian, data yang diperoleh, dan analisis yang telah dilakukan

B. HASIL PENELITIAN

HASIL

Peneliti telah melakukan wawancara dengan 40 partisipan dan dua kali Focus Group Discussion yang terdiri dari Pihak Kecamatan 3 orang , Dinas Kesehatan Kota Surabaya 1 orang, Puskesmas 6 orang, Kader Kesehatan 15 orang, Satgas TB 6 orang, Pengawas Menelan Obat 10 orang di Tiga kecamatan yang menjadi lokasi penelitian.

Analisis data menggunakan teknik *Thematic Analysis* menghasilkan tema sebagai berikut:

1. Manajemen TB Komunitas
    a. Tingkat kewaspadaan

i. Kemudahan proses adminitrasi
Pemerintah melalui DOTS telah banyak melakukan inovasi guna mengurangi angka penemuan, kejadian dan juga tingkat keberhasilan pengobatan dengan memberikan kemudahan administratif bagi penderita TB. Pernyataan dari wawancara berikut menujukkan hal tersebut.
"*beberapa puskesmas, seperti misalnya di kecamatan kenjeran ini, tak ada antrian untuk pasien TB, juga sudah ada kader kesehatan yang siap membantu. Saya misalnya membantu kalo ada pasien yang tak bisa pergi ke puskesmas ya saya yang antrikan mas*" (P1, Kader Kenjeran).

ii. Efek samping
Banyak pasien mengeluhkan tentang beratnya efek samping pengobatan yang dijalani. Di antara keluhan yang paling banyak di terima dan dilaporkan adalah rasa tidak enak makan, lemas, letih dan juga berat badan turun.
"saya itu mas kalo ketemu tukang becak yang penderita itu merasa iba, sekarang selama pengobatan yang sudah 3 bulan ini tidak bisa lagi narik becak, karena katanya badannya lemas" (P14, Kader Sawahan)

iii. Kepatuhan
Hal yang juga sulit ditangani adalah soal kepatuhan minum obat dan cek rutin. Namun dengan usaha kader untuk mengawasi perkembangan pengobatan, tak banyak pasien di tiga kecamatan ini yang mengalami Drop out atau putus obat.
"semenjak saya ikut menjadi kader TB, dulunya saya kader balita juga jadi sudah banyak yang tahu, saya dekati paisen untuik sabar dan menjalani pengobatan, pasien yang saya dampingi alhamdulillah tak ada yang putus obat mas" (P21, Kader Pabean Cantikan)

b. Pelayanan
i. Fasilitas kesehatan
Di Surabaya ada 63 puskesmas yang tersebar di seluruh wilayah dan semuanya bias melayani pengobatan TB. Namun beberapa fasilitas kesehatan tersebut masih banyak yang belum memiliki alat Tes Cepat Molukuler yang digunakan untuk diagnosis cepat TB.
"Di Surabaya itu ada 19 alat TCM bahwa 15 alat itu disebar di puskesmas, nah sumber dananya ini yang banyak dari APBD, dan 4 tersebar di 3 rumah sakit dimana setiap fasyankes yang mempunyai TCM ini kita berikan jejaring. Jadi setiap puskesmas membahwai 1 puskesmas jejaring untuk rujukan. TCM sedangkan yg ada di rumah sakit itu jejaring dengan puskesmas, klinik dan rumah sakit sekitar". (P10, Dinas Kesehatan Kota Surabaya)

ii. Dukungan sosial
Peran warga dan pemerintah sangat penting dalam memberikan dukungan pada pasien TB.
"Kemudian setelah hasil follow up hasilnya negatif kemudian keadaan umum ada peningkatan berat badan kita melaporkan bahwa itu dari pihak ketenagakerjaan waktu itu beliau dapat perjanjian kontrak untuk kerja di pemkot sebagai tukang sapu jadi sampai saat ini dia menjadi tukang sapu kemudian untuk pengobatannya sekarangg sudah mau selesai jadi berikut adalah salah satu bukti respon untuk pemerintah baik tingkat bawah maupun tingkat utama itu berjalan secara balance". (P7, Tenaga Kesehatan)

c. Pendidikan
i. Stigma dan mitos

Masih banyak masayarakat yang memiliki persepsi yang kurang baik tentang penderita TB. Hal ini salah satunya yang menyebabkan penderita TB merasa dikucilkan dari warga, dan juga sulit untuk melakukan interaksi social secara luas dan bebas.
"ada bu RT yang jualan nasi, kemudian ada warga yang tahu kalo dia penderita TB hingga kemudian menyebar. Itu akhirnya jualannya jadi sepi mas" (P7, kader kenjeran)

ii. Kesadaran akan bahaya TB
Banyak juga penderita yang masih memiliki kesadaran rendah tentang bahaya TB. Dari beberapa upaya pencegahan yang di promosikan oleh tenaga kesehatan dan kader TB terindikasi bahwa pendeita TB masih banyak yang tidak menggunakan masker saat keluar rumah atau di rumah.
"*saya waktu kunjungan mikir-mikir mas, ini penderita anaknya kecil-kecil kok ya masih tidak pakai masker. Saat itu saya terus bilang mbak yang di puskesmas, boleh tidak memeriksakan anggota keluarga yang lain kalau-kalau tertular TB*"(P2, Kader pabaean cantikan)

2. Perspektif Tenaga kesehatan
   a. Faktor individu
      i. Keterlambatan diagnosis
      Kasus keterlambatan diagnosis TB biasanya dialami oleh mereka yang melakukan pemeriksaan pada fasilitas pelayanan kesehatan swasta. Hal ini wajar ketika banyak warga yang masih enggan periksa ke puskesmas. Warga yang memiliki tandsa tanda batuk lama dan juga tanda gejala TB yang lain ingin cepat sembuh pergi ke pelayanan swasta, dan beberapa kali periksa baru akan di diagnose menderita TB. Setelah itu mereka akan menruskan perawatan di fasilitas swasta atau minta rujukan arau dirujuk ke puskesmas setempat.
      "ada warga sini, orang menegah ke atas, dulunya pegawai swasta, periksa ke swasta. Tiap periksa tidak tahu penyakitnya dan obatnya mahal. Kemudian keluarganya cerita ke kader TB, baru mereka tahu kalu itu gejala TB dan kemudian mau ke puskesmas setelah habis banyak biaya, padahal di puskesmas gratis" (P11, Kader Tandes)

      ii. Beban finansial
      Penyakit TB merupakan penyakit kronis yang memakan proses penyembuhan yang lama. Banyak penderita yang kemudian mengalami permasalahan finasial. Hal ini terjadi karena banyak warga yang menderita TB juga kebanyakan adalah warga kelas ekonomi menegah ke bawah.
      "*saya punya pasien, dulunya kerja di pabrik, setelah ketahuan dia punya TB, kena PHK, ini nyata mas dan dia tulang punggung keluarga. Akhirnya kami dari asiyiyah membantu urunan"*(P18, Kader Kenjeran)

   b. Pelatihan tenaga kesehatan
      i. Perbanyak pelatihan
      Kader dan tenaga kesehatan masih banyak yang jarang mengikuti pelatihan tentang penaganan TB. Saat ini Asiyiyah adalah satu organisasi masyakarat yang masih konsisten memberikan pelatihan bagi para kader dan juga PMO penderita TB.
      "ada kader baru yang perlu terus menerus ikut pelatihan. Ilmunya akan jadi tambah. Kalau kita yang meberikan ilmu kan kurang lengkap". (P12, Kader Tandes)

      ii. Kekurangan tenaga dan sumberdaya

Dampak yang terasa bagi pelayanan kesehatan untuk pemeriksaan TB adalah kekurangan tenaga ahli laboratorium dan juga perawatan atau petugas kesehatan yang menangani TB. Di beberapa puskesmas hanya memiliki satu laboran dan satu perawata untuk mengeola seluruh pasien TB, padahal puskesmas ini memiliki 5 wilayah kelolaan.
"pernah kita kewalahan, banyak sekali sampel dahak yang dikirim. Beban laboran kian bertambah, padahal kegiatan rutin pemeriksaan yang sehari hari juga terus berajalan." (P6, Puskesmas Tandes)

3. Perspektif kader TB
    a. Altruism sebagai faktor motivasional
    Sebagai kader dan merupakan kerja sosial, warga yang menjadi kader TB sadar akan peran yang mereka lakukan adalah memberikan banyak manfaat pada tetangga dan juga warga lain yang mebutuhkan pertolongan. Kader kesehatan adalah ujung tombak informasi dan pelayanan kesehatan terdepan dan tentu yang paling dekat pendeita langsung. Mereka memegang peranan yang signifikan keseluruhan proses manajemen TB. Beban yang berat tak menjadi soal.
    "saya sudah niatkan menolong sesama, memberi manfaat dan tentu saja ibadah mas" (P 27, Kader Pabean Cantikan)

    b. Kekurangan kader muda
    Problem yang saat ini terjadi adalah sulitnya mencari kader muda. Kebanyakan kader TB saat ini adalah mereka dari golongan yang tak lagi muda dan juga merangkap menjadi kader pada bidang lain, seperti kader posyandu balita, kader sosial dan juga aktif di PKK dan berbagai lapisan kelompok sosial yang lain.
    "sangat sulit mencari kader baru mas, saya ini contohnya saya paksa anak saya untuk menjadi kader TB karena dulu dia pernah menjadi penderita. Jadi bagus membagi pengalamannya pada yang lain. Alhamdulillah anaknya mau dan nyaman, sampai saat ini sudah kurang lebih 3 tahun menjadi kader"(P 25, kader tandes)

    c. Identifikasi kebutuhan akan peningkatan keahlian dan pelatihan
    Kader mengakui bahwa, karena TB yang resistan terhadap obat menjadi semakin banyak di komunitas mereka, mereka membutuhkan lebih banyak informasi tentang manajemen pasien TB-MDR dan memberi nasihat kepada pasien tentang pentingnya kepatuhan untuk mencegah resistensi. Kader merasa bahwa pelatihan yang berkelanjutan akan memperlengkapi mereka untuk mendidik lebih baik dan memberdayakan pasien dan sesama anggota masyarakat.

    "*kita memang butuh pelatihan, ikut seminar atau workshop. Yang sering diikutkan biasanya kader senior, tapi yang muda muda justeru harusnya mendapatkan perhatian banyak karena energi mereka jauh lebih banyak. Beruntung kita sering ikut pelatihan baik dari aiyiyah maupun dinas kesehatan…itu harus terus menerus" (P22, Kader kenjeran)*

    Berbagai macam tanggapan diterima sehubungan dengan konten, durasi, frekuensi dan kualitas pelatihan. Meskipun semua melaporkan menerima pelatihan, beberapa Kader TB merasa bahwa itu tidak memadai karena mereka kurang memahami bagaimana menangani masalah-masalah tertentu, misalnya menjelaskan kepada pasien bagaimana menghasilkan dahak yang berbeda dengan air liur, dan bagaimana menanggapi pasien ketika mereka melaporkan kurangnya makanan yang tersedia sebagai alasan untuk mangkir pengobatan. Mereka merasa bahwa satu sesi pelatihan tanpa pelatihan lanjutan tidak memadai, karena mereka perlu memperkuat topik tertentu dan memperluas pengetahuan mereka.

PEMBAHASAN

Manajemen TB Komunitas

Tiga sub-tema Kepatuhan, Kemudahan Administrasi dan Efek Samping menunjukkan perlunya waspada untuk mengelola dan mengendalikan situasi TB di Indonesia dan dunia. Kepatuhan yang rendah terhadap rejimen medis yang ditentukan adalah masalah di mana-mana. Kurangnya kepatuhan pasien terhadap obat yang diresepkan menimbulkan tantangan serius bagi komunitas perawatan kesehatan global. ALERT akan membantu memantau pasien TB untuk menyelesaikan rejimen pengobatan obat mereka melalui pengingat obat. Ini menjelaskan masalah yang terkait dengan kepatuhan rezim pengobatan untuk pasien TB.

Fasilitas layanan kesehatan, dampak emosional dan dukungan sosial dikelompokkan ke dalam Care sebagai faktor penting dalam mengendalikan dan mengelola situasi TB di Indonesia dan dunia. Sistem perawatan akan membantu pasien menjalani pengobatan dengan pandangan positif dengan menghubungkan mereka dengan kelompok pendukung dan memulihkan pasien dan juga mendukung pemantauan aktif terhadap kemungkinan terpajan TB pada keluarga, teman, atau tetangga. Selain itu, akan memungkinkan pesan dari dokter pribadi dan otoritas kesehatan untuk mendorong pasien untuk menyelesaikan rezim perawatan mereka. Beberapa faktor terkait pasien telah dikutip untuk kepatuhan pengobatan yang buruk oleh pasien seperti pengetahuan yang buruk tentang penyakit, persepsi yang tidak memadai tentang perlunya pengobatan dan kelupaan (WHO, 2003). Meningkatkan kepatuhan terhadap rejimen jangka panjang membutuhkan perhatian dan dukungan sosial dari keluarga dan teman. Adalah umum bahwa beberapa pasien mengalami depresi dan membutuhkan kata-kata harapan dan dorongan dari orang lain untuk kesejahteraan mental dan sosial mereka. Dengan demikian, merawat fasilitas kesehatan dan memberikan dukungan emosional dan sosial kepada pasien yang tertekan dapat membantu pasien mematuhi rezim pengobatan dan dengan demikian mengendalikan dan mengelola penyebaran penyakit mematikan ini.

Studi sebelumnya telah melaporkan sikap sinis dan tidak peduli dari penyedia layanan kesehatan sebagai penghalang utama untuk kepatuhan pengobatan yang efektif (Khan et al., 2005). Dengan demikian, ketidakpatuhan pada pasien tidak hanya karena faktor pribadi seperti pelupa dan pengetahuan yang tidak memadai tentang penyakit tetapi juga karena faktor sosial seperti kurangnya jaringan dukungan yang efektif untuk pasien (Capegemini, 2011). Ketika orang memiliki kontak dan dukungan sosial yang lebih banyak, mereka pada dasarnya lebih bahagia dan lebih sehat.

Pelatihan dan peningkatan Skill

Pengetahuan TB yang buruk dapat memengaruhi perilaku mencari kesehatan dan kepatuhan, berdampak pada pengendalian TB. Dengan basis pengetahuan mereka, Kader mampu mengidentifikasi bidang pengetahuan TB yang kurang pada pasien mereka sehingga mereka merasa terpengaruh oleh manajemen TB. Peran mereka, dikombinasikan dengan hubungan pasien yang baik, idealnya menempatkan mereka untuk meningkatkan kesadaran TB di masyarakat dan mempromosikan kepatuhan di antara pasien. Namun, efektivitas mereka tergantung pada pelatihan dan dukungan yang memadai dari sistem perawatan kesehatan. Sejumlah penelitian mendukung temuan kami tentang kelemahan dalam pelatihan Kader Tb , sejalan dengan kesimpulan kami tentang pelatihan dasar yang tidak memadai, dengan variabilitas yang tidak dapat diterima dalam kursus konten dan durasi. Kurangnya pelatihan penyegaran terus-menerus, yang ditekankan oleh KADER TB kami, merupakan komponen penting yang dilaporkan mengakibatkan hilangnya keterampilan dan pengetahuan.

Kebijakan dan pedoman pengobatan TB terus diperbarui, tetapi hanya dapat diterapkan jika semua tingkat pekerja layanan kesehatan diperbarui, suatu kekurangan yang

diidentifikasi oleh KADER TB setempat. Saluran komunikasi yang memadai antara KADER TB dan petugas layanan kesehatan lainnya sangat penting karena mereka memberi informasi kepada KADER TB tentang masalah yang muncul. Ketidakmampuan melaporkan KADER TB untuk mengklarifikasi konsep tertentu kepada pasien lebih jauh menekankan perlunya pelatihan pengalaman, mungkin dalam bentuk permainan peran, untuk membiasakan mereka
dalam menangani interaksi pasien yang sulit.
KADER TB mengutip sumber terbatas dari informasi yang tersedia, yang penting mengidentifikasi kurangnya bahan tertulis yang sesuai. Telah direkomendasikan bahwa program pelatihan harus mengembangkan materi informasi khusus untuk KADER TB alih-alih menggunakan materi pelatihan yang ditujukan untuk profesional kesehatan formal (WHO, 2010) karena, dengan pendidikan formalnya yang terbatas, kebutuhan informasi KADER TB cenderung berbeda dengan kebutuhan profesional kesehatan lainnya. Karena itu mereka mungkin membutuhkan bahan yang mengandung bahasa yang lebih sederhana, dengan lebih banyak ilustrasi, untuk memenuhi status pendidikan yang lebih rendah (WHO, 2010).
Materi informasi bergambar seperti daftar periksa, kartu, booklet dan leaflet telah berhasil digunakan untuk meningkatkan peran KADER TB dalam malaria, dan dalam kesehatan ibu dan anak dan juga telah terbukti meningkatkan pengetahuan pada pasien dengan kemampuan baca tulis terbatas. Antusiasme yang ditunjukkan oleh KADER TB terhadap konten bergambar dan keinginan mereka untuk memiliki akses ke beberapa bentuk informasi tertulis telah menginformasikan penelitian kami selanjutnya yang sedang berlangsung. Kami kemudian mengembangkan dan mengevaluasi dampak dari buku kecil bergambar yang berisi informasi TB terkait untuk KADER TB dan untuk peran edukasi pasien mereka.

Mitos dan Stigma

Mitos dan stigma TB, kesadaran dan melek kewarganegaraan semuanya terkait dengan kurangnya pendidikan di kalangan masyarakat umum. Walaupun anggota masyarakat umum tidak diwawancarai untuk penelitian ini, namun orang yang kami wawancarai adalah profesional medis dan non-medis yang menangani pasien TB dan masyarakat umum secara teratur. Komentar dan pendapat mereka sangat penting karena mereka menyoroti kekurangan utama yang mereka hadapi dalam mengendalikan dan mengelola penyebaran TB. Kebutuhan untuk mendidik masyarakat umum muncul sebagai faktor kunci dalam mengendalikan situasi TB di Indonesia dan negara-negara lain. Oleh karena itu, tiga sub-tema dikelompokkan dalam tema utama pendidikan. Pendidikan akan menanamkan kewarganegaraan melek huruf di masyarakat umum. Jika sistem Pendidikan TB dikembangkan, itu akan membantu menyebarkan informasi yang tepat waktu tentang daerah rawan TB dan wabah kepada masyarakat umum, rumah sakit dan otoritas kesehatan yang relevan. Dan juga mengurangi mitos dan stigma terkait TB.

Altruisme Kader
Kader yang kami temui dimotivasi oleh kepedulian yang tulus terhadap orang lain, mengungkapkan pengalaman pribadi yang menggerakkan yang mendorong keharusan untuk membantu mereka yang membutuhkan perawatan kesehatan. Penelitian sebelumnya telah mengakui altruisme sebagai faktor pendorong bagi Kader, dengan dorongan untuk membantu orang lain dipengaruhi oleh keyakinan agama, kisah hidup dan pengalaman (Greenspan et al., 2013, hal. 1485).

Meskipun insentif moneter telah dicatat sebelumnya, dan dukungan finansial dari Kader dianjurkan ini tidak disebutkan sebagai faktor pendorong. Sebaliknya, tanggapan dari peserta kami mengungkapkan keterlibatan yang intens dan menikmati pekerjaan mereka yang dihargai oleh penghargaan tinggi yang mereka anggap dalam

komunitas mereka di mana mereka menerima pengakuan dan rasa hormat yang membuat mereka merasa dihargai atas upaya mereka dalam mencoba untuk membuat sebuah perbedaan.

Meskipun Kader Tb menempati posisi rendah dalam hierarki petugas, hubungan pasien yang baik dan penghargaan yang diterima dari pasien berkontribusi pada kepercayaan dan keyakinan mereka bahwa mereka diposisikan dengan baik dan dapat secara positif mempengaruhi hasil kesehatan, mendukung rasio di balik pengembangan program Kader kesehatan untuk meningkatkan layanan kesehatan di masyarakat setempat. Serupa dengan penelitian lain, peran utama mereka dipandang sebagai penghubung antara pasien dan sistem perawatan kesehatan. Studi kami mengidentifikasi peran penting lebih lanjut dari Kader dalam masyarakat dalam mempromosikan pembangunan sosial dan memberdayakan anggota masyarakat melalui pendidikan kesehatan.

Status Luaran berisi status tercapainya luaran wajib yang dijanjikan dan luaran tambahan (jika ada). Uraian status luaran harus didukung dengan bukti kemajuan ketercapaian luaran dengan bukti tersebut di bagian Lampiran

C. STATUS LUARAN

1. Luaran Wajib berupa artikel Internasional masih dalam Proses submit
2. Luaran Tambahan dalam proses revisi setelah mengikutkan artikel ilmiah dalam seminar internasional.

Peran Mitra (untuk Penelitian Terapan, Penelitian Pengembangan, PTUPT, PDUPT serta KRUPT) berisi uraian realisasi kerjasama dan realisasi kontribusi mitra, baik *in-kind* dan *in-cash*.

D. PERAN MITRA

.....

Kendala Pelaksanaan Penelitian berisi kesulitan atau hambatan yang dihadapi selama melakukan penelitian dan mencapai luaran yang dijanjikan

E. KENDALA PELAKSANAAN PENELITIAN

Kendala yang dihadapi dalam pelaksanaan penelitian adalah:

1. Terkait administrasi perijinan yang relatif cukup panjang
   Proses perijinan memerlukan waktu yang cukup panjang mulai dari Bakesbang, kemudian mengajukan ke dinas kesehatan untuk memperoleh ijin ke Puskesmas yang dikehendaki. Proses yang cukup panjang tersebut menjadi kendala dalam penyesuaian jadwal kegiatan yang telah kami susun sebelumnya.
2. Pada saat pelaksanaan penelitian kesesuaian waktu antara peneliti dengan partisipan
   Kendala yang kami hadapi saat pengambilan data terutama kepada partisipan dari dinas kesehatan adalah penyesuaian waktu antara partisipan dan peneliti sehingga perlu beberapa kali penundaan untuk bisa melakukan wawancara. Selain itu juga adanya mispersepsi antara petugas kesehatan dari puskesmas dengan para kader tentang program penanggulangan TB yang telah dilaksanakan. Perbedaan mispersepsi tersebut menjadi kendala bagi peneliti terutama dalam hal menentukan katagori dan analisis tema yang kami tetapkan
3. Upaya mencapai luaran
   Luaran penelitian secara umum tidak ada kendala dan dapat kami capai sebagaimana mestinya.

Rencana Tahapan Selanjutnya berisi tentang rencana penyelesaian penelitian dan rencana untuk mencapai luaran yang dijanjikan

F. RENCANA TAHAPAN SELANJUTNYA

1. Melakukan uji coba Model Pusat Krisis Berbasis Masyarakat pada 3 kecamatan berbeda
2. Melakukan evaluasi efektifitas Model PKBM pada masing masing kecamatan
3. Menilai model PKBM paling efektif untuk manajemen Tuberculosis di Surabaya
4. Membuat Model dan menyempurnakan Model PKBM

Daftar Pustaka disusun dan ditulis berdasarkan sistem nomor sesuai dengan urutan pengutipan. Hanya pustaka yang disitasi pada laporan kemajuan yang dicantumkan dalam Daftar Pustaka.

G. DAFTAR PUSTAKA

1. WHO | Global tuberculosis report 2018. (2019). In *WHO*. Retrieved from https://www.who.int/tb/publications/global_report/en/
2. *Profil Kesehatan Kota Surabaya Tahun 2017*. (2018). Retrieved from https://drive.google.com/file/d/0BwaTO2QdUm-2UXpVZFdFc01HZDNWS0NRMkw2TDVpRjNKZm5J/view
3. Community-based active case finding for tuberculosis in rural western China: A cross-sectional study. (2018). *Indian Journal of Tuberculosis*, *65*(1), 99. https://doi.org/10.1016/J.IJTB.2017.12.008
4. Could repeated prevalence surveys lead to decreasing tuberculosis prevalence in a community? (2015). *Indian Journal of Tuberculosis*, *62*(3), 190–191. https://doi.org/10.1016/J.IJTB.2015.09.022
5. … D. I.-P. P. dan P., & 2011, undefined. (n.d.). Strategi Nasional Pengendalian TB. *Origin.Searo.Who.Int*. Retrieved from http://origin.searo.who.int/entity/indonesia/topics/tb/stranas_tb-2010-2014.pdf

6. Al-Hajoj, S., & Varghese, B. (2013). Qualitative research: Is this a missing link to control tuberculosis in Saudi Arabia? *International Journal of Mycobacteriology*, *2*(3), 126–127. https://doi.org/10.1016/J.IJMYCO.2013.06.004
7. Andrew, S., & Halcomb, E. J. (Eds.). (2009). *Mixed Methods Research for Nursing and the Health Sciences*. https://doi.org/10.1002/9781444316490
8. Aye, S., Majumdar, S. S., Oo, M. M., Tripathy, J. P., Satyanarayana, S., Kyaw, N. T. T., … Aung, S. T. (2018). Evaluation of a tuberculosis active case finding project in peri-urban areas, Myanmar: 2014-2016. *International Journal of Infectious Diseases*, *70*, 93–100. https://doi.org/10.1016/J.IJID.2018.02.012
9. Beck, C. T. (2016). *Routledge international handbook of qualitative nursing research*. Routledge.
10. Borg, W. R., & Gall, M. D. (1989). *Educational research : an introduction* (5th ed.). Retrieved from https://www.worldcat.org/title/educational-research-an-introduction/oclc/18520404
11. Boulanger, R. F., Seidel, S., Lessem, E., Pyne-Mercier, L., Williams, S. D., Mingote, L. R., … Lavery, J. V. (2013). Engaging communities in tuberculosis research. *The Lancet Infectious Diseases*, *13*(6), 540–545. https://doi.org/10.1016/S1473-3099(13)70042-2
12. Collins, D., Hafidz, F., & Mustikawati, D. (2017). The economic burden of tuberculosis in Indonesia. *The International Journal of Tuberculosis and Lung Disease*, *21*(9), 1041–1048. https://doi.org/10.5588/ijtld.16.0898
13. Craig, G. M. (2015). The social context of tuberculosis treatment in urban risk groups in the United Kingdom: a qualitative interview study. *International Journal of Infectious Diseases*, *32*, 105–110. https://doi.org/10.1016/J.IJID.2015.01.007
14. de Vries, S. G., Cremers, A. L., Heuvelings, C. C., Greve, P. F., Visser, B. J., Bélard, S., … Grobusch, M. P. (2017). Barriers and facilitators to the uptake of tuberculosis diagnostic and treatment services by hard-to-reach populations in countries of low and medium tuberculosis incidence: a systematic review of qualitative literature. *The Lancet Infectious Diseases*, *17*(5), e128–e143. https://doi.org/10.1016/S1473-3099(16)30531-X
15. Delgado, E., Monedero, I., & Bhavaraju, R. (2017). Resilience and extensively drug-resistant tuberculosis: the unlikely ally. *The International Journal of Tuberculosis and Lung Disease*, *21*(6), 713–716. https://doi.org/10.5588/ijtld.16.0954
16. Engel, N., & Pai, M. (2013). Tuberculosis diagnostics: Why we need more qualitative research. *Journal of Epidemiology and Global Health*, *3*(3), 119–121. https://doi.org/10.1016/J.JEGH.2013.04.002
17. Escott, S., & Walley, J. (2005). Listening to those on the frontline: Lessons for community-based tuberculosis programmes from a qualitative study in Swaziland. *Social Science & Medicine*, *61*(8), 1701–1710. https://doi.org/10.1016/J.SOCSCIMED.2005.03.040
18. Flick, U., Metzler, K., & Scott, W. (n.d.). *The SAGE handbook of qualitative data analysis*.
19. Fuady, A., Houweling, T. A. J., Mansyur, M., Burhan, E., & Richardus, J. H. (2019). Effect of financial support on reducing the incidence of catastrophic costs among tuberculosis-affected households in Indonesia: eight simulated scenarios. *Infectious Diseases of Poverty*, *8*(1), 10. https://doi.org/10.1186/s40249-019-0519-7
20. Gall, M. D., Gall, J. P., & Borg, W. R. (2007). *Educational research : an introduction*. Pearson/Allyn & Bacon.
21. Gugssa Boru, C., Shimels, T., & Bilal, A. I. (2017). Factors contributing to non-adherence with treatment among TB patients in Sodo Woreda, Gurage Zone, Southern

Ethiopia: A qualitative study. *Journal of Infection and Public Health*, *10*(5), 527–533. https://doi.org/10.1016/J.JIPH.2016.11.018
22. Harper, M., Ahmadu, F. A., Ogden, J. A., McAdam, K. P., & Lienhardt, C. (2003). Identifying the determinants of tuberculosis control in resource-poor countries: insights from a qualitative study in The Gambia. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, *97*(5), 506–510. https://doi.org/10.1016/S0035-9203(03)80007-X
23. Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., … Ursano, R. J. (2007). Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention: Empirical Evidence. *Psychiatry: Interpersonal and Biological Processes*, *70*(4), 283–315. https://doi.org/10.1521/psyc.2007.70.4.283
24. Holloway, I., & Galvin, K. (2016). *Qualitative Research in Nursing and Healthcare*. Wiley.
25. Iribarren, S. J., Rubinstein, F., Discacciati, V., & Pearce, P. F. (2014). Listening to Those at the Frontline: Patient and Healthcare Personnel Perspectives on Tuberculosis Treatment Barriers and Facilitators in High TB Burden Regions of Argentina. *Tuberculosis Research and Treatment*, *2014*, 1–14. https://doi.org/10.1155/2014/135823
26. Joshi, D., Awasthi, A., Saxena, A., Saxena, D., & Mavalankar, D. (2018). Community and facility-based tuberculosis control: Programmatic comparison and experience from Nepal. *Clinical Epidemiology and Global Health*. https://doi.org/10.1016/J.CEGH.2018.08.006
27. KEMENTERIAN KESEHATAN. (n.d.). Pedoman nasional pengendalian tuberkulosis. In *dokternida.rekansejawat.com*. Retrieved from http://www.dokternida.rekansejawat.com/dokumen/DEPKES-Pedoman-Nasional-Penanggulangan-TBC-2011-Dokternida.com.pdf
28. Kusimo, O., Olukolade, R., Hassan, A., Okwuonye, L., Osinowo, K., Ogbuji, Q., … Ladipo, O. A. (2015). Perceptions of community members on tuberculosis and its effect on health-seeking behavior in Nigeria. *International Journal of Mycobacteriology*, *4*, 61. https://doi.org/10.1016/J.IJMYCO.2014.10.023
29. Lorent, N., Choun, K., Malhotra, S., Koeut, P., Thai, S., Khun, K. E., … Lynen, L. (2015). Challenges from Tuberculosis Diagnosis to Care in Community-Based Active Case Finding among the Urban Poor in Cambodia: A Mixed-Methods Study. *PLOS ONE*, *10*(7), e0130179. https://doi.org/10.1371/journal.pone.0130179
30. Macfarlane, L., & Newell, J. N. (2012). A qualitative study exploring delayed diagnosis and stigmatisation of tuberculosis amongst women in Uganda. *International Health*, *4*(2), 143–147. https://doi.org/10.1016/J.INHE.2011.12.002
31. Main, S., Lestari, T., Triasih, R., Chan, G., Davidson, L., Majumdar, S., … Ralph, A. (2019). Training for Tuberculosis Elimination in Indonesia: Achievements, Reflections, and Potential for Impact. *Tropical Medicine and Infectious Disease*, *4*(3), 107. https://doi.org/10.3390/tropicalmed4030107
32. Margarit, A., Simó, S., Rozas, L., Deyà-Martínez, À., Barrabeig, I., Gené, A., … Noguera-Julian, A. (2017). Adolescent tuberculosis: A challenge and opportunity to prevent community transmission. *Anales de Pediatría (English Edition)*, *86*(3), 110–114. https://doi.org/10.1016/J.ANPEDE.2016.03.007
33. Massey, P. D., Wakageni, J., Kekeubata, E., Maena'adi, J., Laete'esafi, J., Waneagea, J., … Speare, R. (2012). TB questions, East Kwaio answers: community-based participatory research in a remote area of Solomon Islands. *Rural and Remote Health*, *12*, 2139. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23094978

34. Nkambule, B. S., Lee-Hsieh, J., Liu, C.-Y., & Cheng, S.-F. (2019). The relationship between patients' perception of nurse caring behaviors and tuberculosis stigma among patients with drug-resistant tuberculosis in Swaziland. *International Journal of Africa Nursing Sciences*, *10*, 14–18. https://doi.org/10.1016/J.IJANS.2018.11.004
35. Norris, F. H., Stevens, S. P., Pfefferbaum, B., Wyche, K. F., & Pfefferbaum, R. L. (2008). Community Resilience as a Metaphor, Theory, Set of Capacities, and Strategy for Disaster Readiness. *American Journal of Community Psychology*, *41*(1–2), 127–150. https://doi.org/10.1007/s10464-007-9156-6
36. Norris, F. H., Tracy, M., & Galea, S. (2009). Looking for resilience: Understanding the longitudinal trajectories of responses to stress. *Social Science & Medicine*, *68*(12), 2190–2198. https://doi.org/10.1016/j.socscimed.2009.03.043
37. Okeyo, I., & Dowse, R. (2016). Community care worker perceptions of their roles in tuberculosis care and their information needs. *Health SA Gesondheid*, *21*, 245–252. https://doi.org/10.1016/J.HSAG.2016.05.004
38. Salehitali, S., Noorian, K., Hafizi, M., & Dehkordi, A. H. (2019). Quality of life and its effective factors in tuberculosis patients receiving directly observed treatment short-course (DOTS). *Journal of Clinical Tuberculosis and Other Mycobacterial Diseases*, *15*, 100093. https://doi.org/10.1016/J.JCTUBE.2019.100093
39. Simeon, D., Yehuda, R., Cunill, R., Knutelska, M., Putnam, F. W., & Smith, L. M. (2007). Factors associated with resilience in healthy adults. *Psychoneuroendocrinology*, *32*(8–10), 1149–1152. https://doi.org/10.1016/j.psyneuen.2007.08.005
40. Sissolak, D., Marais, F., & Mehtar, S. (2011). TB infection prevention and control experiences of South African nurses - a phenomenological study. *BMC Public Health*, *11*(1), 262. https://doi.org/10.1186/1471-2458-11-262
41. Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: interdisciplinary perspectives. *European Journal of Psychotraumatology*, *5*. https://doi.org/10.3402/ejpt.v5.25338
42. Sundaram, N., James, R., Sreynimol, U., Linda, P., Yoong, J., Saly, S., … Khan, M. (2018). Strong, vertical TB programme embedded in a developing primary healthcare system: impact on patient and community experiences in Cambodia. *Health Policy and Planning*, *33*(2), 313–313. https://doi.org/10.1093/heapol/czx164
43. Tetra Dewi, F. S., Sudiya, S., Supriyati, S., Purwanta, P., Madyaningrum, E., Aulia, F. U., … Utarini, A. (n.d.). Preparing Short Message Service Reminders to Improve Treatment Adherence among Tuberculosis Patients in Sleman District, Indonesia. *Indian Journal of Community Medicine : Official Publication of Indian Association of Preventive & Social Medicine*, *44*(2), 81–87. https://doi.org/10.4103/ijcm.IJCM_207_18
44. Theng, Y.-L., Chandra, S., Goh, L. Y. Q., Lwin, M. O., & Foo, S. (2014). Exploratory qualitative study for community management and control of tuberculosis in India. *Acta Tropica*, *132*, 98–105. https://doi.org/10.1016/J.ACTATROPICA.2013.12.014
45. Tilekar, S., Rajaput, D., Varghese, B., & McCreary, L. L. (2017). Community Members' Perceptions of Tuberculosis (TB) Stigmatization in Rural Maharashtra, India. *Annals of Global Health*, *83*(1), 156. https://doi.org/10.1016/J.AOGH.2017.03.349
46. Ziemlé, C. M., Huang, C.-C., Sombié, I., Konaté, L., Somda, P. K., Djibougou, A. D., & Sanou, M. (2014). Tuberculosis in developing countries: conditions for successful use of a decentralized approach in a rural health district. *Pan African Medical Journal*, *17*, 198. https://doi.org/10.11604/pamj.2014.17.198.3094.

Lampiran berisi bukti pendukung luaran wajib dan luaran tambahan (jika ada) sesuai dengan target capaian yang dijanjikan

H. LAMPIRAN

……
……
………………………………………………………………………………………………

Dokumen pendukung luaran Wajib #1

Luaran dijanjikan: Publikasi Ilmiah Jurnal Internasional

Target: accepted/published
Dicapai: Submited

Dokumen wajib diunggah:
1. Bukti submit
2. Naskah artikel

Dokumen sudah diunggah:
1. Naskah artikel

Dokumen belum diunggah:
1. Bukti submit

Nama jurnal: Journal of Taibah University Medical Sciences
Peran penulis: first author | EISSN: 1658-3612
Nama Lembaga Pengindek: scopus
URL jurnal: https://www.sciencedirect.com/journal/journal-of-taibah-university-medical-sciences
Judul artikel: Social Capital and Community Based Tuberculosis Management In Surabaya: A Qualitative Study

INTRODUCTION

East Java, a province in Indonesia, has a TB prevalence of 110 per 100,000 population which can show that solving problems of TB is still difficult and challenging. In 2015, Surabaya has 16,616 suspected TB cases and 2,330 with BTA+, among a total population of 2,848,583. District of Tandes is considered to have the highest prevalence in TB because 551 people were suspected to have TB and 114 people were found BTA+ [1]. In 2016, 109 new TBs were found, with a total of 170 TB sufferers with a success rate of 88.64% [2]. This figure includes the three major TB incidents in the city of Surabaya.

World Health Organization (WHO) states that Tuberculosis (TB) [3] is a global emergency problem that negatively impacts human health in various countries worldwide. Directly observed treatment, short-course (DOTS) strategy has proven to be very effective for TB control, however, the burden of TB in some communities is still very high such as in Indonesia. This may be explained by the poor implementation of the DOTS strategy and TB treatment programs. Failure to mobilize community members to participate in the TB control program, unclear roles of every team member, and who are the appropriate persons to be involved in the TB Management Program activities are the challenges that affect the sustainability and effectiveness of the program [4].

Social capital can be characterized as the willingness of every individual to prioritize community decisions in solving health problems. With these characteristics, good social capital is believed to increase the community's capacity to work together for the common good. Therefore, people in a community with a high social capital status have a good network relationship that will result in horizontal cooperation and mutual norms. Cooperation and mutual norms of all community members will enable them to have high confidence to collaborate and help one another. [5]

Modernization as a result of technological advancement will enable everyone to solve problems independently. With the help of technology, one can manage difficulties and problems without the assistance of so many people. This will condition a person to be independent who does not need so much help and assistance from others to solve a problem. Feeling of independence can eventually decrease the awareness level of a person to live in a 'community' wherein one needs to help each other and cooperate to resolve community challenges thus weaker social capital. Weak social capital in society is a result of individualistic attitude which oppose collective efforts to act on a particular problem. Coleman explained that individual actions are affected by the value of an event, wherein an individual will act based on the interests and benefits she/he will achieve [6]. If this condition is associated with TB case management, it can slow down case management.

The concept of Social Capital is new in the nursing profession. Social Capital is a social ability in forming nursing care based on individual, group, family and community-based culture to optimize the health service system. If this concept is the common ground of understanding of the nursing field, then Social Capital investment is a useful strategy to improve community nursing care in handling TB [7]. It is therefore important to understand the Transcultural Care Model in TB Elimination in the District of Tandes, Surabaya, Indonesia, based on Community Social Capital in handling TB.

RESEARCH METHODS

This is a qualitative field study that was conducted for one month in February-August 2019 to understand the attitudes and perceptions of key informants about how the community felt, and how they experienced various aspects of social capital in their community. The purpose of descriptive qualitative research is to present a comprehensive summary of the data [8].

This study was conducted to understand the attitudes and perceptions of key informants about how people feel, and how they experience various aspects of social capital in the surrounding community. It used a purposive sampling design. Purposive sampling is generally used in a qualitative study because participants are selected purposively for their direct knowledge and experiences to the research question under study (Polit, & Beck 2006). Informants in this study included four (4) social welfare officer from the Village, eight (8) TB Health Volunteer, two (2) TB Nurses at Balongsari and Manukan Kulon Primary Health Center, and two (2) TB patients.

In this study, interview data were analyzed through the following steps: 1) transcribed, read, and re-read interview transcripts in order to find interesting phenomena and useful data; 2) reorganized, classified, and categorized data to produce themes; and 3) Interpreted the data through documenting the findings in the thematic analysis. In this last step of data analysis, the researcher developed theories and arguments based on the statements and propositions in the interview transcripts. Likewise, the researcher developed stories that convey the main ideas developed in the data analysis and presented story citations to support the statements (Flick, 2014).

RESULTS AND DISCUSSION

Results

Norm

Attitudes and Behavior of the Community Constraints on TB Elimination

One obstacle felt by cadres as the TB elimination program is the attitude, behavior of patients and also the community towards TB disease:

> *"Yes, how about that, mas, most of them do not know. Maybe because people used to think that coughing suddenly came out as if they had been infected with witchcraft, but that was before, now patients are more ashamed of their settings*." P2 (cadre)

The statement was revealed by the cadres when conducting counseling to the community and when conducting training to families of patients to become a PMO (Drug Swallowing Supervisor).

In line with the statement of the cadre, the same expression was also expressed by TB patients who had long been treated for TB. At the beginning of the illness, the patient also had a wrong perception of TB disease:

> *"Until frankly I do not know whether someone who has TB should spit with blood when coughing out*."'P6 (sufferer)

The main effort in eliminating TB in the Surabaya District of Tandes is to change the attitudes and behavior of the community in viewing health, especially those related to efforts to eliminate TB. Because attitudes and behaviors are one of the main factors that can break the chain of TB transmission:

> "*There are two possibilities, bro. The first one that may be appearing now is that the patient is unknown like a vicious circle. You are infected because it was also kept a secret. This second point is because the community often isolates because it is contagious*' P4." (Person in Charge of TB Primary Health Center)

Citizens' awareness to check phlegm

Another form of social capital which plays an important role in the efforts to prevent TB transmission is to immediately do TB suspected case finding and be directed to treatment. However, the community is not open for this type of approach which makes TB transmission prevention program difficult to implement:

> "*It is a struggle to go to families who are 'healthy' because we need to be smart in talking. If the people understand us, they will welcome us but there are a lot of people who do not open their doors to us. It is very hard to knock on their doors if the number of family members in a household is little so we need to go back and forth to the community*." P2 (cadre)

Another challenge that was found out in carrying out the TB suspects search program is limited awareness of community people regarding the importance of sputum examination among people of the Tandes District. It is also difficult to maintain the confidentiality of TB sufferers:

> "*We take sputum to people who feel coughing and bring it to the health center for examination. However, we need to go back and forth to the house of TB suspects to encourage them to submit their sputum for testing because they do not appreciate the importance of sputum examination. They also fear that others will learn about their condition which makes them do not like their sputum to be collected.*" P2 (cadre)

Network

Material social support

Surabaya City Health Department has provided free medical assistance for TB sufferers. In addition to providing drug supplies for free, TB patients also get free nutritional intake in the form of formula milk that is given when the patient takes the medicine at the health center. Aisyiyah is another institution who provided financial assistance for underprivileged TB patients by a giving 30,000.00 cash:

> "*There are economic difficulties in providing healthcare to patients. We need to take a pedicab to reach them. Some CSR has also funded by giving 2 USD cash once to TB patients during treatment. If there is no fund at the Primary Health Center, PMT or milk is being given. Sometimes when we see something like that, the cadres themselves take initiative by giving available help possible because we prioritize our sick TB patients*" P1 (cadre)

Another assistance is also accessible to TB patients who were elderly and underprivileged from District of Tandes in the form of meals and groceries:

> "*We also have the term charity 'sodakoh': if there is someone or elderly who is unable to get his/her food, I will whisper to the sub-district chief 'let's get the wheelchair from the sub-district head, then we arrange to buy milk or basic food,' otherwise we ask for help from the CSR*." P12 (welfare)

Formal and Non-Formal Institutional Approach as a foundation

The role of citizens is very influential in building structures and in maintaining cross-sectoral cooperation. Their role also is very important in dealing with health problems in the community:

"*I usually go to the sub-district head to ask for help related to the problem of people who do not know about the TB task force. This is to prevent many fraudsters involving in the TB program. We also bring SK district when we go to the field to help us in delivering TB programs and services*." P3 (cadre, task force leader)

In addition to the existence of formal institutions, having people who are considered 'influential' in the community is important in solving TB health problems:

"It's difficult to collect data alone and you do not have a link in the community. This is why we ask help and build connection and partnership with the village elders and officials." 'P11 (cadre)

Trust

"People also show trust to me. If I let them understand my instruction, they will be happy." P9 (cadre)

Families are less cooperative

Aisyiyah, which is one of the independent TB observers, has carried out various programs in TB Elimination efforts. Some of them are conducting training and assistance to the Drug Swallowing Supervisor or PMO. The main obstacle is the difficulty of the family to participate in these activities:

"It is very difficult to contact a PMO. One would say to his/her mother, 'Mom, there is training, then she would reply: "Yes if God willing, I will come tomorrow." It was that very evening that the trainee informed me that he really cannot come so I rushed to find someone else to replace the PMO. I waited for the confirmation but I did not get any news." P3 (cadre, task force leader)

Experience (Need More Courage)

In the District of Tandes, the health program from the Primary health center has been conducting Outreach care center for both toddlers and elderly who are assisted by local cadres. In the process, many people are found unwelcoming to cadres who run the program:

"If we go around the house, we are told to show any suspicion to the household, otherwise, we will not be welcomed. When we visit a sick person, sometimes, we are not well received. People who are sick with TB in the wider community are like that. This is the reason why, sometimes, we do house visits secretly. It is very difficult for them to receive guests." P1 (cadre)

Health Center can provide access to TB treatment needed by the community and TB sufferers

Primary Health Center, a community health center, is an implementing unit in the health sector that provides various access to information and services for its community catchment. However, there are few health services that some do not receive because of limited awareness about the programs and services Primary Health Center provides:

"*Uh, I was not aware about the TB program of Primary Health Center, that they do direct counseling. I was not informed before about it*." P6 (sufferer)

"*Rich people are ashamed to have a check-up in the health center. It is not until they have TB that they end up going to the health center especially so that treatment in Primary Health Center is free and there is no need to join a queue when getting TB medication*." P9 (cadre)

Sufferers are still reserved in telling about their TB condition

TB is a disease that is easily transmitted. This fact causes the sufferer to feel they don't want to tell the disease to others:

"*Almost all patients do not want to wear masks when leaving the house. Leaving the house wearing a mask is considered as informing their neighbors of their TB condition… Yes, because they feel so embarrassed. One TB patient shared that one would comment: 'How come you are wearing a mask suddenly?' which makes them feel embarrassed*." P3 (cadre, task force leader)

This 'closed' attitude also causes difficulties for cadres in detecting the presence of cases, especially in finding the address of TB sufferers:

"*There are patients that we could not locate given the address. We also cannot contact them by phone. Mostly, the address is not correct. I think this is because of shame, of having sickness with TB.*" P2 (cadre)

DISCUSSION

Social Capital in the Tandes District of Surabaya

Norm

The norm of openness among the community enables them to participate and work together voluntarily in carrying out TB elimination efforts in the Tandes District of Surabaya. The existence of cadres who work voluntarily amid attitudes and perceptions of people from the community, both from patients and from the community, is a form of a good norm that exists in the area.

Bourdieu explained that the benefits that can be obtained by group members in an organization when they have solidarity and camaraderie. Having a good norm is the foundation of a community to achieve common goals [9].

The groups, in this case, are Cadres Aisyiyah and Cadres from Tandes District as program implementers in TB elimination efforts. Both of these programs continue despite various obstacles and continue to strive to find solutions.

Network

Networks are an important part of social capital. In this case, the network in the District of Tandes can be seen at the district level up to the RT. At the district level network, health and development programs are carried out by various institutions, such as the Social and Public Development Section, the Physical and Infrastructure Section, the Economic Section, the Public Order and Public Order Section, and the Government Section.

Networks are products of an investment strategy, individual or collective, consciously or unconsciously. This aims to build or reproduce social relationships that can be used directly in the

short or long term programs. The existence of a network of connections is not given naturally or even socially provided. Network is formed once and for all by the institution's initial actions [9].

The results showed that the Tandes District area had maintained and created a network with various elements involved in TB Elimination efforts:

Trust

In Tandes District, it showed the pattern of how trust is built. The TB program implementation also utilizes the existence of sub-districts and health centers as important institutions in the District of Tandes. With the presence of these groups, it can be seen that TB elimination programs are carried out effectively.

Communities depend on mutual trust and will not appear spontaneously without them. Trust is like a lubricant, 'oiling' the 'wheel' in various social activities [10].

The pattern of community trust has been built unconsciously that will finally make the TB program successful with public trust as the foundation. Public trust will also motivate various people in authority, such as the experts in the sub-district and experts in Primary Health Center, in delivering TB programs in the community. These experts work together to carry out TB programs based on community trust to them.

Community Social Capital in the District of Tandes, Surabaya City

Good norm is demonstrated by the openness of the community in participating and cooperating voluntarily in carrying out TB elimination efforts in the Tandes District of Surabaya.

Networks are an important part of social capital. In this case, the network in the District of Tandes can be shown both at the sub-district level up to the RT. At the district level network, health and development programs are carried out by various institutions, such as the Social and Public Development Section, the Physical and Infrastructure Section, the Economic Section, the Public Order and Public Order Section, and the Government Section. All these institutions will be responsible for TB problems that exist in the community.

In Tandes District, it has been shown how the pattern of trust is built. Various programs in TB elimination efforts will always go hand in hand with various social support groups.

Acknowledgments

The author(s) would like to thank the grant is provided by the Ministry of Research, Technology, and Higher Education, Directorate General of Resources for Research, Technology and Higher Education of Indonesia for providing this research, Faculty of health Sciences, University of Muhammadiyah Surabaya, and Research Center Department of University of Muhammadiyah Surabaya

References

1. KESEHATAN, P. K. S. *PROFILKESEHATANTAHUN 2016*. (DINAS KESEHATAN KOTA, 2016).
2. *Profil Kesehatan Kota Surabaya Tahun 2017*. (Dinas Kesehatan Kota Surabaya, 2018).

3. *WHO | Global tuberculosis report 2018*. *WHO* (World Health Organization, 2019).

4. Lingkungan, D. A. N. P. & Penyusun, T. I. M. Pedoman nasional pengendalian tuberkulosis. (2011).

5. Eriksson, M. Social capital and health – implications for health promotion. *Glob. Health Action* **4**, 5611 (2011).

6. Field, J. *Social capital*. (Routledge, 2008).

7. Kawachi, I., Subramanian, S. V. & Kim, D. Social Capital and Health. in *Social Capital and Health* 1–26 (Springer New York, 2008). doi:10.1007/978-0-387-71311-3_1.

8. Saphā Kānphayābān (Thailand), V. A. & Lambert, C. E. *Pacific Rim international journal of nursing research. Pacific Rim International Journal of Nursing Research* vol. 16 (Thailand Nursing and Midwifery Council, 2012).

9. Richardson, J. G. *Handbook of theory and research for the sociology of education*. (Greenwood Press, 1986).

10. Iribarren, S. J., Rubinstein, F., Discacciati, V. & Pearce, P. F. Listening to Those at the Frontline: Patient and Healthcare Personnel Perspectives on Tuberculosis Treatment Barriers and Facilitators in High TB Burden Regions of Argentina. *Tuberc. Res. Treat.* **2014**, 1–14 (2014).

Dokumen pendukung luaran Tambahan #1

Luaran dijanjikan: Prosiding dalam pertemuan ilmiah Internasional

Target: sudah terbit/sudah dilaksanakan
Dicapai: Sedang direview

Dokumen wajib diunggah:
1. Naskah artikel
2. Bukti sedang direview

Dokumen sudah diunggah:
1. Naskah artikel
2. Bukti sedang direview

Dokumen belum diunggah:
-

Peran penulis: first author
Nama Konferensi/Seminar: The 2019 International Conference on Healthcare and Technology
Lembaga penyelenggara: STIKEP PPNI Bandung
Tempat penyelenggara: Grand Tjokro Hotel, Bandung
Tgl penyelenggaraan mulai: 18 Juli 2019 | Tgl selesai: 19 Juli 2019
Lembaga pengindeks: Scopus
URL website: http://icon-stikepppni.org
Judul artikel: Community Perception of Tuberculosis Management Program in Suburban Surabaya: A Qualitative Study

Community Perception of Tuberculosis Management Program in Suburban Surabaya: A Qualitative Study

Mundakir[1], Asri*[1], Septian G. Winata[1], Pipit F. Wiliyanarti[1], Ratna P. Priyanti[2]

1. Department of Community Health Nursing, Faculty of Health Sciences, University of Muhammadiyah Surabaya
2. Department of Emergency Nursing, STIKES PEMKAB Jombang

*corresponding author: asri.ners@fik.um-surabaya.ac.id

Disclosures

The author(s) received financial support for the research from the Ministry of Research, Technology, and Higher Education, Directorate General of Resources for Research, Technology and Higher Education of Indonesia as at the expense of PDUPT

Acknowledgments

The author(s) would like to thank the grant is provided by the Ministry of Research, Technology, and Higher Education, Directorate General of Resources for Research, Technology and Higher Education of Indonesia for providing this research, Faculty of health Sciences, University of Muhammadiyah Surabaya, and Research Center Department of University of Muhammadiyah Surabaya

ABSTRACT

Tuberculosis (TB) is remains to be major infectious disease problem in Indonesia. World Health Organisation (WHO report in 2018 shows that 10.0 million new TB cases were notified to national health authorities. Indonesia has 842,0000 cases and places it as the country with the third highest number in the world. The national program Directly Observed treatment, short-course (DOTS) started since 2014 has incapable handling TB cases comprehensively. Communities have important role in TB management. The aim of this study was to explore the existed condition of TB management program. A descriptive qualitative study was conducted in three Sub-district, which are an endemic area for TB and have the highest incident. Semi-structured interview was conducted to 25 participants which consist of sub-urban TB task force, community health volunteer, Community health Nurses and sub-district officer. Result reveal four themes as follow: volunteer shortage, do for humanitarian intention, covering the myth and stigma, providing social and economic support. The conclusion, in order to be effective program, community-based TB management need to be improve in the availability of budget, staff, training and resources while maintaining the on going work of TB task force team.

Keyword: TB; Community-based management; community health volunteer; Social support; humanitarian intention; Descriptive qualitative

1. Introduction

World Health Organitation (WHO) states that Tuberculosis (TB) is a global emergency problem for humanity and an important problem in various countries around the world. In Indonesia, although the Directly Observed Treatment Short course (DOTS) strategy has proven to be very effective for TB control, the burden of TB in the community is still high. This is because the implementation of the DOTS strategy and programs for handling TB in its application still have challenges and problems in the community. The main obstacle is the failure to mobilize all community capacities, involving community members to participate, and unclear forms of contributions and who should be involved in TB Handling Program activities that affect the sustainability and effectiveness of the program [1].

East Java Province is one of the provinces in Indonesia which still has problems in tackling tuberculosis with a prevalence of 110 per 100,000 population. In Surabaya 16,616 people were suspected of TB and 2,330 people were TB positive. Based on data from the Surabaya Health Office 2015, the highest prevalence of TB was in Tandes Subdistrict with 551 people suspected TB and 114 people found with TB positive[2]. In 2016 there were 109 new TB, with a total number of 170 TB patients and a Success Rate of 88.64% [3].

Modern society is more likely to solve problems independently through various technological advancements that exist. Individual attitudes and feeling capable of solving problems independently can have an effect on the awareness to live in society as a result is the value in society to help each other, mutual cooperation, and others diminish, depicted by various individual actions that do not lead to a collective goal but lead to a destination according to the individual's wishes. Coleman explained in his ideas about individual actions influenced by the value of an event, that individuals will act based on the interests and benefits obtained from each individual[4]. If this condition is associated with handling TB cases, it can slow down the handling of cases. If the ability of social management is understood as a social ability in forming a nursing care by optimizing the health service system based on the culture of individuals, groups, families and communities, investment in community-based management is a useful strategy for increasing community nursing care to treat TB[5].

Community-based TB management is believed to be able to increase the capacity of the community to work together in solving health problems because the basis of management can be characterized in the form of individual willingness to prioritize community decisions in resolving health problems. Citizens who are in a community with good community management will form a cohectivity which is interpreted by the existence of horizontal cooperation and norms of reciprocity because they will also have high confidence, to collaborate or cooperate and help each other[6].

This study aims to reveal how the community is making efforts to manage tuberculosis with all their ability and resources in their place.

2. Methods

2.1. Design

A qualitative descriptive study[7] was conducted in Tandes, the sub-district with the highest incidence of TB in Surabaya.

2.2. Participants

The participants of this study were selected using purposive sampling method including; 1 official heads of villages, 4 director of the community welfare and safety sub-district office, 3 community nurses who worked at the local public health center, and 18 community health volunteers and Local Health officer.

2.3. Data collection

Data were collected from January to May 2019 in Tandes, which has an especially high prevalence of TB. A total of 104 cases of TB were reported in 2017.

The semi-structured interview questions focused on the influence of Community Perception on TB prevention and control and related experiences. The interviews focused on the participants existence,

role, experience, and connection to the community within TB prevention and control activities. the interview lasts 45 - 60 minutes for one time data retrieval.

The community health workers were interviewed in their homes, and the sub-district officer and the community nurses were interviewed in their workplace to provide them with comfort and convenience. All interviews were recorded and transcribed for data analysis.

2.4. Data analysis

Interview data were analyzed using Uwe Flick[8]. The practical steps of analyzing and representing interview data were performed. Data analysis began with (1) reducing data to locate and examine phenomena of interest. In this phase, the interviews were transcribed, and then the data were read and reread. The next phase was (2) reorganizing, classifying, and categorizing data, in which the researchers generated assertions about topics by reassembling and reorganizing the data, codes, categories, and stories. The last phase was (3) interpreting and writing up findings. In this phase, the researcher considered assertions and propositions in light of prior research and theory to develop arguments. Researchers developed stories that conveyed the main idea developed in the data analysis and presented data excerpts or stories to support assertions.

The stories were sorted to examine the existence of community based management on TB prevention and control.

2.5. Ethical considerations

Ethical approval to conduct this study was granted by the Institutional Review Board Ethical Committee of Airlangga University No. 630-KEPK, the Regional Department of Health (Surabaya, Indonesia), and the Regional Department of National Unity, Politics, and Public Protection (Surabaya, Indonesia). All participants were provided with a participant information sheet written in Bahasa Indonesia, and they signed the consent form prior to participating in the study.

3. Results

Tandes is a sub-district in a suburban geographical area and has the fifth largest area and highest population density in southern Surabaya. Tandes is located approximately 4 m above sea level. The overall site area is approximately 11.07 km2 and is divided into six villages, with a total population of 93.459. Below is the themes found from data analysis.

3.1. Do for humanitarian intention

One of the forms of Community based management, which plays an important role in the efforts to eradicate TB, is Volounteer. In the Tandes sub-district, six volounteers worked in the two primary health centers (PHCs). The volounteers were responsible for the entire TB prevention and control program in the region and implemented it in their own PHCs. In overcoming health problems, especially TB, at the government level, there is an institution called the TB Task Force and for non-government TB elimination programs carried out by the Aisyiyah Organization. Both work together with puskesmas in conducting TB elimination programs. Social awareness is their basic foundation in working to reduce TB problems.

They said, *"we want life to be beneficial for others. The rest is so important that sincerity and maintaining sincerity are difficult.(P1)*

We are also happy if we come to the patient then the patient according to that, the patient is happy, we are also happy. also the name of humans must be beneficial to others too. (P2)

When I saw the patient not recovering and then broke up the medication, I felt unsuccessful in carrying out my duties, I felt sorry for why I could not make the person recover (P3).

Yes because of humanity, another is the intention to seek (religious) reward (P5)

I also do not know maybe it has been my destiny from time to time, I have always loved it. Although you never got anything, you can imagine making a posyandu serving green beans, its CHWs contributions, doing door to door was ridiculed by the person, then the door was closed, especially the some ethnic group. (P7)

3.2. Volunteer shortage

The problem of TB requires complex management involving all elements of the community and requires evaluation of successful treatment for quite a long time. Treatment is complete for 6 months and the ease of transmission of the disease, requires TB observers to carry out monitoring, mentoring and reporting that are really serious. The large number of TB Elimination programs is not balanced with the needs of existing labor or human resources.

> *... yes until now, even now the active CHWs are old. I remember there was a very old CHWs from an area, the oldest CHWs here was someone who was 65 years old and his condition was very healthy (P1)*
> *at most because of laziness, fear ... Most are afraid. for example.....among 10 people who are active only me. there are often people who say Ouch I can't eat two days if there is phlegm it's make me feels nausea... even though (phlegm) it's already closed, yes but I imagine it's still there ... I can't be a CHWs (P2)*

3.3. covering the myth and stigma,

The wrong prejudice about TB is still a probelm that is very difficult to dispel. some people still believe that people with TB must be excluded, or should be ostracized, because they know that it's an infectious disease that's hard to cure. the role of health volunteer is very important, one of which is to cover up this stigma not to spread misinformation to the wider community.

> *it is just counselling, so every opportunity is made to do counselling especially if there is a tuberculosis patient in that area , but we cannot open that such person is a TB patient, so usually if there is a neighbour asking that patient, no, we just do this counselling so that it is no health problem. (P9)*

> *... this is just for neighbourhood, For example, I want to go to A, I don't go directly to A, but to the neighbour first, there are many people who think negatively, so I go to the neighbours first .... People were afraid, especially if there is someone from the puskesmas or from health officer, so they immediately close the door. (P14)*

> *know but don't want to say that he was (TB patient)... "what have you been sick of even though the puskesmas had told me the disease ... I continued to visit in two weeks. "How's the medication, is it already done? Is that fine?" It is okay. "That means I don't know about the disease so much" when in the beginning I knew. Pretend that i don't know. It will Keeping him (TB patient) shy. In fact, it will be nice if he shares it later. (P15).*

3.4. providing social and economic support.

The Surabaya Health Office has provided free medical assistance to TB patients. In addition to the assistance of giving drugs without paying expenses, TB patients also get free nutritional intake in the form of formula milk given when patients take drugs at the Puskesmas. Other parties who also provided material assistance for underprivileged TB patients were Aisyiyah, in the form of 30,000 in cash. But in reality the support is still considered lacking.

The Voulunteers said, "There are those whose economic conditions are very difficult, the puskesmas also needs to ride a pedicab, but there is also funds from the SSR during treatment, only once," P1 (cadre).
Sometimes if you see something like that, the cadres' own initiative is mas, so we give you something, bro. The point is trying to be concerned, there is a distribution of our basic necessities for the sick patient with P1 TB (cadre).

Once, when I was OK, then I gave 25,000 people money, and I didn't feel very happy. (P2) "

The Nurse Said, "Yes, we are still on a social mission, which we complain about is usually we have a visit while we have not been able to give transport money so we also usually hesitate if we have to ask" why haven't you visited this? "(P4)

In Tandes Subdistrict there is still no specific counseling program about TB. This is because TB is still not a priority in community problems. The main TB program is the door knock and cakning program where this program is a program with a ball picking approach or visiting the community one by one to be given counseling and looking for TB suspects. But with the constraints that not all communities receive TB health programs, not all levels of society get counseling about TB disease. So an effective way to provide counseling with the participation of many people is through community social groups.

The Voulunteers said, *"'in the recitation, PKK meetings and also at the puskesmas when there is counseling for us to give brochures about TB, so later if they go back to the RW they can transmit the knowledge they get through the brochure.'(P3).*

Actually, if you look at the condition of TB patients it seems that what they really need is a decent life because all this time we know, even though there are some patients who are already living well, most of them do not live properly from the side of their residence, because they become patients and after they recover it should be given a job, meaning that given the work that does not require or spend a lot of energy. while there are still children who still need their living expenses, which means economic problems, yes, most of them are in economic problems. (P1)

"If there is an automatic posyandu, if there is a posyandu, even though they are not active in community activities, the posyandi is definitely going to participate, yes, the opportunity for us to provide information is also helped by the RT" (P11)

Those who are still on treatment, we still see the main help, how come oh, this mother still needs assistance, if there is no family as Drug swallowing supervisor PMO, I will assist to take medicine and deliver the medicine to patients the house (P12)

4. Discussion

Evidence from this study proves that community-based approved programs are also acceptable.

WHO has issued community-based DOTs to complement health-based DOTs in the high burden of TB, resource-limited countries [7]. Until the patient and community attitudes and perceptions of the community and health facility-based DOT discussed and calculated with this assistance will not be carried out with success.

The findings make the drug cadres and supervisors almost unforeseen women and family members. The responsibility of sick family members in most areas of Surabaya is defined as the role of women [8][9]. The idea because families cannot participate because of DOT is because culture, family or family relationships are not proven in our study. Even though, that is support patients satisfied with them as supporters of care. Studies conducted elsewhere indicate family members are DOT that effectively supports treatment [10,11]. A study conducted in Indonesia, however Australia, did not show benefit in using family members supporting DOT treatment [12].

The context in Australia may be different from Surabaya where large family members are an important part of social networks. In Surabaya and Indonesia at the time of the care of family members taken as family members who were moved inside local culture and values [13]. Members of the caregiver family for chronic diseases such as HIV / AIDS and there is no reason not to believe this phenomenon will be different in TB cases [14]. Future studies should consider the impact of care on TB treatment and how it affects family relationships.

It is very supportive for research in our study that supports motivation to support care by carers and former TB patients for reasons of altruism. The majority of patients can also support other TB patients after completing treatment. This The findings are important for two main reasons: first, it shows the potential for using former TB patients in TB control activities. In one study, former TB patients found to be an important source of information for TB Patients [15]. Former TB patients can also help TB patients and the TB community can indeed be cured. This is very important in Tanzania where many people do not have enough knowledge of TB and delay in seeking treatment [16] the national TB program needs to address this problem based on available local resources.

5. Conclusion

Our findings provide valuable agreement for the effective implementation of relevant, sensitive and acceptable TB control interventions for the needs of patients and society in general. Community-based TB Program is a viable option and can be built based on health facilities in DOTS, especially in developing countries such as Indonesia where the health system is overwhelmed by increasing the number of TB and HIV / AIDS patients. The community-based TB Management must be seen as a complement and perhaps a substitute for a national TB activity program.

.

References

[1] Depkes RI. 2012. *Penanganan Penyakit Tuberkulosis*, Jakarta.

[2] Dinas Kesehatan Kota Surabaya. 2015. Laporan Kejadian TBC di Kota Surabaya.

[3] Dinas Kesehatan Kota Surabaya. 2016. Laporan Kejadian TBC di Kota Surabaya.

[6] Ericsson, M. 2011. Sosial Capital and Health-Implications for Health Promotion. Global Health Action Journal. Swedia.

[4] Field, J. 2008. *Sosial Capital* (2nd Edition). Ney york and London. Routledge.

[5] Kawachi, I. 2007. *Social Capital and Health* (2008 edition). New York ; London: Springer.

[7] Lambert, A. Vickie. 2012. Qualitative Descriptive Research : An Acceptable Design. *Pasific Rim International Journal of Nursing Research*.Thailand.

[8]MacNeil JM. Use of Culture Care Theory with Baganda women as AIDS caregivers. *Journal of Transcultural Nursing* 1996;7:14–20.

[9] Tarimo EM. Assessing the impact of HIV/AIDS on informal care: a qualitative study from an urban Tanzanian context. *Masters Thesis. University of Bergen*; 2004.

[10] Banerjee A, Harries AD, Mphasa N, et al. Evaluation of a unified treatment regimen for all new cases of tuberculosis using guardian-based supervision. *International Journal of Tubercle and Lung Disease* 2000;4:333–9.

[11] Wright J, Walley J, Phillip A, et al. Direct observation of treatment for tuberculosis: a randomised controlled trial of community health workers versus family members. *Tropical Medicine and International Health* 2004;9:559–65.

[12] MacIntyre CR, Goebel K, Brown GV, et al. A randomised controlled clinical trial of the efficacy of family-based direct observation of anti-tuberculosis treatment in an urban, developedcountry setting. *International Journal of Tubercle and Lung Disease* 2003;7:848–54.

[13] Ankrah EM. The impact of HIV/AIDS on the family and other significant relationships: the African clan revisited. *AIDS Care* 1993;5:5–22.

[14] Caldwell J, Caldwell P, Ankrah EM, et al. African families and AIDS: context, reactions and potential interventions. *Health Transition Review* 1993;3:1–16.

[15] Wandwalo ER, Morkve O. Knowledge of disease and treatment among tuberculosis patients in Mwanza,Tanzania. *International Journal of Tubercle and Lung Disease* 2000;4:1041–6.

[16] Wandwalo ER, Morkve O. Delay in tuberculosis case-finding and treatment in Mwanza, Tanzania. *International Journal of Tubercle and Lung Disease* 2000;4:133–8.

Community Perception of Tuberculosis Management Program in Suburban Surabaya: A Qualitative Study

Mundakir[1], Asri*[2], Septian G. Winata[3], Pipit F. Wiliyanarti[1], Ratna P. Priyanti[5]

1. Department of Community Mental Health Nursing, Faculty of Health Sciences, University of Muhammadiyah Surabaya , email: mundakir.ners@fik.um-surabaya.ac.id
2. Department of Community Health Nursing, Faculty of Health Sciences, University of Muhammadiyah Surabaya , email: asri.ners@fik.um-surabaya.ac.id
3. Department of Adult Nursing, Faculty of Health Sciences, University of Muhammadiyah Surabaya , email: septian.ners@fik.um-surabaya.ac.id
4. Department of Community Health Nursing, Faculty of Health Sciences, University of Muhammadiyah Surabaya , email: pipitbiostat@yahoo.com
5. Department of Emergency Nursing, STIKES PEMKAB Jombang, Email: ns.ratnapuji@gmail.com

*corresponding author: asri.ners@fik.um-surabaya.ac.id

ABSTRACT

Background: Tuberculosis (TB) is still one of the main problems of major infectious diseases in Indonesia that is difficult to control. Indonesia is the third highest country in the world in TB cases. The national program, Directly Observed Treatment short course (DOTS) that began in 2014 is unable to deal with TB cases comprehensively. Many programs are related to TB but have not been well integrated. The community is believed to have an important role in TB management because they directly intersect with patients and public health.

Objective: The aim of this study was to explore the existed condition of TB management program.

Methods: A descriptive qualitative study was conducted in three Sub-district, which are an endemic area for TB and have the highest incident. Semi-structured interview was conducted to 25 participants which consist of sub-urban TB task force, community health volunteer, Community health Nurses and sub-district officer.

how long for interview, and what are the focus question? *How to analyze data (explain briefly and clear)*

Result: Result reveal four themes as follow: volunteer shortage, do for humanitarian intention, covering the myth and stigma, providing social and economic support.

Conclusion: The conclusion, in order to be effective program, community-based TB management need to be improve in the availability of budget, staff, training and resources while maintaining the on going work of TB task force team.

Keywords: Community-based management, Community Health Volunteer, Descriptive Qualitative, Humanitarian Intention, Social support, TB

Formatted: Centered

Deleted: [1]

Deleted: [1]

Deleted: [2]

Formatted: Default Paragraph Font, Font: 12 pt

Commented [ICHT1]: Please revised the format. Each author should have affiliation and email address. Make sure all authors included in this paper.

Commented [ICHT2]: STRUCTURED ABSTRACT FORMAT

Deleted: *Disclosures*¶
The author(s) received financial support for the research from the Ministry of Research, Technology, and Higher Education, Directorate General of Resources for Research, Technology and Higher Education of Indonesia as at the expense of PDUPT¶
Acknowledgments¶
The author(s) would like to thank the grant is provided by the Ministry of Research, Technology, and Higher Education, Directorate General of Resources for Research, Technology and Higher Education of Indonesia for providing this research, Faculty of health Sciences, University of Muhammadiyah Surabaya, and Research Center Department of University of Muhammadiyah Surabaya¶

Formatted: Justified

Formatted: Font: Times New Roman

Commented [ICHT3]: Rewrite based on what is unknown and known in researcher own words.

Deleted: Tuberculosis (TB) is remains to be major infectious disease problem in Indonesia. World Health Organisation (WHO report in 2018 shows that 10.0 million new TB cases were notified to national health authorities. Indonesia has 842,0000 cases and places it as the country with the third highest number in the world. The national program Directly Observed treatment, short-course (DOTS) started since 2014 has incapable handling TB cases comprehensively. Communities have important role in TB management.

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: Italic

Commented [ICHT4]: Key words related to the content of the manuscript should be listed in alphabetical order and separated by commas.

Commented [ICHT5]: Key words related to the content of the manuscript should be listed in alphabetical order and separated by commas.

Deleted: B,; Community-based management, ; community health volunteer; Social support; humanitarian intention; Descriptive qualitative…

INTRODUCTION

World Health Organization (WHO) states that Tuberculosis (TB) is a global emergency problem for humanity and an important problem in various countries around the world. In Indonesia, although the Directly Observed Treatment Short course (DOTS) strategy has proven to be very effective for TB control, the burden of TB in the community is still high. This is because the implementation of the DOTS strategy and programs for handling TB in its application still have challenges and problems in the community. The main obstacle is the failure to mobilize all community capacities, involving community members to participate, and unclear forms of contributions and who should be involved in TB Handling Program activities that affect the sustainability and effectiveness of the program (Depkes, 2016).

East Java Province is one of the provinces in Indonesia which still has problems in tackling tuberculosis with a prevalence of 110 per 100,000 population. In Surabaya 16,616 people were suspected of TB and 2,330 people were TB positive. Based on data from the Surabaya Health Office 2015, the highest prevalence of TB was in Tandes Subdistrict with 551 people suspected TB and 114 people found with TB positive(KESEHATAN, 2016). In 2016 there were 109 new TB, with a total number of 170 TB patients and a Success Rate of 88.64 (*Profil Kesehatan Kota Surabaya Tahun 2017*, 2018).

Modern society is more likely to solve problems independently through various technological advancements that exist. Individual attitudes and feeling capable of solving problems independently can have an effect on the awareness to live in society as a result is the value in society to help each other, mutual cooperation, and others diminish, depicted by various individual actions that do not lead to a collective goal but lead to a destination according to the individual's wishes. Coleman explained in his ideas about individual actions influenced by the value of an event, that individuals will act based on the interests and benefits obtained from each individual(Field, 2008). If this condition is associated with handling TB cases, it can slow down the handling of cases. If the ability of social management is understood as a social ability in forming a nursing care by optimizing the health service system based on the culture of individuals, groups, families and communities, investment in community-based management is a useful strategy for increasing community nursing care to treat TB(Kawachi, Subramanian, & Kim, 2008).

Community-based TB management is believed to be able to increase the capacity of the community to work together in solving health problems because the basis of management can be characterized in the form of individual willingness to prioritize community decisions in resolving health problems. Citizens who are in a community with good community management will form a cohectivity which is interpreted by the existence of horizontal cooperation and norms of reciprocity because they will also have high confidence, to collaborate or cooperate and help each other[6].

Numerous programs are related to TB but have not yet provided comprehensive solution. The parties related to TB control will operate with their respective own programs. In addition to those programs, the prevalence of TB cases is still increasing. Many people also still think that TB is not a serious disease, just an ordinary cough so the risk of transmission is very high.This study aims to reveal how the community is making efforts to manage tuberculosis with all their ability and resources in their place.

Add the state of art from your study, what is know? And what is unknown? Make a clearly knowledge GAP

1. METHODS

2.1. Design

A qualitative descriptive studywas conducted in Tandes, the sub-district with the highest incidence of

Formatted: Indent: Left: 0.5 cm, No bullets or numbering
Formatted: Font: Not Italic
Deleted: Organitation
Formatted: Font: Not Italic
Formatted: Indent: Left: 0 cm, First line: 0 cm
Deleted:
Formatted: Font: Not Italic
Deleted: [1].
Formatted: Font: Not Italic
Formatted: Font: Not Italic
Formatted: Left, Indent: First line: 0 cm, Don't adjust right indent when grid is defined, No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers
Deleted: [2]
Formatted: Font: Not Italic
Deleted: %
Formatted: Font: Not Italic
Deleted: [3].
Formatted: Font: Not Italic
Formatted: Font: Not Italic
Commented [ICHT7]: This sentence is very long. To improve readability, consider breaking this into multiple sentences
Formatted: Font: Not Italic
Deleted: [4]
Formatted: Font: Not Italic
Deleted: [5]
Formatted: Font: Not Italic
Formatted: Font: Not Italic
Formatted: Font: Not Italic
Formatted: Font: (Asian) Times New Roman, Bold
Formatted: Indent: First line: 0 cm
Deleted: [7]

TB in Surabaya.

2.2. Participants

The participants of this study were selected using purposive sampling method including; 1 official heads of villages, 4 director of the community welfare and safety sub-district office, 3 community nurses who worked at the local public health center, and 18 community health volunteers and Local Health officer.

Inclusion exclusion criteria?

2.3. Data collection

Data were collected from January to May 2019 in Tandes. A total of 104 cases of TB were reported in 2017.

The semi-structured interview questions focused on the influence of Community Perception on TB prevention, control and related experiences. The interviews focused on the participants existence?, role, experience, and connection to the community within TB prevention and control activities. the interview lasts 45 - 60 minutes for one-time data retrieval.

Interview guideline (brief but detail)

The community health workers were interviewed in their homes, and the sub-district officer and the community nurses were interviewed in their workplace to provide them with comfort and convenience. All interviews were recorded and transcribed for data analysis.

2.4. Data analysis

Interview data were analyzed using Uwe Flick(Flick, 2014). The practical steps of analyzing and representing interview data were performed. Data analysis began with (1) reducing data to locate and examine phenomena of interest. In this phase, the interviews were transcribed, and then the data were read and reread. The next phase was (2) reorganizing, classifying, and categorizing data, in which the researchers generated assertions about topics by reassembling and reorganizing the data, codes, categories, and stories. The last phase was (3) interpreting and writing up findings. In this phase, the researcher considered assertions and propositions in light of prior research and theory to develop arguments. Re- searchers developed stories that conveyed the main idea developed in the data analysis and presented data excerpts or stories to support assertions.

The stories were sorted to examine the existence of community based management on TB prevention and control.

2.5. Ethical considerations

Ethical approval to conduct this study was granted by the Institutional Review Board Ethical Committee of Airlangga University No. 630-KEPK, the Regional Department of Health (Surabaya, Indonesia), and the Regional Department of National Unity, Politics, and Public Protection (Surabaya, Indonesia). All participants were provided with a participant information sheet written in Bahasa Indonesia, and they signed the consent form prior to participating in the study.

RESULTS

Below is the themes found from data analysis.

Do for humanitarian intention

Deleted: which has an especially high prevalence of TB

Deleted: and

Deleted: one

Deleted: [8]

Formatted: Indent: Left: 0.5 cm, No bullets or numbering

Deleted: Tandes is a sub-district in a suburban geographical area and has the fifth largest area and highest population density in southern Surabaya. Tandes is located approximately 4 m above sea level. The overall site area is approximately 11.07 km2 and is divided into six villages, with a total population of 93.459. …

Deleted: 3.1.

Formatted: Font: Not Italic

One of the forms of Community based management, which plays an important role in the efforts to eradicate TB, is Volounteer. In the Tandes sub-district, six volounteers worked in the two primary health centers (PHCs). The volounteers were responsible for the entire TB prevention and control program in the region and implemented it in their own PHCs. In overcoming health problems, especially TB, at the government level, there is an institution called the TB Task Force and for non-government TB elimination programs carried out by the Aisyiyah Organization. Both work together with puskesmas in conducting TB elimination programs. Social awareness is their basic foundation in working to reduce TB problems.

They said, *"we want life to be beneficial for others. The rest is so important that sincerity and maintaining sincerity are difficult.(P1)*

We are also happy if we come to the patient then the patient according to that, the patient is happy, we are also happy. also the name of humans must be beneficial to others too. (P2)

When I saw the patient not recovering and then broke up the medication, I felt unsuccessful in carrying out my duties, I felt sorry for why I could not make the person recover (P3).

Yes because of humanity, another is the intention to seek (religious) reward (P5)

I also do not know maybe it has been my destiny from time to time, I have always loved it. Although you never got anything, you can imagine making a posyandu serving green beans, its CHWs contributions, doing door to door was ridiculed by the person, then the door was closed, especially the some ethnic group. (P7)

Volunteer shortage

Deleted: 3.2.

Formatted: Font: Not Italic

The problem of TB requires complex management involving all elements of the community and requires evaluation of successful treatment for quite a long time. Treatment is complete for 6 months and the ease of transmission of the disease, requires TB observers to carry out monitoring, mentoring and reporting that are really serious. The large number of TB Elimination programs is not balanced with the needs of existing labor or human resources.

> *... yes until now, even now the active CHWs are old. I remember there was a very old CHWs from an area, the oldest CHWs here was someone who was 65 years old and his condition was very healthy (P1)*
> *at most because of laziness, fear ... Most are afraid. for example.....among 10 people who are active only me. there are often people who say Ouch I can't eat two days if there is phlegm it's make me feels nausea... even though (phlegm) it's already closed, yes but I imagine it's still there ... I can't be a CHWs (P2)*

covering the myth and stigma,

Deleted: 3.3.

Formatted: Font: Not Italic

The wrong prejudice about TB is still a probelm that is very difficult to dispel. some people still believe that people with TB must be excluded, or should be ostracized, because they know that it's an infectious disease that's hard to cure. the role of health volunteer is very important, one of which is to cover up this stigma not to spread misinformation to the wider community.

> *it is just counselling, so every opportunity is made to do counselling especially if there is a tuberculosis patient in that area , but we cannot open that such person is a TB patient, so usually if there is a neighbour asking that patient, no, we just do this counselling so that it is no health problem. (P9)*

> *... this is just for neighbourhood, For example, I want to go to A, I don't go directly to A, but to the neighbour first, there are many people who think negatively, so I go to the neighbours first ....*

People were afraid, especially if there is someone from the puskesmas or from health officer, so they immediately close the door. (P14)

know but don't want to say that he was (TB patient)... "what have you been sick of even though the puskesmas had told me the disease ... I continued to visit in two weeks. "How's the medication, is it already done? Is that fine?" It is okay. "That means I don't know about the disease so much" when in the beginning I knew. Pretend that i don't know. It will Keeping him (TB patient) shy. In fact, it will be nice if he shares it later. (P15).

providing social and economic support.

Deleted: 3.4.

Formatted: Font: Not Italic

The Surabaya Health Office has provided free medical assistance to TB patients. In addition to the assistance of giving drugs without paying expenses, TB patients also get free nutritional intake in the form of formula milk given when patients take drugs at the Puskesmas. Other parties who also provided material assistance for underprivileged TB patients were Aisyiyah, in the form of 30,000 in cash. But in reality the support is still considered lacking.

The Voulunteers said, "There are those whose economic conditions are very difficult, the puskesmas also needs to ride a pedicab, but there is also funds from the SSR during treatment, only once," P1 (cadre).
Sometimes if you see something like that, the cadres' own initiative is mas, so we give you something, bro. The point is trying to be concerned, there is a distribution of our basic necessities for the sick patient with P1 TB (cadre).

Once, when I was OK, then I gave 25,000 people money, and I didn't feel very happy. (P2) "

The Nurse Said, "Yes, we are still on a social mission, which we complain about is usually we have a visit while we have not been able to give transport money so we also usually hesitate if we have to ask" why haven't you visited this? "(P4)

In Tandes Subdistrict there is still no specific counseling program about TB. This is because TB is still not a priority in community problems. The main TB program is the door knock and cakning program where this program is a program with a ball picking approach or visiting the community one by one to be given counseling and looking for TB suspects. But with the constraints that not all communities receive TB health programs, not all levels of society get counseling about TB disease. So an effective way to provide counseling with the participation of many people is through community social groups.

The Voulunteers said, *"'in the recitation, PKK meetings and also at the puskesmas when there is counseling for us to give brochures about TB, so later if they go back to the RW they can transmit the knowledge they get through the brochure.'(P3).*

Actually, if you look at the condition of TB patients it seems that what they really need is a decent life because all this time we know, even though there are some patients who are already living well, most of them do not live properly from the side of their residence, because they become patients and after they recover it should be given a job, meaning that given the work that does not require or spend a lot of energy. while there are still children who still need their living expenses, which means economic problems, yes, most of them are in economic problems. (P1)

"If there is an automatic posyandu, if there is a posyandu, even though they are not active in community activities, the posyandi is definitely going to participate, yes, the opportunity for us to provide information is also helped by the RT" (P11)

Those who are still on treatment, we still see the main help, how come oh, this mother still needs assistance, if there is no family as Drug swallowing supervisor PMO, I will assist to take medicine and deliver the medicine to patients the house (P12)

DISCUSSION

Evidence from this study proves that community-based approved programs are also acceptable.

WHO has issued community-based DOTs to complement health-based DOTs in the high burden of TB, resource-limited countries (Dheda, Barry, & Maartens, 2016). Until the patient and community attitudes and perceptions of the community and health facility-based DOT discussed and calculated with this assistance will not be carried out with success.

The findings make the drug cadres and supervisors almost unforeseen women and family members. The responsibility of sick family members in most areas of Surabaya is defined as the role of women (Escott & Walley, 2005; Kusimo et al., 2015). The idea because families cannot participate because of DOT is because culture, family or family relationships are not proven in our study. Even though, that is support patients satisfied with them as supporters of care. Studies conducted elsewhere indicate family members are DOT that effectively supports treatment (de Vries et al., 2017; Massey et al., 2012). A study conducted in Indonesia, however Australia, did not show benefit in using family members supporting DOT treatment (Main et al., 2019).

The context in Australia may be different from Surabaya where large family members are an important part of social networks. In Surabaya and Indonesia at the time of the care of family members taken as family members who were moved inside local culture and values (Craig, 2015). Members of the caregiver family for chronic diseases such as HIV / AIDS and there is no reason not to believe this phenomenon will be different in TB cases (Sissolak, Marais, & Mehtar, 2011). Future studies should consider the impact of care on TB treatment and how it affects family relationships.

It is very supportive for research in our study that supports motivation to support care by carers and former TB patients for reasons of altruism. The majority of patients can also support other TB patients after completing treatment. This The findings are important for two main reasons: first, it shows the potential for using former TB patients in TB control activities. In one study, former TB patients found to be an important source of information for TB Patients (Okeyo & Dowse, 2016)Former TB patients can also help TB patients and the TB community can indeed be cured. This is very important in Tanzania where many people do not have enough knowledge of TB and delay in seeking treatment (Wandwalo & Mørkve, 2000)the national TB program needs to address this problem based on available local resources.

Conclusion

Our findings provide a valuable agreement for the effective implementation of relevant, sensitive and acceptable TB control interventions for the needs of patients and society in general. Community-based TB Program is a viable option and can be built based on health facilities in DOTS, especially in developing countries such as Indonesia where the health system is overwhelmed by increasing the number of TB and HIV / AIDS patients. The community-based TB Management must be seen as a complement? and perhaps a substitute for a national TB activity program.

.

Disclosures

The author(s) received financial support for the research from the Ministry of Research, Technology, and Higher Education, Directorate General of Resources for Research, Technology and Higher Education of Indonesia as at the expense of PDUPT

Acknowledgments

Commented [ICHT8]: Discussion style:
Result (brief)→ compare to previous studies → researcher analysis

Discuss all the themes of your result

Formatted: No bullets or numbering

Deleted: [7]

Deleted: [8][9]

Deleted: [10,11]

Deleted: [12].

Deleted: [13]

Deleted: [14]

Deleted: [15].

Deleted: [16]

Formatted: Indent: Left: 0.5 cm, No bullets or numbering

Deleted:

The author(s) would like to thank the grant is provided by the Ministry of Research, Technology, and Higher Education, Directorate General of Resources for Research, Technology and Higher Education of Indonesia for providing this research, Faculty of health Sciences, University of Muhammadiyah Surabaya, and Research Center Department of University of Muhammadiyah Surabaya

Deleted: ¶

References

Craig, G. M. (2015). The social context of tuberculosis treatment in urban risk groups in the United Kingdom: a qualitative interview study. *International Journal of Infectious Diseases*, *32*, 105–110. https://doi.org/10.1016/J.IJID.2015.01.007

de Vries, S. G., Cremers, A. L., Heuvelings, C. C., Greve, P. F., Visser, B. J., Bélard, S., … Grobusch, M. P. (2017). Barriers and facilitators to the uptake of tuberculosis diagnostic and treatment services by hard-to-reach populations in countries of low and medium tuberculosis incidence: a systematic review of qualitative literature. *The Lancet Infectious Diseases*, *17*(5), e128–e143. https://doi.org/10.1016/S1473-3099(16)30531-X

Depkes. (2016). *Pedoman Nasional Penanggulangan Tuberkulosis*. *Indonesia*. https://doi.org/616.995.24 Ind P

Dheda, K., Barry, C. E., & Maartens, G. (2016). Tuberculosis. *The Lancet*. https://doi.org/10.1016/S0140-6736(15)00151-8

Escott, S., & Walley, J. (2005). Listening to those on the frontline: Lessons for community-based tuberculosis programmes from a qualitative study in Swaziland. *Social Science & Medicine*, *61*(8), 1701–1710. https://doi.org/10.1016/J.SOCSCIMED.2005.03.040

Field, J. (2008). *Social capital*. Routledge.

Flick, U. (2014). *The SAGE Handbook of Qualitative Data Analysis*. *The SAGE Handbook of Qualitative Data Analysis*. https://doi.org/10.4135/9781446282243

Kawachi, I., Subramanian, S. V., & Kim, D. (2008). Social Capital and Health. In *Social Capital and Health* (pp. 1–26). New York, NY: Springer New York. https://doi.org/10.1007/978-0-387-71311-3_1

KESEHATAN, P. K. S. (2016). *PROFILKESEHATANTAHUN 2016*. SURABAYA: DINAS KESEHATAN KOTA.

Kusimo, O., Olukolade, R., Hassan, A., Okwuonye, L., Osinowo, K., Ogbuji, Q., … Ladipo, O. A. (2015). Perceptions of community members on tuberculosis and its effect on health-seeking behavior in Nigeria. *International Journal of Mycobacteriology*, *4*, 61. https://doi.org/10.1016/J.IJMYCO.2014.10.023

Main, S., Lestari, T., Triasih, R., Chan, G., Davidson, L., Majumdar, S., … Ralph, A. (2019). Training for Tuberculosis Elimination in Indonesia: Achievements, Reflections, and Potential for Impact. *Tropical Medicine and Infectious Disease*, *4*(3), 107. https://doi.org/10.3390/tropicalmed4030107

Massey, P. D., Wakageni, J., Kekeubata, E., Maena'adi, J., Laete'esafi, J., Waneagea, J., … Speare, R. (2012). TB questions, East Kwaio answers: community-based participatory research in a remote area of Solomon Islands. *Rural and Remote Health*, *12*, 2139. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23094978

Okeyo, I., & Dowse, R. (2016). Community care worker perceptions of their roles in tuberculosis care and their information needs. *Health SA Gesondheid*, *21*, 245–252. https://doi.org/10.1016/J.HSAG.2016.05.004

Profil Kesehatan Kota Surabaya Tahun 2017. (2018). Surabaya: Dinas Kesehatan Kota Surabaya. Retrieved from https://drive.google.com/file/d/0BwaTO2QdUm-2UXpVZFdFc01HZDNWS0NRMkw2TDVpRjNKZm5J/view

Sissolak, D., Marais, F., & Mehtar, S. (2011). TB infection prevention and control experiences of South African nurses - a phenomenological study. *BMC Public Health*, *11*(1), 262. https://doi.org/10.1186/1471-2458-11-262

Commented [ICHT9]: Be adherence to APA format. It's wrong format. REVISE ALL

Wandwalo, E. R., & Mørkve, O. (2000). Delay in tuberculosis case-finding and treatment in Mwanza, Tanzania. *The International Journal of Tuberculosis and Lung Disease : The Official Journal of the International Union against Tuberculosis and Lung Disease*, *4*(2), 133–138. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10694091

Deleted: ¶

¶

[1] Depkes RI. 2012. *Penanganan Penyakit Tuberkulosis*, Jakarta. ¶

¶

[2] Dinas Kesehatan Kota Surabaya. 2015. Laporan Kejadian TBC di Kota Surabaya.¶

¶

[3] Dinas Kesehatan Kota Surabaya. 2016. Laporan Kejadian TBC di Kota Surabaya.¶

¶

[6] Ericsson, M. 2011. Sosial Capital and Health-Implications for Health Promotion. Global Health Action Journal. Swedia. ¶

¶

[4] Field, J. 2008. *Sosial Capital* (2nd Edition). Ney york and London. Routledge.¶

¶

[5] Kawachi, I. 2007. *Social Capital and Health* (2008 edition). New York ; London: Springer.¶

¶

[7] Lambert, A. Vickie. 2012. Qualitative Descriptive Research : An Acceptable Design. *Pasific Rim International Journal of Nursing Research*.Thailand.¶

[8]MacNeil JM. Use of Culture Care Theory with Baganda women as AIDS caregivers. *Journal of Transcultural Nursing* 1996;7:14–20.¶

[9] Tarimo EM. Assessing the impact of HIV/AIDS on informal care: a qualitative study from an urban Tanzanian context. *Masters Thesis. University of Bergen*; 2004. ¶

[10] Banerjee A, Harries AD, Mphasa N, et al. Evaluation of a unified treatment regimen for all new cases of tuberculosis using guardian-based supervision. *International Journal of Tubercle and Lung Disease* 2000;4:333–9.¶

[11] Wright J, Walley J, Phillip A, et al. Direct observation of treatment for tuberculosis: a randomised controlled trial of community health workers versus family members. *Tropical Medicine and International Health* 2004;9:559–65.¶

[12] MacIntyre CR, Goebel K, Brown GV, et al. A randomised controlled clinical trial of the efficacy of family-based direct observation of anti-tuberculosis treatment in an urban, developedcountry setting. *International Journal of Tubercle and Lung Disease* 2003;7:848–54.¶

[13] Ankrah EM. The impact of HIV/AIDS on the family and other significant relationships: the African clan revisited. *AIDS Care* 1993;5:5–22.¶

[14] Caldwell J, Caldwell P, Ankrah EM, et al. African families and AIDS: context, reactions and potential interventions. *Health Transition Review* 1993;3:1–16.¶

[15] Wandwalo ER, Morkve O. Knowledge of disease and treatment among tuberculosis patients in Mwanza,Tanzania. *International Journal of Tubercle and Lung Disease* 2000;4:1041–6.¶

[16] Wandwalo ER, Morkve O. Delay in tuberculosis case-finding and treatment in Mwanza, Tanzania. *International Journal of Tubercle and Lung Disease* 2000;4:133–8.¶

¶

¶