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ORIGINAL

"Ale Rasa Beta Rasa" a Cultural Value That Is Capable of Overcoming Tuberculosis (Tb) Stigma: Qualitative Research Down in Maluku, Indonesia

"Ale Rasa Beta Rasa": un valor cultural capaz de superar el estigma de la tuberculosis (TB): investigación cualitativa en las islas Molucas, Indonesia

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ABSTRACT

Introduction: tuberculosis (TB) stigma is a public health issue in one of Indonesian regions, Maluku, where cultural identity highly defines the way people interact. Therefore, this study aims to determine the influence of the local value, Ale Rasa Beta Rasa or I feel what you feel, on reducing stigma connected to TB.
Method: this was a qualitative descriptive study conducted in Ambon City, Maluku Province, in February-April 2025. A total of 25 participants were selected using the purposive sampling method, comprising TB patients, family members, academics, healthcare professionals, religious leaders, and survivors. Data was collected using participatory observation, document analysis, and in-depth interviews. In addition, the interviews were verbatim-transcribed and later thematically analyzed using the 6-phase method associated with Braun and Clarke, and the cultural context was taken into consideration.
Results: the 3 main findings included: (1) internalized form of stigma was dominant, where patients hid their illness and sought care beyond their local community; (2) the metaphor "Ale Rasa Beta Rasa" served as the way of cultural capital that induced empathy, collegiality, and social acceptance and subsequently increased the treatment adherence; and (3) religious leaders and TB patients acted as key mediators, providing both advocacy and education in terms of cultural norms and values.
Conclusions: incorporation of cultural values in TB control strategies can be used to improve program sustainability and relevance. The results provide a culturally-based model that can direct the efforts of national stigma-reducing activities, and potentially be modified to fit the use in other communities sharing a cultural commonality. The identified structure, entitled Ale Rasa Beta Rasa, has shown significant potential related to overcoming stigma-related obstacles to treatment in contexts where cultural coherence is pertinent.

Keywords: Cultural Capital; Tuberculosis; Stigma; Qualitative Study.

RESUMEN

Introducción: el estigma de la tuberculosis (TB) es un problema de salud pública en una de las regiones de Indonesia, Maluku, donde la identidad cultural define en gran medida la forma en que las personas

interactúan. Por lo tanto, este estudio tiene como objetivo determinar la influencia del valor local, Ale Rasa Beta Rasa o «siento lo que tú sientes», en la reducción del estigma relacionado con la TB.
Método: se trata de un estudio descriptivo cualitativo realizado en la ciudad de Ambon, provincia de Maluku, entre febrero y abril de 2025. Se seleccionó a un total de 25 participantes mediante un método de muestreo intencional, entre los que se encontraban pacientes con TB, familiares, académicos, profesionales de la salud, líderes religiosos y supervivientes. Los datos se recopilaron mediante observación participativa, análisis de documentos y entrevistas en profundidad. Además, las entrevistas se transcribieron literalmente y posteriormente se analizaron temáticamente utilizando el método de seis fases asociado a Braun y Clarke, teniendo en cuenta el contexto cultural.
Resultados: las tres conclusiones principales fueron las siguientes: (1) predominaba la forma internalizada de estigma, en la que los pacientes ocultaban su enfermedad y buscaban atención fuera de su comunidad local; (2) la metáfora «Ale Rasa Beta Rasa» sirvió como forma de capital cultural que indujo la empatía, la colegialidad y la aceptación social y, posteriormente, aumentó la adherencia al tratamiento; y (3) los líderes religiosos y los pacientes con tuberculosis actuaron como mediadores clave, proporcionando tanto apoyo como educación en términos de normas y valores culturales.
Conclusiones: la incorporación de valores culturales en las estrategias de control de la tuberculosis puede utilizarse para mejorar la sostenibilidad y la pertinencia de los programas. Los resultados proporcionan un modelo basado en la cultura que puede orientar los esfuerzos de las actividades nacionales de reducción del estigma y que, potencialmente, puede modificarse para adaptarse al uso en otras comunidades que comparten una cultura común. La estructura identificada, denominada Ale Rasa Beta Rasa, ha demostrado un potencial significativo para superar los obstáculos relacionados con el estigma que dificultan el tratamiento en contextos en los que la coherencia cultural es pertinente.

Palabras clave: Capital Cultural; Tuberculosis; Estigma; Estudio Cualitativo.

INTRODUCTION

Tuberculosis (TB) is one of the leading global public health concerns affecting various countries. As assessed by World Health Organization (WHO) in 2023, approximately 10,6 million cases of TB were registered across the world, with Indonesia being the second most affected country.[1] To address the prevalence, Nationwide Directly Observed Treatment Short-course (DOTS) program for the control of TB has been used in Indonesia. The report from DOTS program showed that uncontrollable factors were very difficult to overcome, particularly the social and cultural determinants. In Indonesia, Maluku Province is an archipelago that is characterized by high levels of social and cultural heterogeneity, with a significant prevalence rate of TB. Patients in this area have to face deep-seated stigma, which causes affected individuals to hide their sickness and avoid seeking treatment.[2,3,4,5,6]. Examples of this stigma are discrimination and social marginalization, as well as widespread negative prejudice, which leads to patients' hesitation to commence treatment or failure to reveal their status to other stakeholders. The effect of stigmatization is not only to enhance the risk of transmission due to reduced uptake of precautionary actions, but also to affect the success of treatment due to the implicit or explicit communication of disaffiliation messages.[7,8,9,10]

According to previous studies, biomedical interventions often have a low success rate when applied separately in an environment where cultural continuity is strong. The people in Maluku support the saying, Ale Rasa Beta Rasa, which in ordinary lingo means Ale is happy, Beta is happy or Ale is suffering, Beta is suffering. The value system described by this phrase is brotherhood, characterized by respect of solidarity, belongingness to each other, empathy, and selfless deeds. In this paradigm, the value of "Ale Rasa Beta Rasa" can be viewed to be a collective identity, which helps to develop a prosocial behavior and an inclusive disposition toward people in general.[11,12] Ale Rasa Beta Rasa framework is an ordered system of conduct that is aimed at diminishing the stigma of individuals with TB in Maluku. The framework has attempted to instill social awareness and the creation of social support through the implementation of locally pertinent cultural values incorporated into a community-targeted intervention in an attempt to form and construct the social support of people with the disease. It has also been empirically proven that TB-related stigma can be significantly decreased due to multilevel, culture-specific interventions, such as community campaigns, institutional policies, survivor advocacy, and peer-led support groups. To achieve the provision of a locally applicable indicator, it is important to adapt the Van Rie TB Stigma Scale in the Indonesian setting. This scale is expected to provide context to assess stigma in a systematic manner as understood by both patients and community members.[13,14,15,16,17,18]

In a current review of TB surveillance data, there has been a gap between the number of diagnosed patients and those who eventually turn up completing treatment. In addition, there was a significant decrease

in the number of reported cases (911-1915) annually (2020-2024). The results support the necessity of specific intervention measures to enhance case management and treatment compliance, specifically in the context of continuously disrupted socioeconomic life (Secondary Data from the Ambon City Health Office, 2020–2024).

Based on the situation of TB cases in Ambon City, there is an evident mismatch between the number of notified patients and those who receive the actual treatment. In this context, the stigma is one of the major risk factors.[19] According to a study conducted in 2023 by the Tropical Disease Centre in Gadjah Mada University, there is a significant amount of social stigma against TB patients in 6 cities located in Indonesia, including Ambon. The study comprised 1048 patients, and 7,4 % perceived that the community looked down upon their families due to the disease, 10,4 % were underestimated, and 17,2 % perceived risk of being sacked at work, and 20,7 % faced disapproval by peers and the community.[20]

A previous study was conducted in January 2025 on 8 cases of TB in health centres that logged the highest cases in the region. The results showed that patients visited health facilities far apart geographically from their homes, citing shame and fear as the reasons for not wanting TB status to be known. These results support the role of geographical area in treatment-seeking behaviours. Despite the prevalence of the disease, contemporary studies in Eastern Indonesia have not explored how to integrate communal cultural values with stigma reduction program. The absence of such studies is a serious shortcoming in literature as well as in the program implementation. The strategies used at the local level must be globally-compliant with local values, where the cultural identity shapes social relationships. In Maluku, the stigma of being infected with TB negatively affects patients, leading to isolation. The cultural imperative of Ale Rasa, Beta Rasa, or the acknowledgement that a sick person is a suffering individual who has to be supported, provides a vital point of intervention. With the application of this principle, the aspect of stigma or rejection of sick individuals reduces, and the community cohesion can be transformed into a rich source of social capital. This indicates the urgent need to conduct studies on optimising the management of TB in Maluku as well as developing cultural values to enhance public health. Inaccurate cause perceptions, perceived disease association with HIV, lack of awareness of disease causation, and a variety of sociocultural issues affect the distribution of stigma, which varies in different enclaves as observed in a systematic global review.[21]

In the Global TB Stigma Framework developed by World Health Organization (WHO), the significance of response by communities as well as culture is emphasized, but there is a dearth of empirical studies on these aspects focusing on the applicability of cultural beliefs to stigma reduction in Eastern Indonesia. Therefore, this study aims to explain how the local ethical value of Ale Rasa Beta Rasa can serve as a cultural mediator towards the reduction of TB stigma in Maluku and to evaluate how it can provide value addition to culturally sensitive TB control policies.

METHOD

Study Design

A qualitative descriptive design was used to explore the role of local cultural values and stigma associated with patients with tuberculosis (TB) in the Maluku region. This methodology enabled an in-depth understanding of the lived experiences of individuals within their social and cultural contexts. It also allowed the researchers to interpret participants' meanings and perceptions with cultural sensitivity.

Setting

The study was conducted in Ambon City, Maluku Province, between February and April 2025. Ambon was selected as it is the provincial center for TB management and has the highest number of TB notifications in the region. With a high population density and the presence of a provincial referral center, it provided an optimum environment to study the cultural dimensions of stigma. Participants were interviewed in Bahasa Indonesia or the local Maluku dialect as needed. Each interview was audio recorded, transcribed verbatim in the original language, and later translated into English for analysis. Pseudonyms and coded identifiers were used to ensure the confidentiality and anonymity of all participants.

Participants and Sampling

Purposive sampling was employed to recruit 22 participants representing various stakeholder groups, including family members, religious leaders, medical professionals, academics, community officials, and TB patients (both current and former). The inclusion criteria required that participants (1) resided in Ambon City or nearby districts, (2) were aged 18 years and above, and (3) had direct or indirect experience in supporting, treating, or preventing TB. Invitation messages were sent by telephone to verify consent and confirm availability. Interviews were arranged at times and locations convenient for participants. As a gesture of appreciation, participants received small tokens and transport reimbursement. Table 1 provides details of sampling procedures and the establishment of rapport with informants.

Data Collection

Semi-structured interviews: Each interview lasted approximately 30–50 minutes. The interviews explored participants' understanding of TB, experiences of stigma, and perceptions of *Ale Rasa Beta Rasa* as a cultural mechanism of patient support.

Participatory observation: Researchers attended places of worship, community events, and health-related gatherings to observe expressions of solidarity and stigma-mitigation behaviors within cultural settings.

Document review: TB control efforts in Maluku were contextualized through the review of national health reports, policy documents, and media publications. All interviews were audio recorded with participant consent and transcribed verbatim. Field notes from each observation were compiled and integrated into the data set for triangulation.

Data Analysis

Data were analyzed using the six-step thematic analysis framework developed by Braun and Clarke. In the first step, familiarization, transcripts and field notes were read multiple times to immerse the researchers in the data and develop a contextual understanding. During the second step, initial coding, both inductive and deductive coding approaches were employed to identify meaningful data segments related to social solidarity, internalized stigma, and the influence of religious leadership.

In the third step, theme identification, related codes were grouped into broader categories that captured the lived experiences of stigma, community support systems, and cultural responses. The fourth step involved theme refinement, during which themes were reviewed, adjusted, and clarified to ensure consistency and alignment with the overall data set and cultural context of the participants.

Next, in the fifth step, theme definition, each theme was explicitly defined, highlighting its cultural significance and relevance to TB-related stigma. Finally, in the sixth step, narrative construction, data were triangulated through interviews, observations, and document reviews. The credibility of findings was enhanced through member verification and peer discussions to confirm that interpretations accurately represented participants' perspectives.

Ethical Considerations

Ethical approval for this study was obtained from the Hasanuddin University, Makassar Ethics Committee approved the study protocol (No. 1900/UN4.14.1/TP.01.02/2024). All participants gave their written informed consent after being reassured of their privacy and the fact that their participation was entirely voluntary. All transcripts and reports employed anonymized identifiers and pseudonyms. All participants were informed about the study objectives, procedures, and their right to withdraw at any time. Written informed consent was obtained prior to participation. Confidentiality was maintained through the use of pseudonyms and coded identifiers. All digital data (audio files, transcripts, and notes) were securely stored on password-protected devices accessible only to the principal investigators. Data will be retained for five years and then permanently deleted in accordance with institutional data policy.

Avoiding Translation and Interpretation Bias

Given that some interviews were conducted in both Bahasa Indonesia and the Maluku dialect, steps were taken to prevent translation bias. Transcripts were initially written in their original language and subsequently translated into English by bilingual researchers familiar with qualitative health research. A back-translation process was used to verify meaning accuracy, and member checking was carried out to confirm that participants' narratives were faithfully represented.

Potential Bias and Limitations

Although measures were implemented to ensure accuracy, subtle nuances and cultural idioms may not have been fully captured in translation. This limitation was recognized as a potential source of interpretive bias, particularly in themes reflecting emotional or metaphorical expressions. To mitigate this, peer debriefing sessions were conducted to discuss ambiguities and ensure analytical consistency across the research team.

Table 1. Sample Collection Procedure and Informant Relations– Data Collection Techniques – Focus Examined*

Participant Group	Participant Identification (Sampling Method)	Number and Characteristics of Participants during In-depth Interviews	Data Collection Techniques	Focus Explored
Patient TB	All selected cases are based on TB information system (SITB) Health	The study recruited 5 participants that satisfied the condition regarding the diagnosis of TB. They were	In-depth interviewed	Personal experience is an indispensable source of data in trying to comprehend the behavior of individuals

	Centre Register for the years 2024 - 2025	aged between 22 and 53 years; three of them were full-time housewives whereas one worked in a vehicle, used in public transport and the other participant was a student in a university.		and groups in societies. These behaviors are usually influenced by stigma, which is a kind of discredit or disapproval against certain characteristics. On the contrary, social support, which refers to processes by which people get emotional or instrumental help of other people can mitigate the impacts of stigma. However, despite the factors of stigma and the weakness of social support, hope to society existence, the optimistic anticipation of the societal future, does exist, indicating that the collective construct of society and its orientation towards the positive change has not yet lost its relevance and importance.
Patient's family	Directly Observed Treatment (DOT) Supervisor (PMO)	The three persons were a 43-year-old mother, a 27-year-old mother, both at that time permanently employed as a housewife when they obtained the medication of their children. There was also a third participant, 23-year-old brother of the student mother, who took his brother an examination.	In-depth interview and Group discussion	Family response to TB diagnosis, social burden, and family solidarity.
Religious Leader	Influencing the community	Three male religious leaders, aged between 50 yrs and 61 yrs gave unconscious ratings.	In-depth interview and Group discussion	Views on TB, the influence of cultural and religious values, the role of figures as connectors of Ale Rasa Beta Rasa values, and community perception changers.
Academic Figure	Having expertise in Sociology and Anthropology	Two university lecturers, aged 52 and 71, were involved.	In-depth interviewed	Theoretical perspective on stigma and strengthening the approach based on local culture, Ale Rasa Beta Rasa
Healthcare workers who interact with TB patients.	TB Program officers at the Community Health Center and the Health Office of Ambon City and Maluku Province	Four TB program holders, all women, aged 32 to 51 years, were thoroughly interviewed.	In-depth interviews and observation	Interaction with patients, the need for a more empathetic and culturally-based approach, Ale Rasa Beta Rasa in service.
Survivors (former TB patients)	Recovered cases recorded in the SITB Puskesmas Register for the year 2024 - 2025	Two thoroughly interviewed survivors, one a full-time housewife and the other a civil servant, aged 41 and 37, respectively.	In-depth interviews, Focus group discussions	The process of social recovery post-TB, experiences of discrimination, and the support of solidarity in facing stigma.
The general public in areas affected by TB	Having the same residential area as the patient	Three community members were interviewed in depth: a 33-year-old male private employee, a 42-year-old female entrepreneur, and a 51-year-old elementary school teacher.	Group discussion, Participatory observation	General perception of TB, attitudes towards patients, the role and potential of local culture (Ale Rasa Beta Rasa).

Note: * Direct phone conversation with participants was necessary to locate and confirm the addresses of participants who were used in this study since most of participants had mobile phones. After their participation was confirmed, their consent to be interviewed was confirmed and were finally approved to be part of the investigation process.

RESULTS

Qualitative thematic analysis of Ale Rasa Beta Rasa revealed 5 salient themes that showed how the initiative could address stigma related to TB substantially in Maluku. The thematic overview table was organized to facilitate the analysis as it was a systematic method of outlining the themes and their respective sub-themes. In the current discussion, these results had elongated interpretations that were expounded.

Table 2. Themes and Subthemes of TB Stigma Reduction in Maluku

No	Theme	Subtheme	Representative Quote
1	Cultural Empathy in TB Treatment	Ale Rasa Beta Rasa as the Standard in the Community	"Think the saying, I would know the suffering and so we must stick together, is the essence of the aspect of community leadership- empathy. The expression summarizes the notion that as people go through common hardships, they are in charge of strengthening each other. This is a principle that the leaders should learn and internalize so that they can promote cohesion and strength within the group" (P03, Community Leader).
		Social Unity in the Face of Stigma	TB patient will have to face increased social isolation and it is the responsibility of health-care providers, community members and health researchers to act in unison. There is therefore an urgency to make interventions which not only reduce stigma but build social support (P07, Family Member).
2	Cultural and Religious Leaders' Role	Promoting Advocacy via Sermons	"I am preaching that TB is sickness not a curse" (P11, Religious Leader).
		Intermediary between Health Services and Patients	"We enable one way communication of patient with clinic" (P15, Health Volunteer).
3	Mechanisms for Community Support	Groups for Peer Encouragement	"We support one another in pursuing treatment" (P09, TB Survivor).
		Family Support	"My family takes turns taking me to the health center" (P02, Patient).
4	Stigma Eksperiences	Internalized stigma	"To maintain confidentiality, the patient selected to receive therapy in a geographic area that is not close to the place where she resides (P05, Patient). Similarly, the reviewed participant of the qualitative study refused to put on a surgical mask in the workplace; the motivation behind it was the intention to hide an illness to colleagues (P02, Individual).
		Protective Community Responses	"Social distancing is introduced not to serve as a manifestation of hostility but to protect the population" (P07, Family Member). "Given that TB is mainly spread through aerosolized bacteria your neighbor, being cognizant of TB diagnosis in another family would have right to worry about his or her own child playing with the affected counterpart"(Survivor, P04).
5	Cultural Perception of *Ale Rasa Beta Rasa*	Deep Empathy as a Fundamental Principle	Helping others is a vocation of the heart and soul; Ale Rasa Beta Rasa is based on empathy (Religious Leader, P11).
		Religious Doctrine conformance	"Rasa Beta Rasa-a model of empathic care-incorporates the emotional responses into organized way of intervention love, and mutual aid are consistent with our religious teachings" (Religious Leader, P11).
		Utilization of Community Resources	"According to Ale Rasa Beta Rasa principle, widespread dissemination of general information cannot be neglected in order to receive the assistance within the frames of the village funds" (Community Leader, P03).

Summary of Findings

Internal stigma was the most common stigma related to TB in Maluku as patients mostly mask their disease. However, Ale Rasa Beta Rasa value increased in the social support network, including immediate family, religious individuals, TB survivors, and the general population. This led to an increase in social acceptance and treatment compliance.

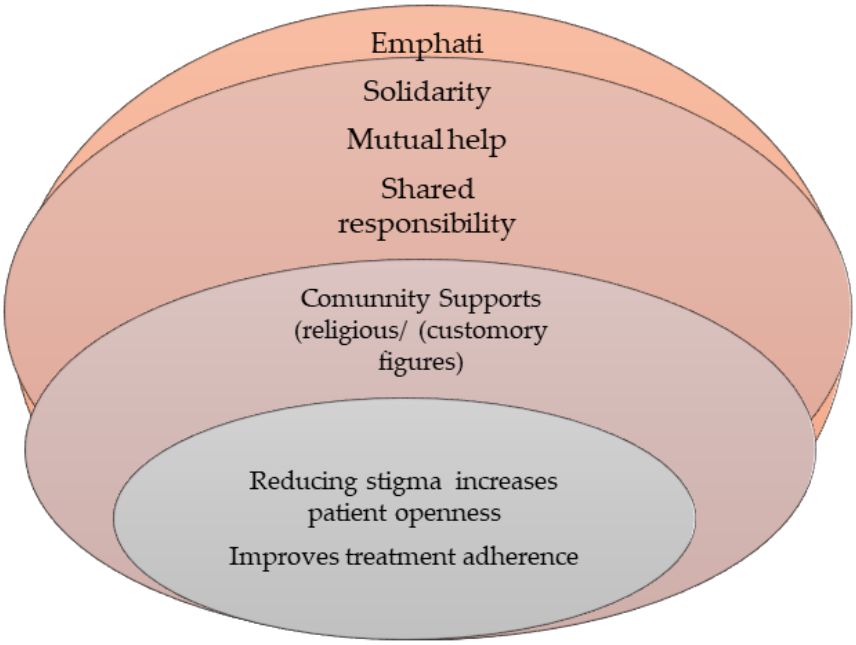

Figure 1. Cultural Capital Ale Rasa Beta Rasa

Table 3. Categories and Main Findings from Participant Interviews

Category	Main Findings of the Research
Description of participant	The age of participants makes up an average of above 25 years, and the gender allocation shows that over a quarter are females. When it comes to the educational level, participants possess various degrees that are secondary education and a master degree. TB patients include family members, healthcare professionals, religious leaders, community leaders, and the survivors in the variety of relationships with TB patients.
Understanding tuberculosis	The proportion of TB patients with limited understanding of the disease is large, and it is partially explained by a lack of sufficient supply of the evidence-based information on the question. As a result, they are not aware of the etiology of TB, measures to prevent it, and modes of transmission. Current deficits can be viewed in their inability to develop proper preventive behaviors, specifically the regular wearing of face masks. This trend is not limited to the specified drawbacks: patients often ignore the necessary routine clinical examination that could be provided even in case of continuous cough and the other symptoms of the lung pathology, deny the treatment until the more convincing signs of the disease occur (e.g., hemoptysis), and do not take the medication adherence properly once it is introduced. Poor response to therapy, insufficient care providers, and the emergence of infection resistant strains are regularly issued as the reason behind non-adherence (individual interviews with patients, their families, and health officers) (individual interview; patients, patients' families, and health officers).
Experience of stigma	There is also an internalized stigma that affects the patients with TB where these individuals detach from their social circles to evade detection specifically when in groups of people with salaried jobs or necessary occupations. The rest of society tends to be protective in nature with its mode more in risk-avoidance rather than in the overt rejection of patients. In this respect, community level stigma is more of a self-imposed social distancing mechanism than a display of blatant social exclusion. Both healthcare workers and patients referred to these patterns based on semi-structured interviews. In line with the results, participants told the story about how stigma, specifically at the initial stages of their disease, led to the inability to share the diagnosis. An example is one patient, who chose to seek another treatment, away from hometown to avoid having relation to neighbours and workmates knowing about the diagnosis. In addition, there was also a refusal to wear masks at work with the argument that it could be seen as a protective gear. The patient eventually lost the job, a consequence that was viewed a result og TB status. Social stigma towards TB was in the form of significant unease, or straightforward rejection. Friends and family members often isolated from those who were sick, and the neighbourhood did not allow children to socialise with other families so much. Moreover, participants stated that relatives and friends restricted their own visits to the patient, and they usually explained them by warning reasons, not by the clear hatred.

Cultural Perception "Ale Rasa Beta Rasa"	Maluku cultural procedure called Ale Rasa Beta Rasa may be evaluated as something much more than special sign of intergroup solidarity, but rather serving as specification of the values of empathy and social capital stockpile enabling communal harmony. These are very important values that can be used as cultural resources in promoting unity and developing communal support of TB patients (individual interview; academic).
	The model in question puts considerable emphasis on mental and internal aspects along with the somatic issues, thereby addressing the emotional status of persons with TB embracing the relevance of the social stigmatization. Data is taken on the basis of a personal interview and is supported by academic literature (individual interview; academic).
	The root of this is Deep Empathy: Ale Rasa Beta Rasa and is based on a moral imperative springing out of both soul and heart to help others because it is an ethical imperative to those in poor health (individual interview; religious figure).
	In the existing theological discourse, Ale Rasa Beta Rasa happens to be an evaluative concept that highlights the role of both ecclesial institutions and local communities as the major agents of social support in events of healing and treatment. Practically, the church as a case in point can sign liturgical intercession on the behalf of the sick and provide them with monetary assistance equal to Rp. 300 000,00. Such exemplars, therefore, exemplify the close correlation between church organisations and pastoral ministry on the one hand and comradeship networks and mutual-aid efforts on the other (individual interview; religious leader).
	The situation with TB becomes one of the areas in which social strategies are essential. In this setting, Ale Rasa Beta Rasa culture serves as a very powerful intervention strategy contributing to the strengthening of social networks and improved quality of life of patients through the development of empathy, solidarism, and reducing stigma (individual interview; religious leader).
	The central ideology of compassion, mutual help, and reciprocity declared in the Quranic sentence Ale Rasa Beta Rasa correlates with the moral and theological concepts of most religions that always emphasize love and compassion over causing harm to others (individual interview; religious leader).
	Since the medical records are confidential documents, it will be imperative to inform the general population about where a patient is located as part of social support programs. That information makes it possible to mobilize the funds raised in a village through the concept of Ale Rasa, Beta Rasa" (individual interview; community leaders).

Table 2 explained how the indigenous values and the initiatives of reducing stigma were connected via campaign called as Ale Rasa Beta Rasa. The initiative clearly drew religious leaders, survivors, and young people into the release of information to the community regarding the disease of TB.

DISCUSSION

The traditional value which was studied to reduce the stigma that was faced by TB patients was Maluku value of, Ale Rasa Beta Rasa. The explanations of the matter were done in the framework of close communities, and 5 interconnecting themes identified by the qualitative analyses illustrated the role of empathy, solidarity, and cultural authority together battling stigmatization.

The study concluded that advanced "Ale Rasa Beta Rasa" was used as a culturally anchored which reduced the stigma associated with TB in Maluku. There were 5 themes experienced TB, religion and moral authority, collective action, living with stigma, and hope, which had challenges and locally devised solutions.

Internalized stigma's dominance

One of the most evident discoveries of the recent study was the prevalence of internalized stigma, when patients with the disease hide to prevent the revelation of the affliction and find the therapeutic help in other communities. This story corresponded to other published papers in South Africa, where non-adherence to treatment and long delays in seeking health were said to be caused by the internalization of stigma.[22] Similar results were found in Malawi and India and indicated that stigma worked many times covertly that affected individuals in terms of whether to disclose their condition or not.[23] The case in Maluku was very different as the stigma existed on an unseen level with patients benefits through their own mental faculties as well as their personal concerns, as compared to actual enactments of societal behavior.

Cultural Capital as a Tool for Reducing Stigma

As a theoretical concept expressed by Bourdieu, Ale Rasa Beta Rasa acted as a cultural capital, which was an asset built into interpersonal relations and available to everyone.[12] This value generated links between the patients and the larger community by ensuring empathy through the expression of feelings between patients and the community, solidarity and a feeling of mutual responsibility. Correspondence between such cultural values and the intentions of the public health aligned with the recommendation of WHO TB Stigma Framework to adopt culturally competent community-centered interventions.[24]

Religious Leaders' and Survivors' Strategic Role

Religious leaders were trusted intermediaries and changed the perceptions of the group through sermons and direct counselling, and faith-based lobbying. A similar process was reported in Kupang, Indonesia, where faith leaders included education about TB in their religious teachings and, as a result, stigma was reduced.[25] Similar results were identified in the current study among TB survivors who attributed the ailment to human stories and shared their personal experiences, supporting the results in China and Pakistan that community opinion change was possible because of the peer-led advocacy.[26]

Protective Rather than Rejective Community Responses

Although the negative connotations attached to the community distancing behavior when dealing with TB epidemics were inevitable, it could be found that a significant percentage of actors who adopted the policy portrayed it as a means of protection, but not discrimination. This trend spoke to the results in Papua New Guinea, where unwillingness was driven mostly by fear that it could infect the members and not any moral decision.[9] Such subtle dynamics highlighted the importance of bringing public health interventions in the way to dispel misinformation concerning the spread of TB without disregarding the community members with good intentions, want to protect others.

Policy and Practice Implications

The results showed the crucial nature of combining Ale Rasa Beta Rasa with Maluku TB control programmes. By internalising this cultural value, health interventions had the capacity to promote treatment compliance, positive perception in the community, and its continued engagement. The strategy was aligned with the community-participation approaches used elsewhere, where the stigma-reduction campaigns were conducted successfully with the incorporation of indigenous values.[27] Plausible practical interventions included the following, training religious leaders and survivors to be cultural health advocates, providing TB education in community gatherings, in religious services, and in local traditions of storytelling, developing stigma-reduction campaigns portraying TB support as a demonstration of Ale Rasa Beta Rasa. This was due to the high cultural cohesiveness of Maluku, and these strategies could most likely attain wide acceptance and sustainability. Furthermore, the approach could be applicable in areas where the same communal values were applied in Indonesia and other countries.

Limitations

This current study, limited to one city of Maluku, was not informative enough to cover the full range of experiences that a member could be able to observe in the province. In addition, the sample size was too small to be considered representative, but was adequate to allow qualitative purposes. Social desirability bias could also have influenced the responses of participants, specifically in groups.

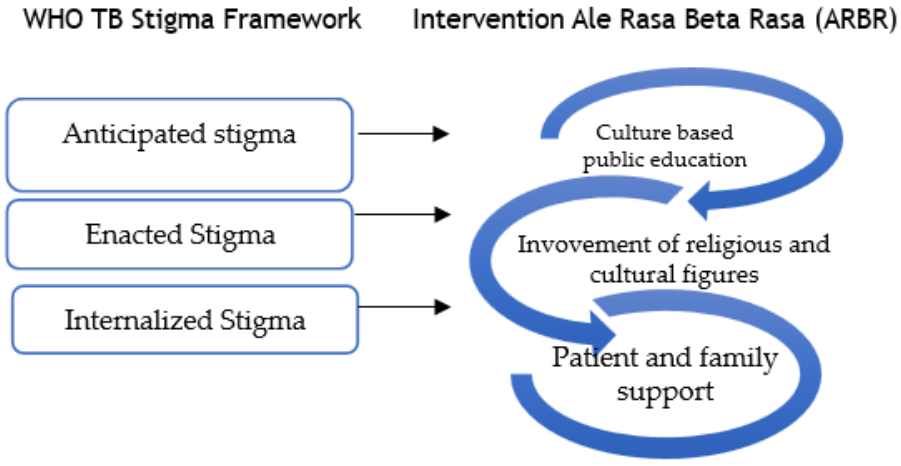

Figure 2. World Health Organization and ARBR Concept Map: Stigma Intervention in Maluku

The scholars in the science of public health and community outreach had a particular perspective on a given study that was unique and led to specific interpretations. The identification and admission of this influence were part of the acknowledgements that allowed keeping the study trajectory transparent. In this line, future studies could be useful in piloting and critically assessing intervention models incorporating the local cultural values in stigma-reduction approaches that could use mixed-method approaches to evaluate both the effectiveness of the intervention models and their scalability.

CONCLUSIONS

In conclusion, this investigation came up with 3 main findings. First, Maluku community had mostly faced inner stigma regarding TB, tended to hide their condition, and sought health care in the outside world as much as possible. Second, the cultural meaning of Ale Rasa Beta Rasa, which included empathy, solidarity, and shared responsibility, worked as cultural capital and could help stay on the protocol of the treatment process, as well as contributed to the acceptance of the patients. Third, religious leaders and TB survivors served as a trusted intermediary, successfully mediating the relationship between the patients, communities, and the health services in terms of advocacy campaigns and culturally sensitive education-related efforts.

This study was an interest since it was the first qualitative empirical study to look at Ale Rasa Beta Rasa, a locally developed cultural based stigma reduction intervention, in an Eastern Indonesian context and to contextualize such results against the broader perspective adopted by WHO. The analysis showed that the articulation of local values into TB-control interventions enabled the process of cultural capital mobilization with the purpose of reducing stigma. Additionally, the results indicated that these culture-sensitive interventions could be used as powerful tools for promoting community cohesion, boosting the performance of the public-health and making the efforts of the stigma-reduction efforts sustainable in Eastern Indonesia and similar communities both, inside and outside the country.

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CONFLICT OF INTEREST

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