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THE DYNAMICS OF SOCIAL STIGMA TOWARD PATIENTS WITH TUBERCULOSIS AND THEIR FAMILIES IN MEDAN CITY

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ABSTRACT
Tuberculosis (TB) remains a major public health issue that affects not only physical health but also generates social challenges in the form of stigma toward patients and their families. This study aims to analyze the dynamics of social stigma experienced by tuberculosis patients and their family members in Medan City, Indonesia. A qualitative approach with a phenomenological design was employed to explore the lived experiences and meanings attributed by the participants. Data were collected through in depth interviews with TB patients, their family members, and healthcare workers involved in TB management. The findings reveal that stigma against TB patients remains prevalent within the community. The identified forms of stigma include social exclusion, discriminatory treatment, negative labeling, and fear of disease transmission. In addition, family members experience secondary stigma, reflected in changes in community attitudes and feelings of shame when a relative's TB status becomes publicly known. Such stigma adversely affects patients' psychological wellbeing, leading to reduced self confidence, social withdrawal, and reluctance to disclose their illness. Conversely, family support plays a significant role in strengthening patients' motivation to adhere to treatment and cope with social pressures. The study further demonstrates that stigma is shaped by social interactions and inadequate public knowledge of tuberculosis. Therefore, continuous health education, strengthened social support, and the implementation of more inclusive approaches to TB care are essential to reducing stigma and improving the well being of individuals affected by tuberculosis.

INTRODUCTIONS

Tuberculosis (TB) remains a major public health concern that not only affects medical outcomes but also gives rise to social challenges, particularly stigma directed toward patients and their family members (Amir & Yulian, 2022). To date, tuberculosis continues to be one of the leading infectious diseases contributing substantially to global morbidity and mortality (Yunilistianingrum et al., 2026). This study aims to analyze the dynamics of social stigma experienced by tuberculosis patients and their family members in Medan City. A qualitative research design employing a phenomenological approach was adopted to gain an in depth understanding of the participants' lived experiences and the meanings they attached to those experiences. Data were collected through in depth interviews with TB patients, their family members, and healthcare professionals involved in tuberculosis management.

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The forms of stigma identified in this study included social exclusion, discriminatory treatment, negative labeling, and widespread public fear of disease transmission. In addition, family members experienced secondary stigma, characterized by changes in the attitudes of people within their social environment and feelings of shame when the illness of a family member became known to the community (Abdurrahiem et al., 2026) . Such stigma often compelled individuals with tuberculosis to withdraw from social interactions because the disease was commonly perceived as disgusting, dangerous, highly contagious, or even associated with mystical beliefs and hereditary factors. Consequently, tuberculosis patients frequently encountered discriminatory practices, including social isolation, rejection, and verbal disparagement, which may constitute violations of the rights of both patients and their family members (Hariadi et al., 2023).

The impact of stigma extends to the psychological well being of patients, leading to reduced self confidence, avoidance of social interactions, and reluctance to disclose their disease status. Conversely, family support has been shown to play a significant role in enhancing patients' motivation to adhere to treatment while helping them cope with the social pressures they experience (Soemarko et al., 2023). This study reveals that the formation of stigma is strongly influenced by social interaction processes and the limited public knowledge of tuberculosis. Therefore, continuous health education, strengthened social support, and the development of more inclusive approaches to tuberculosis care are essential to reducing stigma within the community. Tuberculosis (TB) remains a serious global public health threat despite the availability of effective treatment. This infectious disease continues to cause millions of cases and deaths worldwide each year. Global data indicate that approximately 25% of the world's population has been infected with *Mycobacterium tuberculosis*, with an estimated 1.3 million deaths attributed to tuberculosis annually (Panto et al., 2026).

Medan is one of the cities with a high burden of tuberculosis (TB). Factors such as high population density and unfavorable environmental conditions contribute to the transmission of the disease (Tanjung & Ritonga, 2025). According to the latest statistics, Medan reported the highest number of pulmonary TB cases among districts and municipalities, with 2,430 recorded cases. Furthermore, data from the Medan City Health Office indicated that 10,316 individuals received TB treatment in 2022 (Hasibuan et al., 2024). Individuals with tuberculosis are among the vulnerable populations that frequently experience discrimination, including difficulties in accessing appropriate healthcare services. The World Health Organization (WHO) advocates multisectoral collaboration to address health inequities affecting people with TB. Reducing the burden of tuberculosis requires coordinated action across all sectors to ensure timely, appropriate, and supportive healthcare services while fostering a safe and enabling environment. Poverty, social inequality, malnutrition, comorbidities, discrimination, and stigma have been identified as major drivers of the TB epidemic (Diana et al., 2024).

Social discrimination contributes to the persistence and intensification of stigma toward individuals with tuberculosis. One study reported that 93% of rural communities exhibited stigmatizing attitudes toward TB, while the prevalence reached 95.7% among urban communities. Another study found that 65.4% of primary healthcare center personnel also expressed stigmatizing attitudes toward tuberculosis (Wulan & Nirwan, 2024). Tuberculosis (TB) is a chronic infectious disease that continues to pose a major public health challenge at both the global and national levels. Although TB is curable through consistent and sustained treatment, it remains strongly associated with negative social constructions within society. Tuberculosis is often perceived as a dangerous and highly contagious disease closely linked to poverty, poor hygiene, and physical as well as social vulnerability. These perceptions not only shape public attitudes toward individuals with TB but also generate social stigma that adversely affects the social, psychological, and interpersonal well being of patients and their family members (Jariyah et al., 2024).

Tuberculosis is transmitted when an infected individual coughs, sneezes, or speaks, releasing airborne bacteria that may be inhaled by others, particularly those with weakened immune systems. Nevertheless, TB transmission can largely be prevented through appropriate preventive behaviors. Preventing tuberculosis transmission is a fundamental component of TB control, particularly at the household and community levels. Families play a strategic role because, in addition to being at increased risk of infection due to close and prolonged contact, they serve as the primary source of support for treatment adherence, the adoption of healthy lifestyles, and the implementation of infection prevention measures throughout the course of TB treatment (Sitio & Silalahi, 2021). Social stigma toward tuberculosis (TB) is a social phenomenon that develops through continuous processes of social interaction. It manifests in the form of negative labeling, prejudice, stereotypes, and discriminatory treatment directed toward individuals diagnosed with TB. Patients are often perceived as a threat to their social environment, resulting in rejection, restricted social interactions, and even social exclusion. Consequently, individuals with TB are confronted not only with the physical burden of the disease but also with social pressures that adversely affect their identity, self esteem, and social functioning in everyday life (Rahmawati et al., 2024).

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The impact of TB related stigma extends beyond patients and affects their family members. As the closest social unit, the family plays a strategic role in providing care, participating in decision making, and offering emotional and social support to patients. However, the stigma attached to patients frequently extends to their families, giving rise to secondary stigma. Family members may experience feelings of shame, fear of negative judgment from the community, and social pressure that compels them to conceal the health condition of their relatives. Such circumstances may disrupt family harmony, alter communication patterns, and weaken the family's function as the primary support system for patients (Hariadi et al., 2023; Hidayati et al., 2025).

Within family dynamics, TB related stigma may influence role distribution, emotional relationships, and the ways in which families interpret the illness and the recovery process. Families are challenged not only by the demands of medical care but also by social pressures originating from their surrounding community. These circumstances often give rise to internal conflicts, ambivalent attitudes toward the patient, and dilemmas between protecting the affected family member and preserving the family's social reputation. Therefore, the family represents an important social context for understanding how TB related stigma is constructed, negotiated, and experienced in everyday social life (Utami & Anggraini, 2026). The social burden experienced by tuberculosis patients and their families includes discrimination and stigma from the community, inadequate support from spouses and other family members, and avoidance by healthcare workers due to concerns about disease transmission. Patients also experience physical burdens resulting from treatment side effects, including vomiting, headaches, tremors, and abdominal pain. Family members, meanwhile, bear substantial caregiving responsibilities by dedicating considerable time and physical effort to patient care. In addition, both patients and their families face long term healthcare and treatment costs, while patients may lose their employment because of illness and caregivers may also be forced to leave their jobs to provide continuous care (Cahyawati et al., 2023).

Medan City, the setting of this study, is characterized by a socially complex and heterogeneous population. As a metropolitan area with diverse ethnic, cultural, religious, and socioeconomic backgrounds, Medan provides a dynamic social environment in which patterns of social interaction are continuously shaped and reshaped. This diversity also influences how communities perceive illness, health, and the risk of tuberculosis transmission. Consequently, TB related stigma may emerge in different forms and with varying levels of intensity depending on the surrounding social and cultural context. For this reason, Medan constitutes a relevant setting for examining the dynamics of social stigma associated with tuberculosis from a contextual and in depth perspective (Sheillawany & Susanti, 2026)

Social stigma can be understood as a form of social labeling in which individuals are assigned particular attributes associated with stereotypes and negative judgments, causing them to be treated differently or regarded as deviating from prevailing social norms. It represents a manifestation of social prejudice expressed through practices of differentiation and discrimination against specific individuals or groups (Lolong et al., 2021). From a sociological perspective, stigma is viewed as a discrediting attribute that distinguishes an individual from others and diminishes that person's social identity. Furthermore, social stigma comprises four interrelated dimensions: labeling, stereotyping, social separation, and discrimination. These dimensions operate simultaneously within social relationships, collectively producing unequal treatment toward stigmatized individuals or groups (Mas'udah, 2022).

This study employs Erving Goffman's Stigma Theory, supported by Symbolic Interaction Theory, as the theoretical framework for analyzing the dynamics of social stigma experienced by tuberculosis patients and their families. According to Goffman (1963), stigma is a discrediting attribute that deprives individuals of full social acceptance through processes of labeling, stereotyping, social separation, and discrimination that are constructed through social interaction. In the context of tuberculosis, stigma emerges when society perceives patients as dangerous, highly contagious, or incapable of performing their normal social roles. This perspective is reinforced by Symbolic Interaction Theory, developed by Mead and Blumer, which argues that social meanings are constructed through processes of interaction and interpretation among individuals. Accordingly, public perceptions of tuberculosis are not naturally inherent but are socially constructed and continuously reproduced through everyday (Haykal, 2016). Consequently, stigma directed toward tuberculosis patients not only results in public stigma but also contributes to the development of self stigma, whereby patients internalize society's negative perceptions, leading to feelings of shame, diminished self esteem, social withdrawal, and reluctance to seek or continue treatment openly (Goffman, 1963). These theoretical perspectives therefore provide a comprehensive framework for understanding how social stigma is constructed, experienced, and negotiated by tuberculosis patients and their families within the social context of Medan City.

Previous studies have consistently identified stigma as one of the major challenges faced by individuals with tuberculosis. (Wisnugati et al., 2025), in their study *Determinants Factors of Social and Self Stigma in Tuberculosis Patients: A Literature Review*, examined fourteen articles published between 2020 and 2024 to identify the determinants

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of both social stigma and self stigma among tuberculosis patients. Their findings revealed that social stigma is primarily driven by limited public knowledge of tuberculosis, fear of disease transmission, discriminatory practices, and inadequate social support from both families and surrounding communities. Self stigma, on the other hand, was characterized by feelings of shame, low self esteem, and fear of social rejection. The study emphasized that public health education, strengthened psychosocial support, and inclusive health policies are essential strategies for reducing stigma among individuals with tuberculosis.

Similarly, (Pulungan et al., 2025), in their study entitled *The Relationship between Stigma and Treatment Adherence among Pulmonary Tuberculosis Patients in Lhokseumawe City*, reported that the majority of tuberculosis patients experienced high levels of stigma. Their analysis further demonstrated that higher levels of perceived stigma were associated with lower treatment adherence, although the observed correlation was relatively weak ($r = 0.143$). These findings indicate that stigma is shaped not only by social and environmental factors but also has important implications for treatment adherence and recovery outcomes.

Despite these contributions, previous studies have focused primarily on identifying the determinants of stigma or examining its relationship with treatment adherence. Limited attention has been devoted to understanding how social stigma is experienced, negotiated, and managed by tuberculosis patients and their families within their everyday social interactions. Therefore, this study seeks to address this gap by exploring the dynamics of social stigma experienced by tuberculosis patients and their families in Medan City from a qualitative sociological perspective. This study aims to analyze the dynamics of social stigma experienced by tuberculosis patients and their families in Medan City and to explore how they respond to and negotiate stigma in their daily social interactions. Specifically, the study focuses on identifying the forms of social stigma, examining the processes through which stigma is socially constructed, and analyzing its impacts on the social lives of patients and their family members. The findings are expected to contribute to the advancement of the sociology of health, particularly in the field of social stigma associated with tuberculosis, while also providing evidence based recommendations for the development of more effective community based stigma reduction strategies

METHOD

This study employed a qualitative research approach using a phenomenological design to explore the lived experiences of tuberculosis (TB) patients and their family members regarding the dynamics of social stigma in Medan City. A phenomenological approach was considered appropriate because it enables researchers to gain an in depth understanding of how participants perceive, interpret, and assign meaning to their experiences of living with tuberculosis and the social stigma associated with the disease.

The study was conducted in Medan City, Indonesia, in April 2026. The research setting was selected purposively based on the high prevalence of tuberculosis cases and its relevance to the objectives of the study. Participants were recruited using purposive sampling to ensure that they possessed direct experience relevant to the research phenomenon. The participants consisted of tuberculosis patients, family members of TB patients, and healthcare professionals involved in tuberculosis prevention and treatment programs. Data were collected through semi structured in depth interviews, non participant observations, and document analysis. The interviews focused on participants' experiences, perceptions, and interpretations of the social stigma they encountered during treatment and in their everyday social interactions. All interviews were conducted after obtaining participants' informed consent and were audio recorded with their permission. The interview recordings were subsequently transcribed verbatim to facilitate systematic analysis.

The collected data were analyzed using thematic analysis. The analysis involved several stages, including data familiarization through repeated reading of the transcripts, initial coding, identification and categorization of emerging themes, interpretation of thematic relationships, and synthesis of findings to explain the dynamics of social stigma experienced by tuberculosis patients and their families. To ensure the trustworthiness of the findings, this study applied source triangulation, methodological triangulation, and member checking. Source triangulation was conducted by comparing information obtained from tuberculosis patients, their family members, and healthcare professionals. Methodological triangulation involved comparing data obtained through interviews, observations, and document analysis. In addition, member checking was undertaken by confirming the accuracy of the interview findings with the participants. These procedures enhanced the credibility, dependability, and trustworthiness of the research findings.

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RESULT AND DISCUSSION

The Emergence of Social Stigma Dynamics Among Tuberculosis Patients

Tuberculosis (TB) is an infectious disease that continues to be recognized not only as a public health concern but also as a social issue affecting the lives of patients and their families. This finding indicates that tuberculosis is not merely a biological condition but is also shaped by social constructions that develop within society. The findings revealed that social stigma toward tuberculosis patients in Medan City emerged gradually as their disease status became known to the surrounding community. Based on the interview data, stigma was not experienced immediately after patients were diagnosed with tuberculosis; rather, it developed once members of the community became aware of their health condition. Before their diagnosis was publicly known, patients were able to carry out their daily social activities without experiencing differential treatment. However, after the community became aware of their tuberculosis status, significant changes occurred in their social relationships, as reflected in reduced communication, increased social distancing, and changes in people's attitudes and behaviors during interactions with the patients.

The first patient participant, identified by the initials RF, was a 46 year old male who worked as a public transportation driver in Medan City. He explained that changes in community attitudes became apparent after his neighbors learned that he had tuberculosis. He stated:

"Yes, especially after people found out that I had TB."

This statement indicates that being identified as a tuberculosis patient marked the beginning of changes in the participant's social relationships. Before his illness became known, he interacted normally with people in his neighborhood. However, once his condition was disclosed, some community members became more cautious during interactions and gradually reduced their communication with him.

A similar experience was reported by the second patient participant, identified by the initials SR, a 32 year old woman employed at a laundry service in Medan City. She explained that after her coworkers learned about her tuberculosis diagnosis, several of them began to keep their distance and expressed concern whenever she coughed.

"Some of my coworkers no longer stay close to me, and sometimes they become afraid when I cough."

In addition to experiencing changes in social relationships, SR admitted that she was initially afraid of other people discovering her illness because she feared being socially rejected. These concerns made her more cautious when interacting with others throughout her treatment period.

Despite these experiences, the findings also demonstrated that family members served as the primary source of support during treatment. SR explained that encouragement from her husband and other family members motivated her to continue treatment until recovery. She stated:

"My husband and family kept encouraging me to continue my treatment until I recovered."

According to the participant, family support was manifested through emotional encouragement, assistance throughout the treatment process, and continuous motivation to adhere to the medication regimen prescribed by healthcare professionals. Such support played a crucial role in helping patients remain optimistic and committed to treatment despite experiencing negative attitudes from members of the community.

Social Stigma Toward the Families of Tuberculosis Patients

The findings further revealed that social stigma was experienced not only by tuberculosis patients but also by family members living in the same household. Changes in community attitudes toward patients indirectly affected the social relationships between their families and the surrounding community. Family members also became targets of stigma because many people believed that they faced the same risk of transmitting the disease.

The first family participant, identified by the initials AN, was a 48 year old woman and the mother of participant RF. She explained that after her son was diagnosed with tuberculosis, several neighbors began to change their behavior toward the family. She stated:

"Sometimes, yes. Some neighbors rarely come to our house anymore. I even heard, although not directly from them, that they believed tuberculosis was a hereditary disease that could spread to family members and other people."

This statement demonstrates that family members also experienced changes in their social relationships due to widespread misconceptions about tuberculosis. The belief that tuberculosis is a hereditary disease or can easily spread to all members of the household caused some community members to become more cautious and reduce their interactions with the patient's family. These findings indicate that stigma is attached not only to individuals diagnosed with tuberculosis but also to those who maintain close social and familial relationships with them.

A similar experience was reported by the second family participant, identified by the initials DS, a 35 year old woman who was the older sister of participant SR and lived in the same household during the treatment period. She

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explained that after her younger sister's tuberculosis diagnosis became known, several neighbors began to keep their distance and interacted with the family less frequently than before. Although there was no direct rejection, the participant perceived these behavioral changes as a form of differential treatment toward the family.

Overall, the interview findings indicate that stigma associated with tuberculosis extends beyond patients to their family members because of persistent public misconceptions regarding the mechanisms of disease transmission. Consequently, families not only assume the responsibility of supporting patients throughout the treatment process but also face changes in their own social relationships within the community.

The Role of Healthcare Professionals in Addressing Social Stigma Toward Tuberculosis Patients

The findings indicate that healthcare professionals perceive social stigma as one of the major barriers to the successful treatment of tuberculosis (TB) patients. Based on an interview with a healthcare professional identified by the initials NS, a female tuberculosis program coordinator at a community health center (*Puskesmas*) in Medan City, many patients were reported to fear that their disease status would become known to the public. According to the participant, this fear encourages patients to conceal their illness from people in their surrounding environment because they are concerned about receiving differential treatment.

NS further explained that some patients even requested that their identity and disease status remain confidential while receiving healthcare services. She stated:

"Many patients are still afraid that their neighbors or coworkers will find out they have TB. Some ask us not to record their information in front of other people, and some even say they do not want their neighbors to know because they are afraid of being avoided."

This statement demonstrates that social stigma extends beyond community life and also influences patients' behavior when accessing healthcare services. Fear of social rejection encourages some patients to maintain strict confidentiality regarding their illness, even from people within their immediate social environment. These findings suggest that stigma creates considerable psychological distress, leading patients to conceal their health status rather than risk experiencing discrimination from the community.

In addition to describing the stigma experienced by patients, NS emphasized that limited public knowledge regarding the mechanisms of tuberculosis transmission is one of the primary factors contributing to the persistence of stigma. She explained that many people mistakenly believe tuberculosis can be transmitted easily through ordinary social interactions, whereas the transmission process is far more complex than commonly assumed. She explained:

"Many people have limited knowledge about how TB is transmitted. In fact, transmission does not occur as easily as most people think. Usually, transmission involves prolonged household contact approximately seven hours per day for three consecutive days and it also depends on each person's immune system. If someone's immune system is strong, they are not easily infected with TB."

This explanation indicates that misconceptions regarding tuberculosis transmission constitute one of the principal causes of social stigma toward TB patients. Limited health literacy often leads community members to avoid patients excessively because they assume that any form of social interaction may result in infection. However, according to healthcare professionals, tuberculosis transmission is influenced by prolonged close contact over a certain period and by an individual's immune status. Therefore, improving public understanding of TB transmission through continuous health education is essential for reducing stigma within the community.

Overall, the findings demonstrate that the dynamics of social stigma experienced by tuberculosis patients in Medan City develop gradually over time. Stigma begins when the community becomes aware of a patient's health status and subsequently evolves into negative labeling, stereotyping, changes in patterns of social interaction, and increasing social distance between patients, their families, and the wider community. Although each participant described unique experiences, all reported a similar pattern of altered social treatment following the disclosure of their tuberculosis status. These findings suggest that stigma toward tuberculosis is not determined solely by the characteristics of the disease itself but is socially constructed through public perceptions of TB as a contagious illness. Consequently, efforts to reduce stigma should extend beyond medical treatment by strengthening health literacy, expanding community education, and reinforcing social support systems to ensure that patients can complete their treatment without experiencing discrimination or social exclusion.

The Dynamics of Social Stigma Among Tuberculosis Patients

Tuberculosis (TB) continues to be perceived not only as an infectious disease but also as a social phenomenon that generates various forms of stigma toward those affected by it. Numerous studies have identified stigma as one of the major barriers to tuberculosis elimination because it influences health seeking behavior, treatment adherence, mental

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health, and patients' quality of life (Rizqiya et al., 2021) . The findings of this study indicate that the dynamics of social stigma experienced by tuberculosis patients in Medan City evolve as a gradual process through interactions between patients and their social environment. Based on the interview data, stigma did not emerge immediately after patients received a tuberculosis diagnosis from healthcare professionals. Instead, stigma became evident only after members of the community became aware of the patients' health status. Before their illness was publicly known, patients continued to participate in everyday social activities without experiencing differential treatment. However, once information about their illness spread within the community, noticeable changes occurred in their social relationships, including reduced communication, increased social distancing, and decreased participation in community activities. These findings suggest that stigma is not generated solely by the biological characteristics of the disease but is socially constructed through public perceptions of tuberculosis as a dangerous and highly contagious illness. Similar findings were reported by Diana et al. (2024), who argued that stigma develops through social constructions shaped primarily by public fear of disease transmission rather than by patients' actual medical conditions.

These findings reinforce the stigma theory proposed by Erving Goffman, which conceptualizes stigma as a discrediting attribute that deprives individuals of the social identity previously accepted by society. According to Goffman, stigma arises when there is a discrepancy between an individual's *virtual social identity* and *actual social identity* (Goffman, 1963). In the present study, before the community became aware of the patients' tuberculosis diagnosis, they were perceived as healthy individuals capable of fulfilling their normal social roles. However, once their disease status became known, their social identity shifted, and they came to be perceived as potential sources of infection. This transformation in social identity resulted in differential treatment and a decline in social acceptance. Consequently, the findings demonstrate that stigma toward tuberculosis is shaped more by social interpretations and community perceptions than by the disease itself. These results are consistent with the findings of (Nuttall et al., 2022), who concluded that tuberculosis related stigma is a socially constructed phenomenon that develops through processes of labeling and social interaction.

The findings further indicate that the development of stigma follows several interrelated stages. The first stage begins when patients receive a tuberculosis diagnosis; however, discriminatory treatment has not yet emerged because their condition remains unknown to the wider community. The second stage occurs when the diagnosis becomes publicly known, initiating a process of labeling, whereby individuals are identified as tuberculosis patients. The third stage involves the formation of stereotypes portraying patients as individuals who can easily transmit the disease. These stereotypes subsequently influence community behavior, leading to increased social distancing, reduced communication, and avoidance of direct interaction with patients. Over time, these experiences contribute to the development of self stigma, characterized by feelings of shame, low self esteem, fear of rejection, and a tendency to conceal the illness from others. This pattern demonstrates that stigma is a gradual social process rather than an isolated event. These findings support the systematic review conducted by (Aitambayeva et al., 2025), which concluded that tuberculosis related stigma evolves from public stigma into self stigma, ultimately affecting treatment continuity and patients' quality of life.

The findings also demonstrate that labeling represents the initial stage in the formation of social stigma. This is illustrated by the experience of participant RF, a 46 year old public transportation driver in Medan City, who explained that changes in community attitudes became apparent only after his neighbors learned about his tuberculosis diagnosis.*"Yes, especially after people found out that I had TB."* This statement indicates that the identity of being a tuberculosis patient became a new social identity that altered the way the community perceived and treated the participant. Before receiving this label, he was accepted as an ordinary member of society. However, after his tuberculosis status became known, he experienced various forms of differential treatment, including increased caution from others, reduced communication, and greater social distance. According to Goffman (1963), these experiences represent the consequences of the labeling process, in which society assigns a particular identity that subsequently becomes the basis for stereotyping and discrimination. Similarly, Wisnugati et al. (2025) identified labeling as a primary determinant contributing to social discrimination and diminished self confidence among tuberculosis patients.

In addition to labeling, this study found that public fear of disease transmission was a dominant factor reinforcing social stigma. Participant SR, a 32 year old employee at a laundry service in Medan City, reported that after her coworkers learned about her tuberculosis diagnosis, several of them reduced their interactions with her and appeared fearful whenever she coughed. These findings suggest that social distancing is not based solely on medical knowledge regarding the mechanisms of tuberculosis transmission but is largely influenced by socially constructed

IMPLICATIONS

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Theoretical Implications

This study significantly advances the sociology of health by empirically validating Erving Goffman's Stigma Theory and Symbolic Interactionism within the context of infectious diseases in Indonesia. The findings demonstrate that tuberculosis-related stigma is not an inherent biological attribute, but rather a socially constructed "spoiled identity" that emerges through labeling and everyday social interactions (Goffman, 1963; Nuttall et al., 2022). Furthermore, the documentation of "courtesy stigma" experienced by family members extends theoretical boundaries beyond individual patients, illustrating how stigma permeates household dynamics and disrupts primary support systems (Hariadi et al., 2023; Hidayati et al., 2025). This biopsychosocial perspective challenges purely biomedical paradigms, emphasizing that TB stigma is continuously negotiated through shared cultural meanings and limited health literacy, thereby enriching existing frameworks on the sociology of infectious diseases (Kılıç et al., 2025; Diana et al., 2024).

Practical Implications

From a practical standpoint, the findings offer critical insights for healthcare professionals and community health workers. The study underscores the urgent need for healthcare providers to adopt a dual role: transcending traditional curative functions to become active educators who dismantle community misconceptions about TB transmission (Soemarko et al., 2023; Wulan & Nirwan, 2024). Since family support is pivotal in mitigating adverse stigma effects and enhancing treatment adherence, practical interventions must engage families through psychoeducational programs, equipping them to resist social pressure and maintain a supportive environment (Nababan et al., 2024; Widyastuti et al., 2024). Additionally, leveraging digital health technologies, such as anonymous health chatbots or targeted social media campaigns, can provide accessible education without fear of judgment, while continuous training for healthcare workers remains essential to ensure stigma-free, compassionate clinical environments (Diana et al., 2024; Kusbandia et al., 2024).

Policy Implications

At the policy level, this study advocates for the integration of stigma reduction as a core, measurable component of national tuberculosis elimination strategies, rather than a peripheral concern (WHO, 2023; Panto et al., 2026). Policymakers must foster multisectoral collaboration, engaging education, social welfare, and media sectors to address structural drivers of stigma, such as poverty, social inequality, and inadequate housing (Diana et al., 2024; Tanjung & Ritonga, 2025). Furthermore, developing rights-based legal frameworks is crucial to protect patients from discrimination in healthcare and employment, ensuring strict medical confidentiality. Finally, institutionalizing peer-led advocacy groups and patient support networks can empower survivors, enhance long-term treatment adherence, and align local TB control efforts with the broader Sustainable Development Goals (SDGs) agenda for health equity (Anindhita et al., 2024; Aitambayeva et al., 2025).

CONCLUSIONS

The study also indicates that stigma is produced through processes of symbolic interaction, whereby community members assign particular meanings to tuberculosis as a dangerous, highly contagious disease associated with specific social conditions. These socially constructed meanings subsequently shape the ways in which people interact with patients and their families, resulting in behaviors such as maintaining social distance, reducing communication, avoiding direct contact, and engaging in discriminatory practices. Conversely, patients interpret these responses as forms of social rejection, which adversely affect their psychological well being, self confidence, and willingness to disclose their disease status.

This study concludes that tuberculosis related stigma is influenced not primarily by the biological characteristics of the disease itself but rather by social constructions and limited public health literacy regarding tuberculosis. Therefore, stigma reduction requires comprehensive and sustained health education, improved public understanding of tuberculosis transmission and treatment, and stronger family and community support systems. In addition, healthcare professionals should continue to develop more effective community based communication strategies to reduce stigma toward tuberculosis patients, thereby facilitating optimal treatment outcomes and improving the quality of life of both patients and their families.

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