

# Social Support and Quality of Life in Cancer Patients: A Study of Palliative Shelters in West Java

Laili Rahayuwati, Tuti Pahria<sup>1</sup>, Kusman Ibrahim<sup>1</sup>, Ike Nurhidayah<sup>2</sup>, Habsyah Saparidah Agustina<sup>3</sup>

Departments of Community Nursing, <sup>1</sup>Medical Surgical Nursing, <sup>2</sup>Pediatric Nursing and <sup>3</sup>Psychiatric Nursing, Faculty of Nursing Universitas Padjadjaran, Bandung, Indonesia

## Abstract

**Background:** The risk of lifestyle and environment will lead to an increase in cancer prevalence. Therefore, it needs managing support for palliative cancer patients. The purpose of the study was to obtain the correlation between social support characteristics and cancer patients' quality of life. **Method:** This research using a cross-sectional approach was conducted in several palliative shelters. Samples were 93 respondents, obtained using a quota sampling technique. The variables used were social support (family, friends, and others) and the cancer patient's quality of life. **Result:** The results showed that social support received at a high level was most obtained from the family as many as 65 respondents (69.9%). Furthermore, the social support factor of cancer patients related to the quality of life was friends' support (p-value <0.05), while other factors were considered irrelevant. The collecting data technique was used due to the dynamics of patients seeking treatment at the West Java provincial referral hospital. **Conclusion:** the friend's support is significant for improving the quality of life of cancer patients. Peer groups are an essential component in managing health care in the community.

**Keywords:** Cancer patients, palliative shelters, quality of life, social support

## INTRODUCTION

Cancer has become a health problem for the world community, including in Indonesia. Cancer is a disease caused by abnormal cell growth. These abnormal cells develop quickly, are out of control, and continue to divide. Some cancer risk factors include behavior and lifestyle, age over 40 years, hormonal imbalances, growth deterioration, and aging.<sup>[1]</sup>

Cancer in Indonesia ranks sixth as the cause of death, and around 800,000 Indonesians develop cancer each year.<sup>[2]</sup> According to the results of the 2013 Basic Health Research, the prevalence of cancer in Indonesia is 140 per 100,000 population, or there are 347,792 cancer patients. The highest cancer prevalence is cervical cancer, which is 80 per 100,000 population, then breast cancer that is 50 per 100,000 population, and prostate cancer by 20 per 100,000 population.<sup>[3]</sup>

Cancer patients who came to the hospital were mostly at an advanced stage, namely IIB-IVB as much as 66.4%, stage IIB as much as 37.3%, and stage IA-IIA 28.6%. This delay is undoubtedly very detrimental to people with cancer themselves because the life expectancy of cancer patients is primarily

determined by the stage or severity of cancer suffered. This condition results in a low life expectancy in cancer patients.<sup>[4]</sup>

The effects of cancer are not only physical but also psychological, social, and spiritual. Physical changes in the body cause changes in self-image, causing feelings of being sad even to depression. Cancer also causes a person to feel different and have problems in social relationships because of the fear and rejection of patients against the disease (Potter and Perry, 2005). Psychological health aspects have a vital role in cancer patients. This mental health aspect can be helped by social support from the environment around the patient and the wider community.<sup>[5]</sup>

Cancer patients need social support, but sometimes it is not fulfilled due to various factors. Social support can come from

**Address for correspondence:** Prof. Laili Rahayuwati,  
Department of Community Nursing, Faculty of Nursing Universitas  
Padjadjaran, Bandung, Indonesia.  
E-mail: tatisarihati@protonmail.com

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

**For reprints contact:** WKHLRPMedknow\_reprints@medknow.com

**How to cite this article:** Rahayuwati L, Pahria T, Ibrahim K, Nurhidayah I, Agustina HS. Social support and quality of life in cancer patients: A study of palliative shelters in West Java. *Matrix Sci Med* 2022;6:40-7.

**Received:** 30-11-2020,

**Revised:** 10-10-2021,

**Accepted:** 07-10-2021,

**Published:** 12-04-2022

### Access this article online

Quick Response Code:



**Website:**  
www.matrixscimed.org

**DOI:**  
10.4103/mtsm.mtsm\_58\_20

family, friends, relatives, employers at work, or even support from the government. In several research results, the provision of social support has a positive impact on the quality of life of cancer patients and helps patients to adapt to disease conditions to carry out daily life.<sup>[6]</sup> Social support can be obtained and sourced from individuals and the environment around the patient. According to the study, sources of social support can come from three specific sources, namely family, friends, and significant others.<sup>[7]</sup>

The impact of social support depends on how sufferers interpret the social support they receive or what is referred to as perceived social support. This is important to know because the success of social support depends on how the social support recipient interprets the process of how the support has a positive impact on patients.<sup>[8]</sup> However, if people with cancer do not obtain social support, this can lead to a decrease in the quality of life in these cancer patients. The results of research conducted show that social support is essential in improving the cancer patient's quality of life. A person with low social support has a lower quality of life compared to sufferers with excellent social support.<sup>[9]</sup> Quality of life includes global health status, functional scale, and symptom scale. These three indicators can reflect the general quality of life, ability of daily activities, and perceived symptoms.<sup>[10]</sup> Quality of life related to health can be interpreted as a response from a sufferer to social activities, emotional, work, and relationships between families, and feeling happy. There is a match between what is expected and the reality obtained, the satisfaction in social and emotional activities, as well as the ability to hold socialization with others.<sup>[11]</sup>

Meeting the needs of cancer patients not only in the treatment of physical symptoms but also in the fulfillment of psychological and social needs is considered necessary in improving the quality of life of cancer patients.<sup>[12]</sup> Cancer patients need social support from other people around them to improve the patients' quality of life. Research shows there is optimism in cancer patients for recovery that is influenced by social support.<sup>[13]</sup> This means that social support plays a vital role in preventing psychological problems experienced by cancer patients. The support provided will reduce depression, increase calmness in patients, and enthusiasm for recovery.<sup>[14]</sup>

One of the improvements in quality of life can be fulfilled with social support. This becomes an essential role in improving the quality of life from various aspects in general, in physical, social, environmental, and psychological satisfaction. There is adequate social support, which will make them feel the full attention of the surrounding environment so that patients will be enthusiastic in achieving the desired health.<sup>[15]</sup>

Palliative care is an approach that aims to improve the quality of life of patients so that patients and families can face problems related to the disease, treatment, and care. According to World Health Organization (WHO), palliative care improves the patients' quality of life and families facing issues related to life-threatening conditions through the prevention and relief of

suffering from early identification, careful and careful assessment, and management of pain and other symptoms including physical, psychosocial issues, and spiritual.<sup>[16,17]</sup> Palliative care cannot only be given when curative measures have stopped but must start from establishment diagnosis, continue along with curative treatment, until the time of death and postdeath.

Globally, it is realized that the need for palliative care is increasing in line with an aging population and high rates of chronic and noncommunicable diseases.<sup>[16]</sup> Various physical, psychosocial, and spiritual issues of patients and families caused by chronic illness symptoms can be tackled by holistic and multidisciplinary care offered by palliative care.<sup>[18]</sup> Indonesia, with an increasingly high rate of HIV infection, and also as one of the countries with a high rate of cancer cases in Southeast Asia, can benefit from palliative care.<sup>[19]</sup>

Palliative care can be provided not only at the hospital but also at the family and community level. Studies show that the quality of life of patients and families can be improved with good home care, and most patients prefer to be treated in their own homes than in hospitals.<sup>[20]</sup> With a growing population and a limited number of hospitals, both in general in the world and Indonesia in particular, being treated at home is the best option with significant potential to reach people who need health services.

Until now, palliative care services are not provided optimally; some are still interrupted by palliative care from the hospital to the community. Besides, palliative care is still given individually by health workers so that the care provided is not integrated.

In line with the challenges of being aware of the need for palliative care globally and understanding the vital role of nurses in palliative care both in hospitals and in patients' homes, efforts are needed to review and develop research palliative care to increase palliative care assistance for health workers in West Java.

## Literature review

Research in China about the relationship status of social support, health insurance and clinical factors with the quality of life of Chinese women with breast cancer showed that the social support of family members, friends and neighbors are high, high income, and treatment with traditional Chinese medicine affects significantly to the quality of life of breast cancer patients.<sup>[21]</sup>

The quality of life of cancer patients is also examined by a research regarding the quality of life of cancer patients undergoing chemotherapy. This research uses qualitative methods with a phenomenological approach.<sup>[22]</sup> The results showed that cancer patients undergoing chemotherapy were not passionate in his life as long as the effects of chemotherapy were still perceived, feeling that it was no longer useful, becoming heavily dependent on financial matters with his partner, postponing Hopes and ideals to focus on cancer treatment and feel the condition better.

Research about the pattern of the life of breast cancer clients in maintaining the quality of his life studied qualitative on 6 informants in Garut Regency.<sup>[6]</sup> This research shows that the domain appears as a pattern of the life of women who have breast cancer in Sundanese culture, namely: (1) The devotion of Sundanese Women, (2) the adaptation of breast cancer clients in living life, and (3) the meaning of the end of life.

## METHODOLOGY

This quantitative study used a cross-sectional approach during the 2019 period in several palliative shelters for cancer patients around the West Java referral hospital. The shelters were: Rumah Teduh, Rumah Singgah Sedekah Rombongan, and Rumah Singgah IZI in Bandung city.

Samples were taken using an accidental sampling technique. This technique was used due to dynamization (in and out of old and new patients at the open house). The results of the data collection obtained 93 respondents. Research variables were sources of social support consisting of family, friends, and others and the cancer patients' quality of life while data analysis using statistical software. Ethical clearance was obtained from the Medical Ethics Committee of Universitas Padjadjaran.

## RESULTS AND DISCUSSION

This research was carried out in several of the following palliative shelters: Rumah Teduh, IZI Shelter, and Alms Group Shelter (Rumah Singgah Sedekah Rombongan), Rumah Teduh, established in 2015 in Jalan Sederhana Gang Sukalaksana Kelurahan Pasteur, Bandung, consisted of 15 shelters, each with a capacity of 15–20 people. Rumah Teduh shelters have spread across several big cities and regencies, such as Bandung City, Bandung Regency, Jakarta, Sukabumi, and Cirebon.

The IZI shelter, founded by a foundation called the Zakat Initiative, was established as a form for zakat funds distribution collected from the Zakat initiative foundation. IZI shelter was built in May 2018 and has spread throughout Indonesia, with a total of 16 shelters. An IZI shelter can accommodate more or less 20–30 patients.

The Alms Group Shelter located in the Sukajadi area was established in 2012. Similar to the IZI shelter, a foundation from Yogyakarta built the Alms Group shelter. The capacity of the Alms Group Shelter is around 15–20 people. A former patient of the shelter devotes himself as a voluntary administrator who manages the Alms Group shelter in the Sukajadi area.

The three shelters have relatively the same rules as entry requirements such as having a BPJS card either class III independent or government assistance, submitting a personal identification file, reference letter/treatment card from the Regional Hospital, or RSUP Hasan Sadikin Bandung. Generally, patients and families are free of charge while staying at Cancer Shelters. The three cancer shelter homes are not owned by themselves but rented. The facilities offered

by the three shelter homes are the same. The shelter manager provides mattresses, kitchens, bathrooms, cooking utensils, basic foodstuffs that can be processed by the patient's own family, first aid kits, and ambulances to deliver patients for free.

All three are also private shelters, and the average patient knows the existence of the shelters from village employees who take patients to the RSUP, from fellow patients, or from shelter officials who frequently check conditions in the RSUP waiting room. However, it is unfortunate; the three shelter homes are often overloaded in accommodating patients. So the facilities and places provided are inadequate for patients and their families who need it.<sup>[23]</sup>

Based on interviews, patients and families felt much helped by the existence of the shelter. Patients who come can save their expenses in conducting cancer treatment, which takes a long time in terms of residence, daily meals, and transportation going back and forth to Bandung from their respective villages.

Those who stay overnight are also happy because they can share the joys and sorrows with people who are in a similar condition. They can complement each other, give physical and mental support also adds to the kinship.

Although sometimes, if the place is full and the patient's condition is not right, this condition makes it a bit uncomfortable. But so far, the patients who live in open houses are pleased with the availability of similar shelters and hope that there are more shelters so that they can help more patients with the same conditions as them. Demographic characteristics in this study included age, gender, education level, marital status, and family income.

Table 1 shows that almost half of the respondents were elderly, amounting to 46 respondents (49.5%). Meanwhile, the majority of the sexes of the respondents were male totaling 63 respondents (67.7%). Viewed from marital status, the majority of those married were 63 respondents (67.7%). The work status of respondents showed that almost all respondents did not have a work of 77 respondents. Family income data showed that all respondents had income below the Regional Minimum Wages Upah Minimum Regional (UMR) in Bandung, amounting to 93 respondents (100%). The education level of the majority of respondents was a graduate of primary education (elementary school and not graduated elementary school) totaling 65 respondents (69.9%). The types of cancer most of the respondents were high-risk cancers in women totaling 54 respondents (58.1%).

Table 2 shows that 53 respondents (57.0%) had a high level of social support. The most high level of social support received from the family subscale was 65 respondents (69.9%). Followed by another significant subscale of 61 respondents (65.6%), and the last is the friend's subscale, which had a sufficient level of almost half the respondents of 49 respondents (52.7%). It did not found low social support in all subscales of social support received by cancer patients at shelter homes.

**Table 1: Frequency distribution of demographic characteristics of cancer patients in the shelter home (n=93)**

	Frequency (%)
Age	
Teenager	11 (11.8)
Adult	36 (38.7)
Elderly	46 (49.5)
Gender	
Female	30 (32.3)
Male	63 (67.7)
Marital status	
Married	63 (67.7)
Single	10 (10.8)
Widow/widower	20 (21.5)
Occupation	
Work	16 (17.2)
Does not work	77 (82.8)
Income	
<3,000,000	93 (100)
>3,000,001	0
Education	
Primary education	65 (69.9)
Middle education	27 (29.0)
Higher education	1 (1.1)
Type of cancer	
High-risk cancer in women	54 (58.1)
Other types of cancer	39 (41.9)

**Table 2: Frequency distribution of overall social support and based on cancer patient subscale at shelter homes (n=93)**

	Frequency (%)
Overall social support	
High	53 (57.0)
Enough	37 (39.8)
Low	3 (3.2)
Family support	
High	65 (69.9)
Enough	27 (29.0)
Low	1 (1.1)
Friend's support	
High	33 (35.5)
Enough	49 (52.7)
Low	11 (11.8)
Significant others support	
High	61 (65.6)
Enough	26 (28.0)
Low	6 (6.5)

Table 3 shows the relationship between demographic factors and social support showed that the demographic factors of cancer patients in shelter homes associated with the occurrence of significant social support were age and marital status ( $P < 0.05$ ), while other factors were considered irrelevant.

Table 4 shows that the demographic factor of cancer patients related to the quality of life is the patient's age ( $P < 0.05$ ), while other factors were considered irrelevant.

Table 5 shows that the social support factor of cancer patients related to the quality of life is friend's support ( $P < 0.05$ ), while other factors were considered irrelevant.

Data obtained from the results of this study indicated that the majority of respondents were in the elderly group (49.5%). This is in line with cancer risk factors that women over 30 years old are more likely to get cancer. This risk will increase until the age of 50 years or the elderly.<sup>[24]</sup> Besides, it found that the majority of patients were male (67.7%). This condition was not comparable with data from a recent study that cancer occurs least in men. Although it generally occurs in the group of postmenopausal women, currently, it is found at a very young age, such as <25 years.<sup>[25,26]</sup>

The results of this study also showed that the majority of respondents were at the level of primary education (69.9%). This is consistent with the results of research conducted by Silvia (2015) that the level of education is related to receiving information about the early symptoms of cancer experienced by someone (Silvia, 2015). The marital status of most respondents was married patients (67.7%). This is in line with a study conducted by Moghimi-Dehkordi *et al.*, which reports that the majority of cancer patients are patients with married status.

The respondent's employment status showed that almost all respondents did not have a job with 77 respondents (82.8%). Regarding family income, all respondents had an income below the UMR in Bandung, amounting to 93 respondents (100%). The type of cancer from the majority of respondents was high-risk cancer in women totaling 54 respondents (58.1%).

Social support was sourced from the three sources discussed in cancer patients in the shelter homes; most were in the high category amounting to 53 respondents (57.0%). The majority of social support received by cancer patients came from families (69.9%). These results indicated that the social support received by most cancer patients was fulfilled. If social support was not met in cancer patients, the adverse effects that would occur could cause psychological disorders in cancer patients, and the patient's treatment process. Furthermore, if the social support of cancer patients were not fulfilled, it would also have an impact on their quality of life.<sup>[9]</sup>

Social support for cancer patients in open houses showed that 37 respondents (39.8%) were in a sufficient category. This result needs to get more attention, especially in patients who do not have a family who accompanied him during treatment. Therefore it is necessary to socialize to the manager to pay more attention so that social support and social interaction with patients can meet appropriately. This can prevent stress and can improve individual mentality directly.<sup>[27]</sup>

Social support for cancer patients in the low category was three respondents (3.2%). This could be interpreted as the existence

**Table 3: Relationships between demographic factors and social support of cancer patients at shelter homes (n=93)**

	Social support, frequency (%)			P	Family support, frequency (%)			P	Friend's support, frequency (%)			P	Significant other's support, frequency (%)			P
	High	Enough	Low		High	Enough	Low		High	Enough	Low		High	Enough	Low	
Age																
Teenager	5 (45.5)	5 (45.5)	1 (9.1)	0.274	7 (63.6)	3 (27.3)	1 (9.1)	0.088	4 (36.4)	6 (54.5)	1 (9.1)	0.508	4 (36.4)	5 (45.5)	2 (18.2)	0.034
Adult	23 (63.9)	11 (30.6)	22 (5.6)		27 (75.0)	9 (25.0)	0		15 (41.7)	15 (41.7)	6 (16.7)		25 (69.4)	7 (19.4)	4 (11.1)	
Elderly	25 (54.3)	21 (45.7)	0		31 (67.4)	15 (32.6)	0		14 (30.4)	28 (60.9)	4 (8.7)		32 (69.6)	14 (30.4)	0	
Gender																
Female	37 (58.70)	23 (36.50)	3 (4.80)	0.357	42 (66.7)	20 (31.7)	1 (1.6)	0.532	21 (33.3)	35 (55.6)	7 (11.1)	0.725	39 (61.9)	19 (30.2)	5 (7.9)	0.494
Male	16 (53.3)	14 (46.7)	0		23 (76.7)	7 (23.3)	0		12 (40)	14 (46.7)	4 (13.3)		22 (73.3)	7 (23.3)	1 (3.3)	
Marital status																
Married	39 (61.9)	23 (36.5)	1 (1.6)	0.275	48 (76.2)	15 (23.8)	0	0.112	24 (38.1)	31 (49.2)	8 (12.7)	0.798	48 (76.2)	14 (22.2)	1 (1.6)	0.006
Single	5 (50.0)	5 (50.0)	0		7 (70.0)	3 (30.0)	0		4 (40.0)	5 (50.0)	1 (10.0)		4 (40.0)	5 (50.0)	1 (10.0)	
Widow/widower	9 (45.0)	9 (45.0)	2 (10.0)		10 (50.0)	9 (45.0)	1 (5)		5 (25.0)	13 (65.0)	2 (10.0)		9 (45.0)	7 (35.0)	4 (20.0)	
Occupation																
Working	10 (62.5)	6 (37.5)	0	0.687	12 (75.0)	4 (25.0)	0	0.824	4 (25.0)	8 (50.0)	4 (25.0)	0.177	14 (87.5)	2 (12.5)	0	0.116
Does not work	43 (55.8)	31 (40.3)	3 (3.9)		53 (68.8)	23 (29.9)	1 (1.3)		29 (37.7)	41 (53.2)	7 (9.1)		47 (61.0)	24 (31.2)	6 (7.8)	
Education																
Primary education	35 (53.8)	27 (41.5)	3 (4.6)	0.454	43 (66.2)	21 (32.3)	1 (1.5)	0.756	21 (32.3)	35 (53.8)	9 (13.8)	0.647	44 (67.7)	16 (24.6)	5 (7.7)	0.688
Primary education	18 (66.7)	9 (33.3)	0		21 (77.8)	6 (22.2)	0		12 (44.4)	13 (48.1)	2 (7.4)		16 (59.3)	10 (37.0)	1 (3.7)	
Higher education	0	1 (100.0)	0		1 (100.0)	0	0		0	1 (100.0)	0		1 (100.0)	0	0	
Type of cancer																
High-risk cancer in women	32 (59.3)	19 (35.2)	3 (5.6)	0.227	36 (66.7)	17 (31.5)	1 (1.9)	0.554	17 (31.5)	30 (55.6)	7 (13)	0.63	36 (66.7)	14 (25.9)	4 (7.4)	0.821
Other type of cancer	21 (53.8)	18 (46.2)	0		29 (74.4)	10 (25.6)	0		16 (41)	19 (48.7)	4 (10.3)		25 (64.1)	12 (30.8)	2 (5.1)	

**Table 4: Relationships between demographic factors and cancer patients' quality of life at shelter homes (n=93)**

	Quality of life, frequency (%)		P
	Low	High	
Age			
Teenager	3 (27.3)	8 (72.7)	0.041
Adult	22 (61.1)	14 (38.9)	
Elderly	17 (37.0)	29 (63.0)	
Gender			
Female	32 (50.8)	31 (49.2)	0.114
Male	10 (33.3)	20 (66.7)	
Marital status			
Married	29 (46.0)	34 (54.0)	0.567
Single	3 (30.0)	7 (70.0)	
Widow/widower	10 (50.0)	10 (50.0)	
Occupation			
Work	4 (25.0)	12 (75.0)	0.075
Does not work	38 (49.4)	39 (50.6)	
Education			
Primary education	27 (41.5)	38 (58.5)	0.309
Middle education	15 (55.6)	12 (44.4)	
Higher education	0	1 (100)	
Type of cancer			
High-risk cancer in women	25 (46.3)	29 (53.7)	0.796
Other type of cancer	17 (43.6)	22 (56.4)	

**Table 5: Relationship between social support and cancer patients' quality of life at the shelter home (n=93)**

	Quality of life, frequency (%)		P
	Low	High	
Social support			
High	25 (47.2)	28 (52.8)	0.856
Enough	16 (43.2)	21 (56.8)	
Low	1 (33.3)	2 (66.7)	
Family support			
High	29 (44.6)	36 (55.4)	0.629
Enough	13 (48.1)	14 (51.9)	
Low	0	1 (100)	
Friend's support			
High	22 (66.7)	11 (33.3)	0.002
Enough	14 (28.6)	35 (71.4)	
Low	6 (54.5)	5 (45.5)	
Significant other's support			
High	27 (44.3)	34 (55.7)	0.957
Enough	12 (46.2)	14 (53.8)	
Low	3 (50.0)	3 (50.0)	

of patients with low social support because not all patients who are at shelter homes were included in this study. Interactions and activities that can improve social relations between patients and the patient's family need to be performed so that patients feel cared for, as social support can be obtained not only from families but also from spouses, friends, social contacts, and the surrounding community.<sup>[28]</sup>

Sources of the social support used in this study were family, friends, and significant other. Data showed that social support sourced from family was the highest category totaling 65 respondents (69.9%). This is in line with the study of Hakim, which states that social support from families in cancer patients is an essential thing in dealing with stress and psychological disorders and can improve the quality of life experienced by cancer patients.<sup>[29]</sup>

In other sources of social support that were significant other sources showed the high category of 61 respondents (65.6%). Another significant source could be interpreted as a source of special people in the patient's environment who could make patients feel comfortable and valued. Meanwhile, at the final source, that is, friend's support showed a high category of 33 respondents (35.5%). This showed that the bond between patients at the Shelter Home showed interactions that supported each other, especially the relationship between patients. Emotional support and appreciation were much felt among fellow patients at the Shelter Home. Hence, mutually supporting each other makes patients feel comfortable and valued.<sup>[5]</sup>

In this study, the results obtained from the quality of life of cancer patients at the Rumah Singgah included in 3 significant aspects, namely global health status, functional scale consisting of physical function, role function, emotional function, cognitive function and social function and scale of symptoms consisting of fatigue, nausea and vomiting, pain, difficulty breathing, insomnia, loss of appetite, constipation, diarrhea, and financial difficulties. From these three aspects, back to 2 categories, namely high and low categories following the opinions of the respondents themselves based on the three points discussed earlier.

The global health status showed that the average cancer patient at Rumah Singgah stated that their global health status was classified as high quality of life (54.8%). This condition could occur because most patients were in the final stage of treatment so that most patients were able to adapt to the side effects that arose since the first treatment. The treatment process can affect the health status of patients because there are some side effects experienced by the treatment process.<sup>[30]</sup>

On a functional scale, social functions showed good averages for all respondents. This result was obtained due to the place setting; a shelter home could be a suggestion for cancer patients to fulfill their social functions. Moreover, care for fellow patients increased because patients provided mutual support and input in overcoming problems faced by fellow patients. This needs to be maintained or even improved, considering that social function is essential in improving the quality of life in cancer patients who are likely to experience stress and other disorders.<sup>[9]</sup> While the lowest functional scale was obtained in the role and cognitive function, this occurred because most of the patients claimed that they could no longer carry out their role in the community because of their illness. Besides, most respondents were women. They claimed that they could not carry out their role as mothers to take full care of their children.

For the scale of symptoms, most often felt by most respondents were fatigue, pain, and insomnia. This was because most patients were still undergoing treatment and were required to visit the hospital relatively often. Cancer diagnosis and treatment often cause physical side effects, such as fatigue and pain. The incidence of pain could result in patients having difficulty sleeping and resting, which caused high insomnia in respondents. They found it difficult to sleep because they were not comfortable with the pain felt.

Furthermore, another thing that is most often found in most respondents was financial difficulties, which was due to the low incomes of all respondents. Based on the data obtained, all respondents had an income below the minimum wage (100%). This made financial difficulties very often found in the majority of respondents. Most of the respondents were users of BPJS healthcare costs to finance the treatment process they were undergoing. This is in line with research conducted by Shankaran, *et al.*, on colon cancer patients who were experiencing financial difficulties despite having health insurance because patients became unproductive to work to earn for the family.<sup>[31]</sup> The results of this study indicated that the demographic factors of cancer patients in Rumah Singgah that were associated with the occurrence of other significant social support were age and marital status ( $P < 0.05$ ).

The results of this study found that the demographic factor of cancer patients related to the quality of life was the age of the patient ( $P < 0.05$ ) with the elderly. This is confirmed by WHO (2004), in addition to gender, occupation, education, type of therapy undertaken, stage, and social function, age also affects the quality of life of people with breast cancer.<sup>[32]</sup> Besides, it is also in line with Sasmita, study, which states that there is a significant relationship between age, education, marital status, staging, and family support with the quality of life of breast cancer patients.<sup>[33]</sup>

The results of this study differ from studies conducted by Moghimi *et al.*, (2008) that among demographic factors such as age, education, and marital status have no significant relationship with quality of life, only employment status is related to the quality of life.<sup>[34]</sup> This is in line with research that age and education level do not have a significant relationship with the quality of life of climacteric women but differ from work status and parity, which have a significant relationship with the quality of life of climacteric women.<sup>[35]</sup>

The results of this study indicated that the social support factor of cancer patients related to the quality of life was friend's support ( $P < 0.05$ ). Manning-Walsh study reinforces that social support from friends and family can help reduce the adverse effects of symptoms of quality of life.<sup>[36]</sup> In addition, the study results in China confirm that support from friends and neighbors improves the quality of life of patients.<sup>[21]</sup>

The study limitation indicated that cross-sectional design cannot explain the dynamics of patients. The next study

would be more comprehensive by the explanation of patients' dynamics using the panel method.

## CONCLUSIONS

The most significant relationship is friend support by improving the quality of life. Nevertheless, full family support from univariate data is also a necessity in improving the quality of life of cancer patients. However, there are records that many patients experience problems in health insurance, so that this factor will affect the quality of life of patients and their families. This shows the importance of social support in improving the quality of life of cancer patients. Furthermore, support for policy and quality development in some palliative shelters, which so far has been more developed by private organizations and institutions.

## Financial support and sponsorship

Nil.

## Conflicts of interest

There are no conflicts of interest.

## REFERENCES

1. World Health Organization (WHO). International Agency Research for Research on Cancer. Latest World Cancer Statistics Global Cancer Burden Rises to 14.1 Million New Cases in 2012: Marked Increase in Breast Cancers Must be Addressed. Online access 3-9-2020. Available from: [https://www.iarc.fr/wp-content/uploads/2018/07/pr223\\_E.pdf](https://www.iarc.fr/wp-content/uploads/2018/07/pr223_E.pdf).
2. Trihono. Riset Kesehatan Dasar (Riskesdas). Penyajian Pokok-Pokok Hasil Riset Kesehatan Dasar 2013. Badan Penelitian Dan Pengembangan Kesehatan Kementerian Kesehatan RI. Jakarta. 1-306; 2013.
3. Kementerian Kesehatan RI. Bulan Peduli Kanker Payudara (InfoDATIN). Jakarta. Pusat Data Dan Informasi Kementerian Kesehatan RI. 7 Oktober 2016; 2016.
4. Allifni M. Pengaruh Dukungan Sosial Dan Religiusitas Terhadap Motivasi Berobat Pada Penderita Kanker. Jakarta. Universitas Islam Negeri Syarif Hidayatullah; 2011.
5. Sarafino PE. Studi Kualitatif Pola Kehidupan Pasien Kanker Payudara a Qualitative Study on Breast Cancer Patients ' Life. USA: John Wiley and Sons Inc; 2011.
6. Rahayuwati, L., Sari, S., Witdiawati, W. Enculturation in the life pattern of breast cancer patients: An ethno-nursing study on sundanese women. *Jurnal Ners*, 12 (1), 99-107; 2017. doi: <http://dx.doi.org/10.20473/jn.v12i1.4143>.
7. Zimet GD, Dahlem NW, Zimet SG, Farley GK. The multidimensional scale of perceived social support. *J Pers Assess* 1988;52:30-41.
8. Chrishianie. Gambaran Persepsi Terhadap Dukungan Sosial Pada Remaja Yang mengalami Kehamilan di Luar Nikah. Indonesia. Universitas Katolik Atma Jaya; 2014.
9. Li C, Chen M, Chang T, Chou H, Chen M. Social support buffers the effect of self-esteem on quality of life of early-stage cervical cancer survivors in Taiwan. *Eur J Oncol Nur* 2015;19:486-94.
10. Rapley M. Quality of Life Research: A Critical Introduction. Vol. 13. University of East London, UK: Springer International Publishing; 2004.
11. Fayers PM, Machin D. Quality of Life: The Assesment, Analysis and Interpretation of Patient-Reported Outcomes. 2<sup>nd</sup> ed. England: John Wiley and Sons Ltd; 2007.
12. Broeckel JA, Jacobsen PB, Balducci L, Horton J, Lyman GH. Quality of life after adjuvant chemotherapy for breast cancer. *Breast Cancer Res Treat*. 2000 Jul;62(2):141-50. doi: 10.1023/a:1006401914682.
13. Wardiyah A, Afyanti Y, Budiati, T. Faktor yang mempengaruhi optimisme kesembuhan pada pasien kanker payudara. *J Keperawat* 2014;5:121-7.

14. Coyne E, Wollin J, Creedy DK. Exploration of the family 's role and strengths after a young woman is diagnosed with breast cancer : Views of women and their families. *Eur J Oncol Nurs* 2012;16:124-30.
15. Castro M. Quality of Life in Female Breast Cancer Survivor in Panama. Graduate Theses and Dissertations. 1-65; 2013.
16. World Health Organization (WHO). Global Atlas of Palliative Care at the End of Life. Worldwide Hospice Palliative Care Alliance, World Health Organization, Britannia Street, London; 2014.
17. 17Krug K, Miksch A, Peters-Klimm F, Engeser P, Szecsenyi J. Correlation between patient quality of life in palliative care and burden of their family caregivers: A prospective observational cohort study. *BMC Palliat Care* 2016;15:4.
18. Effiong A, Effiong AI. Palliative care for the management of chronic illness: A systematic review study protocol. *BMJ Open* 2012;2:e000899.
19. Kimman M, Norman R, Jan S, Kingston D, Woodward M. The burden of cancer in member countries of Asian nations the association of Southeast (ASEAN). *Asian Pac J Cancer Prev* 2012;13:411-20.
20. World Health Organization (WHO). National Cancer Control Programmes: Policies and Managerial Guidelines. 2<sup>nd</sup> ed. Geneva: World Health Organization (WHO); 2002.
21. Yan B, Yang LM, Hao LP, Yang C, Quan L, Wang LH, *et al.* Determinants of quality of life for breast cancer patients in Shanghai, China. *PLoS One* 2016;11:e0153714.
22. Kewaina Kolin, M. Y., Warjiman, W. and Mahdalena, M. Kualitas Hidup Pasien Kanker Yang Menjalani Kemoterapi, *Jurnal Keperawatan Suaka Insan (JKSI)*, 1(1), pp. 1-12. 2017. doi: 10.51143/jksi.v1i1.21
23. UNAIDS. Together We Will End AIDS. Joint United Nations. Switzerland. 1-160; 2012.
24. Tjindarbumi. Pengelolaan Multidisiplin Untuk Mencapai Kualitas Hidup Yang Baik Bagi Penderita Kanker Payudara. Semarang, Indonesia. Kumpulan Naskah Ilmiah Muktamar VIPERABOI; 2003.
25. National Cancer Institute. Nasopharyngeal Cancer Treatment. U.S.A: National Cancer Institute; Online access 3-Sept-2020. 2009.
26. World Health Organization (WHO). GLOBOCAN 2008: Cancer Incidence and Mortality Worldwide; 2010. Available from: <https://www.iarc.fr/news-events/globocan-2008-cancer-incidence-and-mortality-worldwide/>. [Last accessed: 02-Feb-2022].
27. Friedman MM. Buku Ajar Keperawatan Keluarga: Riset, Teori dan Praktek. Jakarta: EGC; 2010.
28. Taylor ES. Health Psychology. 7<sup>th</sup> ed. New York: Mc Graw Hill Inc.; 2009.
29. Hakim R. Hubungan Dukungan Keluarga dengan Kualitas Hidup Pasien Kanker yang Menjalani Kemoterapi di RSUD Keraton Pekalongan. *Pekalongan: Jurnal Kesehatan STIKES Muhammadiyah Pekajangan*; 2013.
30. Rulianti MR, Almasdy D, Murni AW. Hubungan depresi dan sindrom dispepsia pada pasien penderita keganasan yang menjalani kemoterapi di RSUP Dr. M. Djamil Padang. *J Kesehat Andalas* 2013;2:137-40.
31. Shankaran V, Jolly S, Blough D, Ramsey SD. Risk factors for financial hardship in patients receiving adjuvant chemotherapy for colon cancer: A population-based exploratory analysis. *J Clin Oncol* 2012;30:1608-14.
32. Sasmita S. Faktor Yang Mempengaruhi Kualitas Hidup Pasien Kanker Payudara di RSUP Dr. M. Djamil Padang. Diploma thesis, Universitas Andalas, Padang, West Sumatra; 2016.
33. World Health Organization. The World Health Organization quality of life (WHOQOL)<sup>®</sup> - BREF, 2012 revision. World Health Organization. Online access 13-Apr-2020; 2004.
34. Moghimi-Dehkordi SA, Zeighami B, Tabatabaee H, Pourhoseingholi M. Predictors of quality of life in breast cancer patients under chemotherapy. *Indian J Cancer* 2008;45:107.
35. Trisetiyaningsih Y. Faktor-Faktor Yang Berhubungan Dengan Kualitas Hidup Perempuan Klimaterik. *Media Ilmu Kesehatan* 2015;5:30-9. Available from <http://ejournal.stikesayaniy.ac.id/Index.php/Mik/Article/View/48>.
36. Manning-Walsh J. Social support as a mediator between symptom distress and quality of life in women with breast cancer. *J Obstet Gynecol Neonatal Nurs* 2005;34:482-93.