

EVIDENCE-BASED COMMENTARY**SOCIO-ECONOMIC APPROACH AS A PROMISING INTERVENTION TO REDUCE LEPROSY-RELATED STIGMA**

Received: 06-12-2019 • Accepted: 17-12-2019

<http://dx.doi.org/10.21460/bikdw.v4i2.160>

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Leprosy is still a public health concern in some parts of Indonesia with further impact on patients and family social activities and financial independence. This inequality is related with stigmatization of leprosy patients and family, thus lead them into poverty and social rejection, even though the patient has been declared cured. In the case of chronic infection, the patient's condition may become worse due to poverty and isolation from society. Dadun et al.¹ conducted a mixed-method study on the effectiveness of socio-economic intervention to reduce stigma on leprosy patients, specifically in Cirebon district, West Java, Indonesia. There were 29 leprosy patients within intervention group (microfinance, livestock provision, and skills training), 57 persons within counselling-contact group and 57 persons within control group (no intervention and counselling). The SARI stigma score (SSS) reduced by -8.45 points (CI 95% -13.94 to -2.96) within intervention group, and smaller within counselling-contact group (-6.54, CI 95% -9.60 to -3.48) and control group (-5.63, CI 95% -8.92 to -2.34). Furthermore, there are slight improvement of participants quality of life using WHOQOL-BREF questionnaire among intervention group (4.32 points, CI 95% - 1,38 to 10.09) compared to control group (-2.00, CI 95% -5.49 to 1.56). The qualitative study with focus group, interview, and observation shown that the intervention has improve life satisfaction, decision-making capability, overall health, mobility, recognition and acceptance, and working capacity.

This study has shown that non-health intervention is beneficial to reduce leprosy-related stigma and help the patients and family gaining their financial independence, which further supports their physical and mental well-being. However, the results seemed to have low effect size and low power, which is quite common in complex public health intervention studies. The differences were also not quite significant as the author stated that some of intervention group participants had already involved in socioeconomic activities with unknown distribution, as the random allocation was done to each clusters of sub-districts, not specifically to each participant. Nevertheless, the findings of this study are in concordant with previous research in similar country background such as India and Nigeria.^{2,3}

The socio-economic intervention should be considered mostly in people affected by health inequalities, stigmatised and had low opportunity in overcoming their financial hardship, such as leprosy patients and other disabled people. However, the impact on stigma and quality of life was not convincingly high to apply this intervention in the larger community. This study has not explored the specific cultural background and stigma from community (not affected by leprosy or not having disability) standpoint, where it might affect the generalisation of qualitative impact of socioeconomic intervention to other cities with higher prevalence of leprosy (Central Java, East Java, North Sulawesi, Bali and Yogyakarta). Further study might be needed to address the impact of different culture in the success of intervention, with larger sample and longer follow-up period.

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