

The Leprosy Care Cadre Tracking (Kader Tangguh Peduli Lepra: KETAPEL) Model with Social Learning Theory Approach Increases the Leprosy New Case Detection

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This study aims to determine the effect of the Leprosy Care Cadre Tracking Model (Kader Tangguh Peduli Lepra: KETAPEL) in the detection of new cases of leprosy using the social learning theory approach in Kolo Subdistrict, Bima City, Indonesia. This research is a quasi-experimental study with a one-group pretest and post-test design. This study was carried out in Kolo Subdistrict, Bima City during March – October 2021. This research was conducted on 20 leprosy care cadres who had to receive the Leprosy Care Cadre Tracking (Kader Tangguh Peduli Lepra: KETAPEL) model to find new cases of leprosy. In this model, cadres received counselling and training in the area of a social learning theory to approach with the community for discovering new cases of leprosy in Kolo Subdistrict, Bima City. The number of new cases discovered by cadres was recorded before and after implementation of the KETAPEL model. Data analysis was carried out using paired t-test with a p-value ≤ 0.05 . Results showed that there was a significant difference in the detection of new leprosy cases in Kolo Subdistrict, Bima City, before and after the application of the KETAPEL model ($p=0.000$). New case detection increased 100% from 19 to 38 cases after the implementation of the KETAPEL model. It is concluded that KETAPEL model developed for the identification of new cases using the social learning theory approach improves the identification of leprosy cases. This model can be applied either regionally or in a wider area. Such model/ approach needs to be studied in other social and cultural settings.

Keywords : Leprosy, New Cases, Social Learning Theory, Case Identification

Introduction

Leprosy is an infectious disease caused by infection of *Mycobacterium* (Siregar 2004, Talhari et al 2015, Ploemacher et al 2020, Santacroce et al 2021). The incidence of leprosy in 2015 was 210,758 cases and increase to 719,330 in 2000. More than 80% of leprosy cases are found in India, Brazil, Myanmar, Madagascar, and Nepal (Mandal 2006). According to Ministry of Health Republic of Indonesia as cited in Gunnara et al (2020), in the year 2015, in Southeast Asia

region, there are 156,118 cases, 28,806 cases in the Americas, and 20,004 cases found in Africa. This high incidence of leprosy leads World Health Organization (WHO) to implement various strategies to reduce the number of leprosy cases even though the incidence is relatively still high. The incidence of leprosy in the world at the end of 2017 was 193,118 cases with a prevalence rate of 0.3 per 10,000 population (WHO 2018). Based on the Global Leprosy Update, Indonesia reported 17,202 new cases in 2015 and Indonesia

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was ranked third in terms of the highest number of leprosy cases in the world after India and Brazil (WHO 2016).

Social problems due to leprosy arise due to the fear experienced by people with leprosy in society (leprophobia) (Sulistyarini & Pudjiastuti 2017, Bahtiar et al 2021, Siallagan et al 2021). Low knowledge, lack of socialization in society, and stigma in society result in a lack of community participation in eradicating leprosy (Singh et al 2019). Disabilities in leprosy patients also have an impact on decreasing self-confidence in social activity, this causes withdrawal behaviour from the surrounding environment that affects the quality of life of the patients (Mukin et al 2022).

In Indonesia, West Nusa Tenggara is a province that has a high prevalence of leprosy where the number increased from 223 cases in 2017 to 253 cases in 2018. Based on data from the Bima City Health Office in 2019, the number of leprosy affected persons (LAPs) was 43 cases, and this increased to 45 in 2020. Asakota District has the most case in Bima City. In 2019 there were 32 cases, and 37 cases in 2020, 30 of them came from the Asakota sub-district. The lack of correct information about leprosy creates a wrong perception in society. Some people think of leprosy as a curse, a hereditary disease, the result of witchcraft, wrong eating, to a highly contagious and incurable disease, which has an impact on the high incidence of leprosy in Asakota District (Kurniadi et al 2023). This problem is important and requires full attention for finding a solution. Efforts to prevent and eradicate leprosy are still being carried out by the government in several programs such as education and dissemination of information through various programs at the health Office and at the Public health centre (Puskesmas) Program. Even though prevention efforts through the health service program have been carried out, the incidence of leprosy

still tends to increase from year to year. Various models of prevention and detection of new cases by using social media to convey information on leprosy transmission have been tried. However, the prevention program has not been able to motivate the community to merely consult or go to health facilities by themselves. Moreover, due to the limited number of health care professionals in the Public health center (Puskesmas), the leprosy case detection mostly is done using passive case detection model. However, passive detection model is known to be less effective in leprosy new case detection (Dharmawan et al 2023). Considering such conditions, it is necessary to establish a specific cadre of infectious diseases to detect leprosy cases earlier.

The health cadre is one of the community leaders who is tasked with developing the community and helping health services in the community. Health cadres will later look for and find leprosy sufferers by way of early diagnosis, conducting examinations of all family members and neighbours who are in frequent contact with leprosy sufferers, then an examination was carried out on suspected leprosy sufferers who were passively found by health cadres by health center staff. Such conditions may be prevailing in other parts of Indonesia as well as other countries like India and Brazil still having relatively larger numbers of leprosy cases.

Social learning theory is a combination of learning theory and social behaviour which suggests that new behaviour can be obtained through observation, modelling, and imitation (Resnick & Avers 2011). This method is considered suitable for making models in the detection of leprosy cases. Therefore, the researchers of this study have developed a leprosy care cadre tracking model (Kader Tangguh Peduli Lepra: KETAPEL) in finding new cases of leprosy. The implementation of this model begins with exploring methods

according to needs, providing education to cadres, and testing model's application. Based on this, this study aims to determine the effect of the leprosy care cadre tracking model (Kader Tangguh Peduli Lepra: KETAPEL) in the discovery of new cases of leprosy with the social learning theory approach in Kolo Village, Bima City.

Materials and Methods

This research is a quasi-experimental study with the one group pretest and post-test design. The research was carried out in the Kolo Village, Bima City, Indonesia during March – October 2021. The population in this study were all cadres who are members of the leprosy care cadre (Kader Tangguh Peduli Lepra: KETAPEL). The inclusion criteria for the study sample included newly formed health cadres, aged 20-40 years, with at least high school education or equivalent, located in the Kolo sub-district, Kota Bima. The exclusion criteria for the study sample included cadres who did not want to come in contact with leprosy patients and health cadres who were pregnant. The number of cadres who meet the criteria is 20 people, with the total sampling method.

The independent variable of this study is the leprosy care cadre tracking model (KETAPEL model), while the dependent variable of this study is the discovery of new leprosy cases. The process of searching for leprosy cases was carried out before and after the application of the KETAPEL model. Furthermore, to observe whether this model that used a social learning theory approach influenced the discovery of new cases in Kolo sub-district, Kota Bima, this study compared the number of cases discovered before and after KETAPEL model implementation. The inclusion criteria of study population for new cases detection were people living in Kolo sub-district, Bima City who willing to become study subject. Meanwhile, the exclusion criteria included people who not willing to join the study.

Data collection was carried out after obtaining permission from the Bima City Bappeda which was forwarded to the Kolo Village Head.

Data were analyzed using paired samples T-test samples with $p \leq 0.05$. Statistical analysis using SPSS (IBM Statistics, USA).

Application of the "KETAPEL" Method

The leprosy care cadre tracking model (Kader Tangguh Peduli Lepra: KETAPEL) was developed using social learning theory approach. The KETAPEL method was carried out in three stages. The first stage (March-April 2021) was an exploration stage of the cadre's initial knowledge about leprosy. Exploration activities were carried out in the first year by exploring the knowledge of health cadres about leprosy in Asakota District, Bima City. The exploratory method was carried out through observational research and qualitative research. The second stage of research (May-July 2021) focused on education, namely developing the ability to identify leprosy sufferers and forming strong cadres who care for leprosy. The development of identification ability was carried out by providing symptom identification education, including spots on the limbs, itching complaints, and responses when the skin is stimulated. The third stage (August-October 2021) was the direct application in the field, where cadres applied the knowledge, they were provided for the search for new leprosy cases. The implementation of the model has depicted in the flow diagram (Fig. 1.) The new case detection was for new leprosy cases before and after receiving education.

Results

The characteristics of the respondents are summarised in Table 1. Of the 20 health cadres who were involved in new leprosy case detection, it was found that 60% of the respondents were aged 19-30 years, 55% of the respondents had

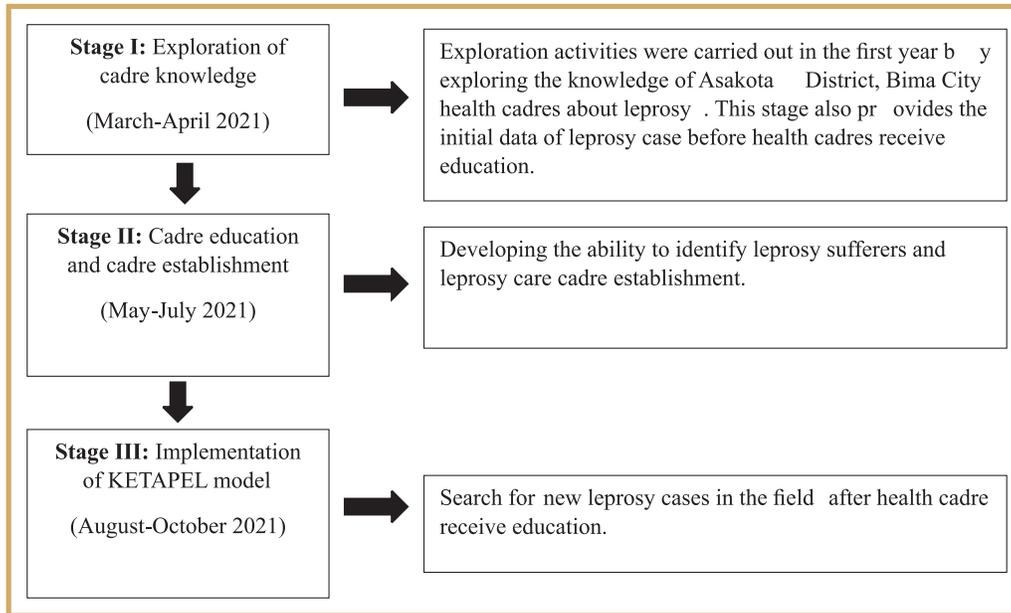


Fig. 1 : Stages of KETAPEL model implementation in this study.

Table 1 : Distribution of health cadres according to characteristics in Kolo District Bima City.

Characteristics	N=20	Percentage
Age		
• 19 - 30 years old	12	60.0%
• 31 - 40 years old	3	15.0%
• 41 - 50 years old	5	25.0%
Education		
• High School	11	55.0%
• D3	2	10.0%
• S1/D-IV	5	25.0%
• Nurses	2	10.0%
Occupation		
• Health care provider	10	50.0%
• Housewives	7	35.0%
• Teacher	3	15.0%

a high school educational background and 50% were health workers.

The health cadre received education/training to develop the ability to identify leprosy case

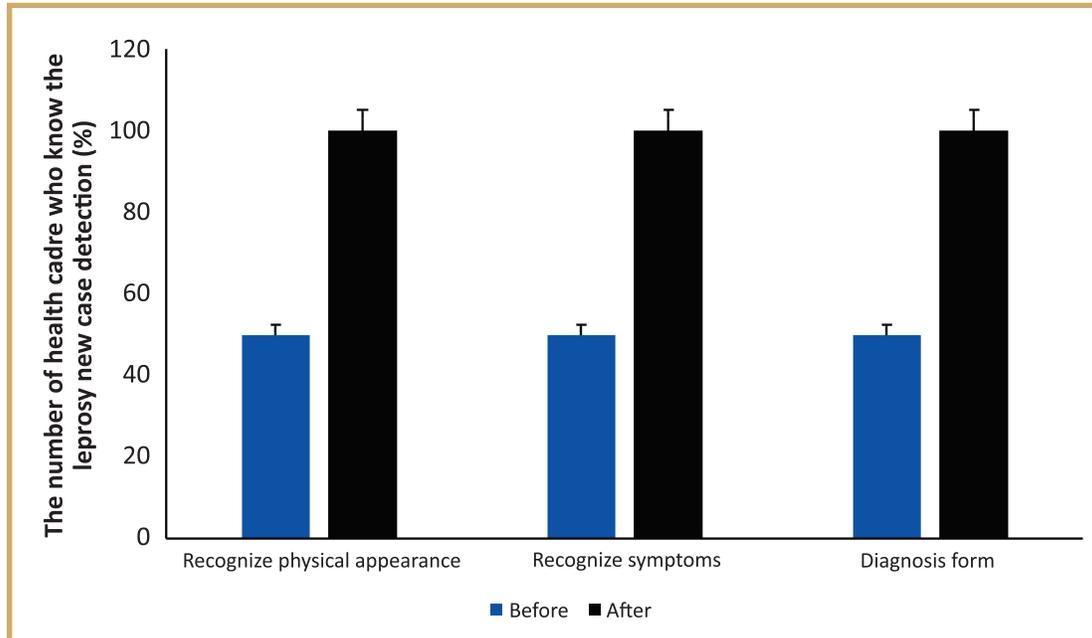


Fig. 2 : The health cadre's knowledge on the physical appearance, symptoms of leprosy, also the use of diagnosis form in the leprosy detection.

Table 2 : The effect of the tracking KETAPEL model for leprosy care cadres on the detection of new cases of leprosy using a social learning theory approach in Kolo sub-district, Bima City using paired pre-test and post-test samples.

Parameter	Pre-Test	Post-Test 1	Sig. (2-tailed)
	Before the KETAPEL model implementation	After the KETAPEL model implementation	
	N	N	
The detection of new cases	19	38	0.000

and leprosy care cadre establishment. In this phase, the health cadre received education to recognize symptoms, including spots on the limbs, itching complaints, and responses when the skin is stimulated. The health cadre also received an education to communicate with villagers to actively find the new case by examine the villager physical appearance, other symptoms, and using diagnosis form. From education stage, the number

of health cadre who were able to recognize physical appearance, symptoms, and were able to diagnose increased from 50% to 100%. By using this model, the health cadres from non-health care provider (housewives and teachers) also were able to recognize leprosy case and able to communicate with villager together with health care from health care provider profession (Fig.2).

The leprosy detection was done in 495 Kono villagers. The number of leprosy cases obtained by health cadres before the KETAPEL model implementation was given is 19 cases. After implementing the KETAPEL model, there was a 100% increase in the new case detection, becoming 38. Based on the paired t-test, there was a significant difference between the detection of new cases of leprosy before and after the implementation of the KETAPEL model ($p=0.000$) (Table 2).

Discussion

The results of the implementation of "KETAPEL" in this study are closely related to the process of finding new cases of leprosy in the Kolo sub-district, Bima City. Prior to the intervention, only 19 cases of leprosy were found, then it doubled to 38 cases after the outreach and training of leprosy cadres (Kader Tangguh Peduli Lepra: KETAPEL) with a social learning theory approach was carried out. This shows that the implementation of the KETAPEL model with this approach has a significant effect on increasing the detection of leprosy cases. Early case finding plays an important role in preventing disability (Herlinawati et al 2022) which is supported by research (Kamal & Martini 2015) which shows that the case-finding method passively affects grade 2 disability in leprosy patients.

Leprosy detection methods involving cadres are known to be very important (Herlinawati et al 2022). Health cadres are the community leaders who are tasked with developing the community and helping the smooth running of health services in the community, therefore the researchers created a leprosy care cadre (Kader Tangguh Peduli Lepra: KETAPEL) that focuses on just one disease in early detection to find new cases, which is very helpful in the process of finding cases leprosy in the community. Cadres are given counselling and training with a social learning

theory approach in the process of approaching the community to find new leprosy cases. A social learning approach is done by approaching clients and observing patterns of behaviour and attitudes as well as conducting examinations of all family members and neighbours who often come in contact with leprosy sufferers. The cadre then examines suspected leprosy affected person (LAPs) that a healthcare provider passively finds in a public healthcare center (Puskesmas). The suspected LAPs will be given a special approach to faster leprosy detection and to maintain patients' social live during the detection. The social learning approach in this study aimed to observe people's behaviour, attitudes and emotions toward leprosy. This is in line with Bandura (1986) in social learning theory which shows the importance of the process of observing and imitating the behaviour, attitudes and emotions of others. This theory explains human behaviour in the context of continuous reciprocal behavioural interactions between cognitive behaviour and environmental influences.

Lockwood and Kundan as cited in Saguni (2007) show that there are implications of the social learning theory approach in cases of other diseases, namely by learning from other people, a person can change the wrong perception about a disease so that in the end the disease problem can be resolved. In this study, most of the respondents considered leprosy to be a dangerous and serious disease. Respondents in the study also showed a similar opinion (Soedarjatmi et al 2009), because the disease can cause physical changes, and this disability can last a lifetime. Lack of knowledge makes sufferers do not understand the early signs of leprosy, which also causes sufferers to be embarrassed to come to the Puskesmas (Kamal & Martini 2015). This is in line with Adhikari et al (2014) where social problems due to leprosy arise due to the fear that leprosy sufferers experience

in society (leprophobia). Low knowledge, lack of socialization, and bad stigma in society result in a lack of community participation in eradicating leprosy.

This study shows that with the development and use of KETAPEL using a social learning approach in the community, efforts to detect leprosy early and find new cases of leprosy have result in better results. Thus, it can be concluded that the low detection of new cases of leprosy can be influenced by the approach used by cadres in finding new cases of leprosy. The increase in the detection of leprosy cases after the cadre's social learning approach with the community can also be associated with an increase in community knowledge and understanding after the intervention. This is in accordance with research (Noordende et al 2019, Dharmawan et al 2021, Herlinawati et al 2022) that one of the obstacles in the discovery and control of leprosy is the low level of knowledge about the disease in the public. Tesema and Beriso (2015) reported that 80.7% of the level of public knowledge about leprosy is still low due to a lack of efforts to disseminate information about leprosy. In addition, Nur et al. (2019) have observed that more respondents have good knowledge after being given information about leprosy. Knowledge is an essential factor because one's knowledge influences the formation of one's behaviour (Fabrigar et al 2006). The higher a person's knowledge about health, the greater the person's efforts to improve health (Juwariyah & Nuridayanti 2022).

Several efforts to prevent and eradicate leprosy are being done by the government(s). Education and dissemination of information through various programs at the Health Office and at the Puskesmas Program. Even though prevention efforts through the health service program have been carried out, the incidence of leprosy

has been increasing from year to year. Various models of prevention and detection of new cases by using social media to convey information on leprosy transmission are being tried. However, the prevention programs that have been developed have not been able to motivate people to consult about the leprosy they suffer from (Kurniadi et al 2023). Based on what has been explained previously, it can be concluded that by forming leprosy care cadres (Kader Tangguh Peduli Lepra: KETAPEL) using a social learning approach in the community, the early detection of leprosy and the discovery of new cases of leprosy have an effect.

The strong point of this model is the social learning-based model which highlights the role of the health cadre that actively interacts with the villager to examine either suspect or healthy villagers to increase the detection range. This model also provides insight that this model using social learning approach can be applied not only to the health care professional and still provide a positive outcome. This model is also useful in the rural area where health facilities and health care professionals are limited. The health cadre can be a first line in the early detection of the case detection in the rural area. By using this model, health cadre establishment could enrol a non-health care providers to join the team. By using social learning-based model, the health cadres could follow instruction and applied the instruction in the community. By using this model, health cadres are also trained to understand physical appearance, symptoms, and use detection methods in leprosy detection. Generally, the KETAPEL model consist of three essentials step including Stage I: Exploration of cadre's knowledge. Exploration activities were carried out in the first year by exploring the knowledge health cadres about leprosy. This stage also provides the initial data of leprosy case

before health cadres receive education. Stage II: Cadre's education and establishment: This stage focuses on development of the health cadre's ability to identify leprosy cases. This stage also consists of leprosy care cadre establishment by creating a program for teamwork. Stage III: Implementation of KETAPEL model: In this stage, the trained health cadres begin to search for new leprosy cases in the society. To conclude, in this study this KETAPEL model using principles of social learning theory has been proven to be double for the detection of new leprosy cases and better compared with conventional approaches. This model needs to be tried regionally or on a wider scale in Indonesia or other countries like India, Brazil where leprosy is still a problem.

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