Leprosy control activities integration into the general health system, in the endemic area of South Gujarat region

Sir,

The National Leprosy Control Program (NLCP) was started in 1954-'55. It had separate staff and an exclusive set up, having no connection with the general health system (GHS), and was renamed as the National Leprosy Eradication Program (NLEP), in 1983, with the introduction of multidrug therapy (MDT).[1] The program received a further drive during the World Bank-assisted first NLEP project in 1993-2000 and a second one during 2001-2004, with the objective of decentralizing NLEP responsibilities and integrating anti-leprosy activities into the GHS, in a phased manner.[2] The phased implementation of MDT in the Valsad district led to a drop in the prevalence rate (PR) from 32.01 / 10,000 population in 1985, before the integration of NLEP in GHS, to 2.91 in March, 2008, after integration. Similarly, the New Case Detection Rate (NCDR) was reduced to 698 in March, 2008, from 3425, in 1985. In the present study, the objective was to conduct an operation research in the endemic Valsad district, to assess the progress of integration of leprosy control activities in the GHS, using defined indicators like, validation of diagnosis by checking patients in the field, status of the Simplified Information System (SIS), Information, Education and Communication (IEC) activities, Disability Prevention and Medical Rehabilitation

(DPMR) activities, including Micro Cellular Rubber (MCR) shoe distribution and reconstructive surgeries, and MDT logistics.

A total of 39 primary health centers (PHCs) functioning in the five talukas of Valsad district including, Kaprada (8), Umergam (8), Dharampur (7), Pardi (7), and Valsad (9), were taken into consideration. A PR of more than five was found in three primary health centers (PHCs) of Umergam taluka and four PHCs of Kaprada taluka. From these, two PHCs were selected from each taluka. One PHC was selected each from the remaining talukas, having PR between two and five per 10,000 population. The study was conducted during September, 2008. Interviews were conducted after taking the informed consent from Block Health Officers, Medical Officers (MO), Female Health Workers (FHW), Multipurpose Health Workers (MPHW), and other health staff available at the PHCs. In 1999, the PR was 9.15, which was reduced to 2.91 by 2008. The new case detection rate was also reduced from 15.06 to 4.29, during the same period. Other indicators like the proportion of the multibacillary cases, the proportion of child cases, and the proportion of deformities showed similar favorable changes from 1999 to 2008. In nine PHCs, a PR of 3 to 5 was found, while only three PHCs had a PR of below 1.

Out of seven PHCs visited, five MOs (71%) were newly recruited Ayurvedic or Homeopathic doctors and they did not have any kind of training regarding NLEP. They had a poor knowledge of the disease and the NLEP, but paramedical workers (FHWs and MPHWs) had received some training. Good quality training regarding various components of NLEP was needed at the district level, to improve NLEP in Valsad. Similar observations were made by Pandey *et al*,[2] in their study. In spite of FHW and MPHW training, they were still not very oriented to the task of MDT delivery and maintaining patient care, although they were helping in the identification of suspects and follow up of cases under treatment. Other studies have also emphasized the need for training of GHS staff, for leprosy care.[3, 4]

Validation was done at different levels, first at the subcenter level, by searching for patients in the field, asking for the patient treatment card, and verifying the clinical diagnosis and treatment. To diagnose a patient of leprosy in the field, the WHO classification for multi bacillary (MB) and pauci-bacillary (PB) leprosy was used as per the guidelines under NLEP. A total of 23 patients were visited for accuracy of diagnosis, of which 11 were found to be MB and 12 PB leprosy. No patient was found wrongly diagnosed as tinea instead of leprosy. If any patient, diagnosed or under treatment, was to be found missing, a confirmatory visit was made by the GHS fortnightly during a house-to house visit. However, no such visit for confirmation was made by authors, because of time constraints. Validation of records was then done at the PHC level, including diagnosis, classification, and treatment completion on three patients, each from the visited seven PHCs (total 21). Patient cards were available from all the 21 patients visited at the PHC level and their treatment records were found at the PHCs. It was found as per treatment registers, but the records were inadequately filled. MDT drug records and availability of MDT drugs was assessed and found adequate. Some authors have reported poor drug records in their studies.[2,4] Slogans and posters were found written in the rural areas visited and other activities were carried out as per planning and budget allocation.

Before integration, a number of registers and patient cards were maintained at different levels of vertical structure, for monitoring, analysis, and interpretation of data. However, after integration with GHS, efforts have been made to simplify the present leprosy information system to the extent that it suits the new functionaries and managers of the GHS. Maintenance of records at PHCs and subcenters was assessed under SIS including patient card (LF 01), treatment record (LF 02), MDT drug stock register (LF 03), and monthly reporting form (LF 04), utilized by PHCs. Out of 33 health staff interviewed, 31 (94%) had taken training of DPMR. Line listing of the disability workload was done at all the PHCs visited. Ulcer care kit and MCR shoes were provided and available at all the PHCs. Compared to the PR of Gujarat state (0.82) and of India (0.74),[5] Valsad district (2.91) has to still improve program implementation in the form of integration at PHCs and subcenters.

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