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Letter

LCDC (Leprosy Cases Detection Campaign) - Aiming at Cent Percent Detection of Leprosy Cases in the Community Based on a Line of Pulse Polio Campaign in Leprosy Endemic State

Letter

Sir,

India alone, contributes about 58.8% and 81.2% of the newly detected cases of leprosy, globally and in the South East Asian region, respectively [1]. Cases were detected mainly by passive surveillance. Detection of leprosy cases will lead to a diminution of the source of infection in the community, mainly because undetected and untreated cases will transmit the disease agent to other people in the community. Pockets of high endemicity are still prevalent in a few states in India indicating ongoing disease transmission of leprosy. LCDC (Leprosy Cases Detection Campaign) is a first of its kind initiative taken by Govt of India, Ministry of Health and Family Welfare and was implemented in high endemic districts of the country, online with a pulse polio campaign in the months of March and April 2016 [2]. It is primarily a door to door search with physical examination and identification of suspects followed by confirmation accompanied with inbuilt component of supervision and monitoring. This exercise aims at not missing any case in the community. States like Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Odisha and Uttar Pradesh have been selected for LCDC on the basis of Prevalence Rate (PR) of districts ranging from 1-1.36 per 10,000 population. 50 districts of these states were included in this campaign. The author has followed the campaign in the high endemic state of Chhattisgarh of central India from the preparatory phase to confirmation of suspected cases of leprosy. The state is identified as one of the few remaining endemic provinces for leprosy elimination in India i.e. as of March 2015; annual new case detection rate is three times higher than the country [3]. The state with 2% population contributes about 4% of new leprosy cases. 70% (out of 146) of the total blocks were endemic for leprosy [4]. In the state of Chhattisgarh; three districts (two tribal districts) were selected for the campaign. Among these districts, 20 blocks were included having a population of 2,558,873 with 5,254 search teams.

Various campaign committees were constituted from state to block level with clear objectives and for fast track decision, so that activities are completed, adhering to guidelines and timelines with

flexibility based on preparations. These also included progress, problems encountered, proposed solutions and new action points with clearly defined responsibilities and timely deadlines. The committee also supervised, supported, monitored and ensured implementation of the highest quality LCDCs in the districts. State level two day workshop was conducted for the district and block officers in preparation of micro-planning, financial, human resource and IEC (Information, education and communication) strategy. These trained officers briefed this strategy about the campaign to other medical officer, peripheral health workers and supervisors, a week before the campaign. Half day orientation training was organized in batches for (Accredited Social Health Activist) and voluntaries at sector level under the supervision of a medical officer.

Microplanning for door to door campaign was prepared at 20 block levels with the help of peripheral health workers and supervisors. The duration of the house to house search and case detection operation was decided in the areas on the basis of the number of ASHAs (Accredited Social Health Activist). Each team was allocated with clear-cut, well-demarcated areas clearly mentioning the starting and ending points, identifiable with landmarks. Each house was visited by teams in search of cases in which each team comprised of two members. For better calibration of the campaign, each team had a male and female surveyor where males would be examined by male surveyor and correspondingly females by female surveyor.

A minimum of 15-20 houses in rural areas and 20-25 houses in urban areas were covered by each team per day. One member of the team had to inquire about signs and symptoms of leprosy and physical examination of all the persons in the family and enlist the suspected case/s. Second member of the team had to fill up the specially designed tally sheet. Alongside he/she also had to mark the door of the house as an L/date (Surveyed house) and X/date (locked house on the day of the survey) using a chalk. All X houses were recorded and revisited the following day of the survey. This is the first time campaign in which house marking is followed. The first level supervisors (ANM and MPW) had administered, the number of houses covered each day as per the microplan and extended their support to the team whenever required. Three tier internal supervisors and external monitored were

Table 1: House coverage, suspects and confirmation of leprosy cases during LCDC.

District	Population of district	Total number of Houses Visited by search teams	Population Coverage (%)	*X houses	Conversion of X houses to L** houses by search teams	No of Suspected cases by search team	PB	MB	TOTAL
Rajnandagaon	12,77,817	2,29,344	1118183 (87.5)	12985 (5.6)	3511(27.0)	1954	51	43	94
Sarguja	7,78,532	1,63,798	620351 (79.6)	3877 (2.3)	2903(74.8)	947	28	14	42
Jashpur	50,2524	1,23,029	474368 (94.4)	4657 (3.7)	2302(49.3)	1103	7	8	15

(*X house- All or some eligible inhabitants of the house were not examined for various reasons like-Persons not at home for the following reasons away to farms/ fields, place of work, school or market places, Visiting friends or relatives and locked house. *L-houses- All persons staying in the house have been examined by search team).

identified during the campaign and reported daily to the next level.

The suspected cases were line listed, compiled and were then sent to be confirmed by medical officers as local plan. During this campaign, 86% of the population covered in 20 blocks of the state and 4004 leprosy suspected cases were registered for confirmation. 151(19% of Total annual new detected) cases were confirmed as of leprosy and enrolled for MDT (Multi Drug Therapy) of which 86 (57%) were PB while 65 (43%) were MB cases as showed in **Table 1**. As compared to the year 2014-15, there was 181% change in case detection due to this campaign.

When active surveillance is followed, the proportion of PB is supposed to be 90% or more and MB should be less than 10% or less. Delay detection could be a major cause of this shift from Paucibacillary to Multibacillary. In proportion to every case detected there is a large burden of undetected cases, which are the most important source of infection to the vulnerable in the community. A few cases of leprosy can be detected immediately after their occurrence, but a majority after a certain delay. Another fact, says that there is an ASHA called Mitanin in Chhattisgarh, a community health volunteer at every habitation level. Under National Health Mission (NHM), there is a provision of performance based incentives to Mitanin for promoting her role in MDT services. Since, she is a local inhabitant of the community she is likely to be helpful for awareness about leprosy, encourage self-reporting and referral of suspects with other MDT services. The ASHA-population ratio is 1: 320 in the district which means that there is one trained volunteer on every 71 households (household size is 4.5). This distinctive campaign did find an exceptionally high number of hidden leprosy cases in the community, nor ASHA or general care health workers were able to identify them routinely which otherwise found them in its area during an active campaign. Thus, it can be concluded that there has been underutilization of a rich network of ASHA and their community services in the high endemic leprosy districts. It is now clarified that there is a need for periodic training and handholding support to all ASHA in future. Over the years, it is evident that focus on active search drives along with the strengthening of health services is the only answer to leprosy elimination in endemic areas. There is a

need to utilize the platform prepared by this campaign and sustain the leprosy activity at the village level by the involvement of local leaders. It's essential that the efforts or IEC activities are reinforced at village levels to be regularly repeated, for making a successful & sustained effect. As detection of so many cases shows the possibility of many more hidden cases in the community, which can only be detected through effective and sustained IEC activities. Increased coverage of the population would increase the detection of cases. The only way of ensuring that all new cases are detected is to record them as soon as they occur to improve the coverage and by involving PRI (Panchyat Raj Institute) at the local level. More recurrent surveys may result in more detection of cases in the community. Such campaigns should be invigorated and conducted on a yearly basis to further expand our future scope to find out hidden cases of leprosy in the community and enabling scope for early detection, helps in early identification of disabilities, declines bacillary load in the community by providing MDT and certainly helps to achieve the eradication goal in the mere forthcoming future.

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