

PART II

**Voluntary Reporting versus
Active Search Approach
for Leprosy Detection**

A comparative study in Madhya Pradesh and Chhattisgarh

Vimarsh Samiti, Bhopal
2002



Contents

Background	72
Objectives	73
Materials and Methods	75
Results	78
Experiences with the Active Search Approach (ASA)	78
Experiences with the Voluntary Reporting Centre (VRC) approach	80
Partners in the MLEC process	82
Personnel involved and reach of services	82
Training of personnel	83
IEC activities undertaken during MLEC III	83
Case-detection	84
Distribution of cases according to age and type of leprosy	85
Impact of MLEC III in case-detection	86
Costs	86
Levels of knowledge	88
Assessment of the effectiveness of ASA and VRC approaches	89
Gendered responses	90
Partnering with other government departments	90
Conclusion: VRC or ASA?	91

List of Tables

Table 1: Personnel involved and reach of services in MLEC-III in the study areas	83
Table 2: Cases identified and confirmed during MLEC III	84
Table 3: Distribution of cases according to age group and leprosy type	85
Table 4: Total expenditure on MLEC III in the study areas	87
Table 5: Cost per case detected	88

List of Figures

Figure 1: Map showing the four study sites in Madhya Pradesh and Chhattisgarh	76
Figure 2: Trends in case-detection rate	86



Background

The Leprosy Division of the Government of India (GOI) had proposed a study to compare the effectiveness of the Voluntary Reporting Centre (VRC) approach adopted in urban areas of Madhya Pradesh with that of the Active Search Approach (ASA) adopted in urban areas of Chhattisgarh for the Modified Leprosy Elimination Campaign III (MLEC III) in October and November 2001. This study, commissioned by DANLEP (Madhya Pradesh), retrospectively documented the MLEC process in four urban areas of the states of Chhattisgarh and Madhya Pradesh. The study documented the process adopted in each area, including the inputs and the activities carried out, the personnel and volunteers involved, the IEC strategy, organization of services, timings of activities, costs and the results in terms of suspected, examined and detected cases, number of persons attending the VRCs/case confirmation centres, and level of information in the community about leprosy and its treatment.



Objectives

The main objective of the study was:

To compare the effectiveness of the Active Search Approach (ASA) with that of the Voluntary Reporting Centre (VRC) approach in detecting cases of leprosy during MLEC III in selected urban areas of Chhattisgarh and Madhya Pradesh.

The specific objectives of the study were:

- To document the inputs (money, materials, personnel and time) invested in each of the selected areas for MLEC III;
- To describe the process adopted and activities carried out for informing/educating the communities about leprosy;
- To describe the process adopted and activities carried out for detecting cases of leprosy;
- To describe the roles of various people/agencies involved in MLEC III;
- To assess and compare the levels of information about the signs and symptoms of leprosy, its treatment and curability and the availability of services;
- To document and compare the number and type of cases detected (MB/PB, age, sex, SC/ST) during VRC and ASA;

- To calculate and compare the costs per case detected in the selected areas;
- To locate the cases detected on maps of the selected urban areas, including the location of VRCs/case confirmation centres and thereby identify areas in which patients have not been identified and the possible reasons for this;
- To make an assessment about which of the two approaches was the most effective and under what conditions.





Materials and Methods

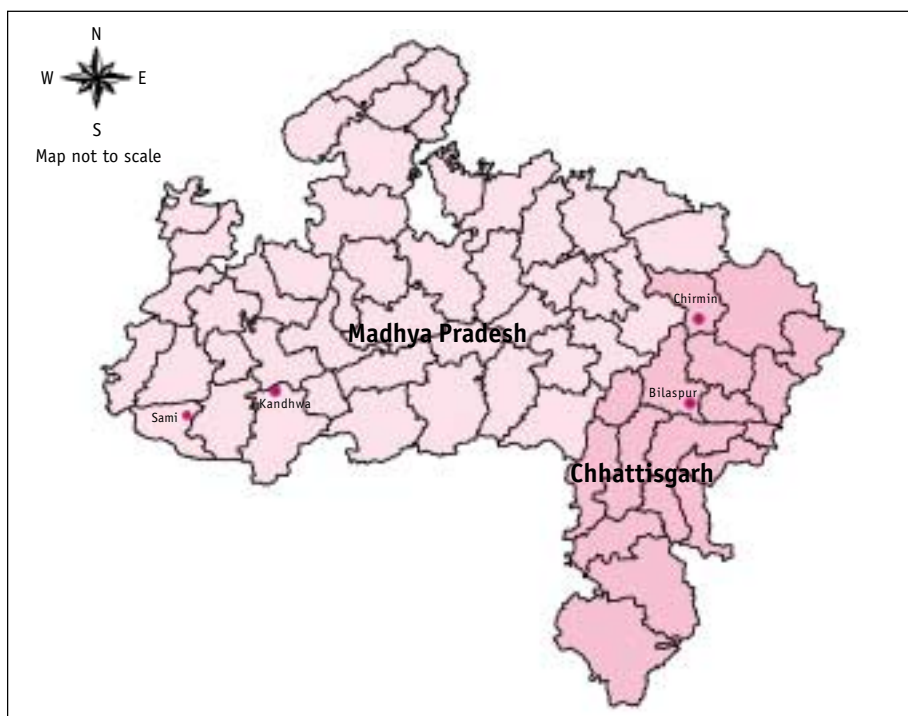
The study sites selected for ASA were Bilaspur and Chirmiri in Chhattisgarh and for VRC were Khandwa and Sarni in Madhya Pradesh. The selection was done keeping in view the fact that one high and one low prevalence town should be included from each state and that the towns should match each other in terms of their demographic characteristics. Bilaspur and Khandwa, with populations around 3 lakh each, had high prevalence rates (above 5/10,000 pop.), and both were large railway junctions, district headquarters and important commercial centres of their respective regions. Both these towns have a hinterland from where there is a large-scale migration of unskilled and unorganised labourers. In addition, there is an extensive out-migration of female domestic workers. Sarni and Chirmiri, on the other hand, are both mining towns, which have large public sector establishments. Both have a low prevalence rate (2.7/10,000) and have a population of around one lakh each.

In the initial phase of the study, relevant data and literature such as guidelines, plans, budgets, reports and other relevant project documents related to MLEC III were reviewed. A rapid field tour to Bilaspur (ASA area) and Khandwa (VRC area) was undertaken and open-ended discussions with NLEP functionaries were conducted. This helped in grounding the study and crystallizing the methodology and the field work plan.

Based on this initial research phase, a detailed study protocol defining sample, survey instruments and methodology was finalized. A pilot survey was carried out in Sarni to check the study protocol, which was modified accordingly.

The key respondent interviews covered administrators, NLEP personnel, other functionaries involved in MLEC, NGO/citizen groups, volunteers, etc., who

Figure 1: Map showing the four study sites in Madhya Pradesh and Chhattisgarh, respectively



had participated in the MLEC. It helped to throw light on the process that had gone into the MLEC and helped in identifying the strengths, weaknesses, lacunae and possible alternative approaches.

The information (location of VRCs/case confirmation centres, suspected cases identified, cases voluntarily reported, cases confirmed, etc.) had been projected on maps with ward boundaries. This helped in identifying areas in which patients had not been identified and the possible reasons for the same. In Chirmiri, administrative maps with ward boundaries were not available. Elections had not taken place since its conversion from the status of sada (urban notified area) to a municipality and therefore the demarcation of wards had not been finalized.

In order to assess and compare the levels of awareness in the populations about the signs and symptoms of leprosy, its treatment and curability and

the availability of services, five per cent of the households (approximately 7000) in each of the four towns were randomly sampled for a brief questionnaire study.

Ten corner meetings were held in selected areas to gain an understanding of the trends that emerged from the questionnaire study. This method was adopted in place of focus group discussions (FGDs). The corner meetings were purposively sampled and addressed the general public, volunteers and functionaries.

The information gathered has been collated and analysed to present the process and the best alternative system to the current approach suggested.



A woman being examined at a Voluntary Reporting Centre.



Results

Experiences with the Active Search Approach (ASA)

Bilaspur

Regular consultations between the NLEP and District Leprosy Elimination Society (DLES) had marked the implementation of MLEC-III in Bilaspur. With a high PR and a population of almost three lakh, the absence of any provision for honorarium for NLEP functionaries was a major constraint in conducting the campaign, and it was very difficult to enrol sufficient numbers of volunteers. The District Collector and the nodal officer (an ADM-rank officer), helped by co-opting the Mayor and members of the Municipal Corporation and the Integrated Child Development Scheme (ICDS) for providing volunteers. The NLEP on its own contacted the National Cadet Corps (NCC), Bharat Scouts and Guides and schools under the Education Department. While a few NGOs and interested citizens did join in, their number was negligible, and the Ward Supervisors were pressed into action.

A total of 127 teams, each with one male and one female worker, were formed to cover the 55 wards. Most of the teams consisted of one Anganwadi Worker (AWW) and one NCC cadet or Ward Supervisor. A number of IEC activities were conducted during the door-to-door search. The programme was launched on Mahatma Gandhi's birth anniversary on 2 October 2001 with a big school rally. Posters, *rath yatras*, banners, wall paintings, hoardings, fillers and roll strips on cable television broadcasts, announcements on cycle rickshaws, quiz contests in schools and *kala jathas* comprised the IEC activities. Traders' associations and NGOs helped with banners and posters.

Between 29 October and 3 November, active search for leprosy cases was carried out. The volunteers introduced themselves, explained the signs and symptoms of leprosy and gave details of the case confirmation centres. In

case a suspected case was found, details were filled in and a copy of it handed over to the household. Given the total target of around 2000 households per team (about 200 households per day), a physical examination at the household level was not possible. In discussions with the volunteers and NLEP functionaries it was learnt that a large number of houses had been skipped if found locked or if there was delay in the door being opened. In such cases, the volunteers, in consultation with the neighbours, filled in basic details of these households. In a random questionnaire administered by the study team, it was found that only in 15% of the households, people actually recalled having been visited.

When data were collated, these showed that four wards had been missed out during the campaign, comprising some 90,000 people. NLEP functionaries, from different parts of the district, covered this population at a later date (26 -29 November). Most of the wards where work had not been carried out in phase I were in the railway areas; state health services and the municipality services are generally not developed in the areas serviced by railways.

It was surprising that while so many people claimed that no visit had been made to their households, 44 cases were confirmed at the care and concern camps (CCCs), showing that the MLEC did have a strong impact, even if it was less than what was hoped. The PR for the month of November rose from below one to 2.5.



Active search for leprosy cases being done in a poor neighbourhood.

Chirmiri

Unlike Bilaspur where the district administration actively participated in the MLEC-III, the activities in Chirmiri were handled by the NLEP functionaries as in the past. As most of the population of this mining town depended on the hospitals and dispensaries operated by the South Eastern Coalfields Limited (SECL) for their medical needs, there was no inclination to assist the district health services with this activity. Additional challenges for the intervention included shift-based working hours and widespread alcoholism among mine workers.

In this context, Non-Medical Assistants (NMAs) and Non-Medical Supervisors (NMSs) managed to organize IEC activities and active case search. Forty survey teams of two persons each (one male, one female) comprising assistant teachers, *shiksha karmis*, National Service Scheme (NSS) volunteers and staff from the general health system (GHS), conducted a thorough search with the help of Auxilliary Nurse Midwives (ANMs) and Multi-purpose Workers (MPWs).

IEC activities in Chirmiri consisted of school rallies, *rath yatras*, roll strips on cable television broadcasts, *kala jathas* and announcements through audio cassettes at the local fair-cum-market (*meena bazaar*) and *Durga Puja pandals*. Banners, wall paintings and broadcasting at the local cinema hall were parts of the IEC activities. In addition, the NLEP co-opted the trade unions who agreed to print and distribute pamphlets to workers at various pay-points and entry points to the mining areas. The results of these efforts were that a total of 156 suspected cases were identified during the MLEC-III, of which 14 were finally confirmed as leprosy cases.

Experiences with the Voluntary Reporting Centre (VRC) approach

Khandwa

The NLEP staff, under the direction of an Assistant Surgeon at the Civil Hospital (acting District Leprosy Officer) carried out most of the work. The voluntary reporting system was not a very comfortable idea within the NLEP, as people did not believe patients would come for treatment based on IEC alone. However, a plan was made within the prescription of the GOI and the Government of Madhya Pradesh (GOMP) guidelines, but efforts were made to incorporate certain aspects of active search.

The work was initiated with a couple of school rallies. Simultaneously, training was conducted for doctors, ANMs and Lady Health Visitors (LHVs) of the general health services (GHSs) so that they could man the VRCs. NLEP functionaries were trained in the reporting systems. Volunteers from Nehru Yuva Kendra (NYK) were trained to manage one-to-one contacts and send suspected cases to the VRCs. All the training programmes were of one-day duration and people of different categories (MOs, ANMs and LHVs) were trained in a common session.

IEC activities spanned from 2-27 November but were intensified towards the end. In addition to the rallies, posters, hoardings, wall paintings, boards/banners on popular commercial establishments, slogans on bus shelters, strip rolls on cable TV broadcasts and audio propaganda, including the leprosy *rath*, were parts of the IEC activities. Clowns on stilts walked in front of the leprosy *rath* and talked to onlookers about the disease and its cure and informed them about the VRCs. As many as 13 information kiosks were set up at local *haats*. The local Lions' Club and Dena Bank donated 100 banners.

During the last two days volunteers from NYK stood on the main roads and in the markets. They interacted with people on an individual basis and directed suspected cases to the VRCs. When a need was felt they also knocked on the doors of households to search for patients. NYK volunteers used handbills for their search. In all, five cases were identified in a population of three lakh.

Sarni

Sarni turned out to be a less appropriate study site in terms of comparison, because an intensive and highly effective active search was conducted three months prior to MLEC-III. The district had received a budget for the special leprosy elimination campaign (LEC) in October 2000 for three urban areas. As the district was reeling under a severe outbreak of malaria at that point of time, health functionaries, including NLEP staff, were involved in the high-priority malaria prevention and control efforts. Therefore, after the rains, it was decided to use the LEC allocation for an active search in Sarni between 6 and 11 August 2001. The active search identified 32 new cases in a population of less than a lakh, increasing the PR to 5.4. Therefore, during the time of MLEC III, not a single new case was identified. Only

rudimentary IEC activities were undertaken just as a show off. Three VRCs were opened at the three large hospitals in the town. In spite of this low key IEC, 20 suspected cases turned up although none was confirmed.

Partners in the MLEC process

As in the past, the NLEP partnered with a number of government departments and non-governmental organizations for conducting MLEC. The partners varied from town to town. In Bilaspur, women volunteers were drawn from the AWWs of the ICDS and male volunteers from the Municipal Corporation and NSS. However, it turned out that the 'volunteers' had participated on the directives of their officers, who had issued orders based on the instruction of the District Collector.

In Chirmiri, the NMS and NMAs used their personal contacts to enrol volunteers who were mostly assistant teachers and *shiksha karmis*. The Block Medical Officer (BMO) helped to involve MPWs and LHVs. A common complaint among the organizers was that their seniors did nothing to co-opt the senior administration of SECL, which, according to them, would have made a big impact. A unique effort was made in terms of convincing trade union leaders to participate especially in motivating workers to co-operate with volunteers who came to search for leprosy cases.

In the VRC areas, the need for volunteers was limited. In Khandwa, Nehru Yuva Kendra volunteers were used for establishing one-to-one contact with the people. Apart from this, only donors such as Dena Bank and Lions' Club were co-opted. In Sarni, because no major activity was undertaken, only the three hospitals were actively involved.

Personnel involved and reach of services

The ratio of services to population varied significantly from town to town, e.g. the ratio of CCCs/VRCs to population varied from 1:16,000 in Khandwa to 1:36,000 in Sarni. In both the ASA areas, they were around 1:25-27,000.

The ratio of personnel to the quantum of work was also remarkably different. The number of households covered per team per day in Bilaspur was 192, while in Chirmiri it was 98.5.

Table 1: Personnel involved and reach of services in MLEC-III in the study areas

Heads	ASA		VRC	
	Bilaspur	Chirmiri	Khandwa	Sarni
Total population	2,43,958	82,640	2,20,762	1,07,852
No. of households	45,059	11,822	29,037	19,920
No. of teams	127	40	NA	NA
No. of days of h/hold. survey	6 + 4	3	NA	NA
No. of households per team	1,920	295.5	NA	NA
H/holds/team/day	192	98.5	NA	NA
No. of CCCs/VRCs	10	3	14	3
Avg. pop. per CCCs/VRCs	24,396	27,546	15,769	35,950
No. of days the CCCs/VRCs functioned	6	8	2	2

Source: Total Population and no. of Households: Census of India 2001
 No. of teams, no. of days of household survey, no. of CCCs/VRCs, no. of days the CCCs/VRCs functioned: NLEP office, Bilaspur, Chirmiri, Khandwa and Sarni

Training of personnel

About Rs. 49,000 were spent on training in the four towns. Volunteers were trained for the survey in the ASA areas. The volunteers were drawn from various organizations. For the VRC approach in Khandwa, volunteers were trained to guide cases although they did not necessarily go from door to door. Medical officers, ANMs and LHVs of the GHS were trained so that they could man the VRCs. NLEP functionaries along with some GHS personnel were trained in the reporting systems.

IEC activities undertaken during MLEC III

Posters, rallies, wall paintings and billboards were used in all the four areas. The leprosy rath (chariot), which had been fabricated using a NLEP vehicle, was another common feature. The vehicle had been decorated with banners and posters and a public address (PA) system fixed on it. These vehicles went round the district. Recorded audio messages were broadcast from autos, cycle-rickshaws and *tongas*. In all the four towns, broadcasts were made on popular cable television networks. Quizzes were organized in select government schools in three towns, except Khandwa. In the Active Search

Areas, leaflets on leprosy and its signs and symptoms were dropped in each household. In Bilaspur and Chirmiri, street plays/kala jathas were organized in public places. In Chirmiri, slides were shown in movie theatres during the shows. A very popular and eye-catching strategy was used in Khandwa, where an amiable-looking clown walked on stilts alongside the rath and talked to the bystanders about leprosy and MLEC.

Case-detection

Cases suspected, identified and confirmed

In the two ASA urban areas a significant number of cases was identified during MLEC III. Bilaspur produced 44 new cases in a population of three lakh whereas Chirmiri had 14 cases in a population of around one lakh. In Bilaspur, 387 suspected cases were identified during the active search, but only 276 (70%) of these came to the CCCs. In Chirmiri, only 27% turned up in the CCCs. In both these towns the data suggested that most of the remaining cases were checked at home, but subsequent investigations revealed otherwise. Follow-up of suspected persons who failed to turn up at the centres was done in Chirmiri, but not in Bilaspur. However, staff were reluctant to reveal the absence of follow-up in the official records and had therefore reported that follow-up had taken place. In the VRS areas, the number of new cases identified was low. In Sarni, the LEC conducted in the recent past resulted in no new cases being identified; in Khandwa, there were no such reasons for not identifying any new cases

Table 2: Cases identified and confirmed during MLEC III

No. of cases	ASA		VRC	
	Bilaspur	Chirmiri	Khandwa	Sarni
No. of suspected cases identified in ASA	387	156	NA	NA
No. of cases that came to VRC/CCC	276	41	121	20
Cases checked at homes	84	115	–	–
No. of cases confirmed	44	14	5	0

Source: Office of the DLOs, Bilaspur, Korea, Khandwa and Betul

Distribution of cases according to age and type of leprosy

An important result of the analysis was that in the ASA areas more female cases were identified, while the opposite was the case in the VRS areas. In Khandwa, all the identified cases were males, while in Bilaspur and Chirmiri more female than male cases were identified, both among adults and children.

Discussions with the volunteers and organizers revealed that women did not voluntarily come to the centres. Social constraints prevented them from giving priority to their personal health needs. In the family, it's the male who gets the first attention. However, with ASA the female suspected cases can also be identified. Once women come to know that they might be suffering from leprosy they are not hesitant to seek treatment, as this disease is often considered to be a threat to the current or prospective marriage.

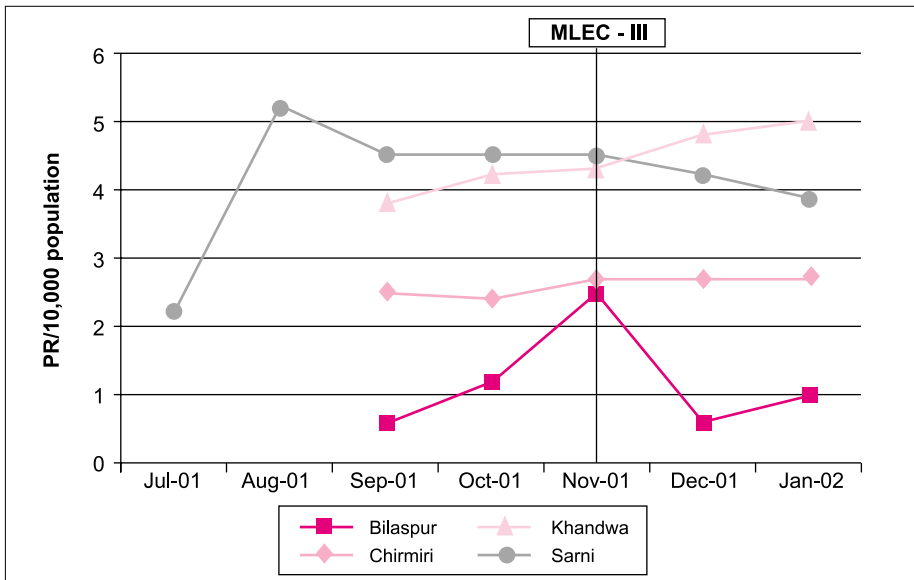
It can therefore be concluded that the one-to-one contact in the ASA helped to identify a number of women patients who otherwise had gone unnoticed both by the family as well as by the NLEP. In the VRS areas there was no special effort made to address the problem of women not coming forward for treatment.

Table 3: Distribution of cases according to age group and leprosy type

ASA	PB	MB	SSL	Total
Adult male	13	7	0	20
Adult female	24	3	0	27
Male child	2	0	0	2
Female child	8	1	0	9
VRC	PB	MB	SSL	Total
Adult male	3	0	1	4
Adult female	0	0	0	0
Male child	1	0	0	1
Female child	0	0	0	0

Source: Urban Leprosy Centres in Bilaspur, Chirmiri, Khandwa and Sarni.

Figure 2: Trends in case-detection rate



Source: NLEP Office, Bilaspur, Chirmiri, Khandwa and Sarni

Impact of MLEC III in case-detection

In Bilaspur and, to a lesser extent, in Chirmiri, a large number of cases were found during MLEC III (44 & 14 respectively). In Bilaspur, the PR increased to 2.5 from 1.2 in the previous month. In Khandwa, the PR increased to 4.2 from 3.8 immediately prior to the intervention. Sarni was an exception because of the LEC having been conducted in August, which had raised the PR significantly.

The impact of MLEC III in finding new cases can be said to be quite effective in the ASA areas. However, there is a need to evaluate these findings as there seems to be tremendous scope for improved case-detection.

Costs

Personnel/manpower, training and IEC

The total manpower cost was calculated at approximated rates. Opportunity costs were not considered. The honorarium that would be paid if the government had hired the services of the participating volunteers were calculated as a unit cost of Rs 35, with the exception of schoolchildren

@ Rs. 15. The unit costs were based on the remuneration paid by the NLEP on other similar assignments. A common rate was used for all four towns.

The IEC costs were met from four sources: directly by the state government; by the MLEC district funds; the ULC/Block funds; and through contributions. In the ASA areas a large proportion of the contribution for IEC came from the state government in the form of handbills and posters. In contrast, in the VRC areas the state's contribution for IEC was nil. Here, local contributions were significantly higher.

Two types of costs were calculated: 1) The financial cost or the cost to the government which covered the expenses incurred by the government (state, district or sub-district); it only accounted for the cash transacted by the government; and 2) the economic cost, which calculates the value of voluntary manpower and involvement of voluntary agencies, citizen groups or individuals, mostly in the form of IEC materials. It should be noted that the manpower costs were calculated on parallel government rates and not as opportunity costs.

Table 4: Total expenditure on MLEC III in the study areas (in Rs.)

Heads	Bilaspur	Chirmiri	Khandwa	Sarni
1. Training	34,500	12,700	1,800	0
2. IEC	593,300	192,233	49,610	8,450
a. State government	514,100	161,000	0	0
b. District budget	3,000	2,000	4,115	0
c. Town/Block budget	16,750	8,095	9,600	2,000
d. Local contribution	59,450	21,138	35,895	6,450
3. Manpower	134,654	23,770	79,581	4,553
Total Economic Cost (1+2+3)	762,454	228,703	130,991	13,003
Total Financial Cost (1+2a+2b+2c)	568,350	183,795	15,515	2,000

Cost per case detected

This section attempts to calculate the cost per case detected in the four towns.

Table 6 shows that for the government the cost of detection per case was apparently lower in the VRC areas. However, VRC produced significantly lesser cases than expected.

It should be noted that the difference between the financial and economic costs per case was not significant in the ASA areas (1.25 & 1.16), whereas in the VRC areas the difference was rather high (3.13). Comparing Bilaspur and Khandwa, and assuming that the relevant factors including the actual prevalence of leprosy were near equal for the two cities, these findings would suggest that the additional cases found in Bilaspur were more difficult and more expensive to detect. Hence, the comparison offers an indication of the required investment to detect hidden cases in an urban scenario.

Table 5: Cost per case detected

Costs	Bilaspur	Chirmiri	Khandwa	Sarni
A. Number of cases	44	14	5	0
B. Total cost	7,62,454	2,28,703	1,30,991	13,003
C. Actual cost	6,11,050	1,96,838	41,810	6,450
D. Economic cost per case (D/A)	17,329	16,336	26,198	NA
E. Financial cost per case (E/A)	13,888	14,060	8,362	NA
Ratio D:E	1.25	1.16	3.13	NA

Levels of knowledge

To assess and compare the levels of information about the signs and symptoms of leprosy, its treatment and curability and the availability of services, a questionnaire was administered to five per cent of the households in each of the four cities. The questionnaire survey was carried out in April 2002, i.e. five to six months after MLEC III. The time-lag would have resulted in a decreased recall. However, the analysis clearly revealed a poor ability to reproduce the information disseminated during MLEC III on leprosy, its causes, its cure, and about the campaign itself.

The curability of leprosy was best recalled in comparison to other categories. In Sarni 48% of the people interviewed considered leprosy as a curable disease. This was the highest score in the four cities and should be attributed partly to the intensive LEC campaign held in August 2001 by the NLEP, and partly to the fact that a majority of the town's population is educated and most people have access to television, radio and other mass media facilities. Similarly, Sarni also recorded a higher recall than the other three towns for the categories of knowledge regarding MDT and its availability. Respondents

from the other three towns also recalled these two categories better. Knowledge of the cause of leprosy was poor in all the four cities.

Assessment of the effectiveness of ASA and VRC approaches

The two approaches used in the two states had varying impact. Discussions with various individuals and organizations involved in MLEC III revealed that both the ASA and VRC approaches had advantages and disadvantages.

IEC

IEC was an important part of MLEC, both in the VRC and ASA areas. However, it was the backbone of the MLEC activities in the VRC areas. If we look at the comparative costs we can see that both the ASA areas had a higher per capita IEC cost.

For the sake of comparison, the cost of handbills that were distributed by the surveyors during the active search has been deleted from the IEC costs of the two Chhattisgarh towns. The costs of IEC per person were: Bilaspur: Rs. 0.39, Chirmiri: Rs. 0.47, Khandwa: Rs. 0.22 and Sarni: Rs. 0.08. While Sarni has to be disregarded for reasons discussed above, Khandwa was a telling example. In spite of being a VRC area, the per capita cost of IEC was half that of the ASA areas.

This could help us infer that the low rate of case-detection cannot be clearly blamed on the VRC approach, but also on the quality and quantity of IEC. Hence, the low case- detection rate matched the relatively low investment in the essential IEC component in the VRC campaign.

Both in the ASA and VRC areas, the IEC component held tremendous scope for innovation. In all the four study areas, it was noticed that the NLEP functionaries took the budget allocations as IEC guidelines. However, the need was to tailor the IEC to the local socio-economic conditions and field realities. Very few special attempts were made to address marginalized sections such as women and children. This could have been the result of the past experiences of earlier MLECs. Efforts need to be made to instil positive innovativeness in MLEC IV.

Capacity-building for VRC

IEC-based case-identification has been a success in a number of experiments outside of MLEC due to faith in the power of IEC as well as the capability of the system to handle this approach. In the VRC areas, NLEP functionaries showed very little faith in the success of MLEC based on IEC alone. While they all agreed that IEC was important and essential, they believed that without a door-to-door search, case-identification in large numbers was not possible. While the intervention on the one hand proved them right, on the other hand the poor result could be an outcome of the lack of enthusiasm, pointing to the need to work with a positive attitude and build capacity for effective IEC.

Gendered responses

The study pointed to a pronounced difference in the male/female patient ratio in the VRC and ASA areas. In Khandwa, not a single female patient was identified, whereas in both Chirmiri and Bilaspur the female new cases outnumbered the male new cases for both adults and children. Discussions with the volunteers and organizers in Khandwa revealed that women did not voluntarily come to the centres. This has to do with the social construction of gender, which prevents them from giving priority to their personal health needs.

While one cannot conclusively state that active search is better than VRC, special approaches need to be adopted in VRC areas to address the needs of potential women leprosy cases.

Partnering with other government departments

The MLEC III systems required a large amount of coordination and partnership with other government departments. In the ASA areas, the fact that no honorarium was paid to workers demanded partnership with the general administration. The experiences of NLEP functionaries were negative in this regard. They said that while they still had to do all the work, the leadership and decision-making had shifted away from their programme. This interrupted, hindered and slowed down the functioning of the programme. While the very nature of VRC, as the implementers understood it, minimized the need for constant partnership and coordination, this problem was clearly felt.



Conclusion: VRC or ASA?

The question that finally arises is whether to prefer ASA or VRC. While *prima facie* ASA generated many more cases, the study did not find any one approach to be the only or the perfect solution. Both the approaches had advantages and disadvantages.

One issue that strongly came out of the study was that the effectiveness of IEC cannot be decided on its quantum. IEC needs to be planned for and tailored to the needs of specific target groups (ward-, sex- and community-wise).

Local innovations need to be encouraged and precautions need to be taken that the budget allocations are not so detailed that district-level functionaries are forced to treat them as guidelines and instructions. In addition, capacity-building and attitudinal change for VRC needs to be focused on.

A mixture of the two approaches would be ideal. While ASA should be continued in high-prevalence urban areas, a mixture of the two should be taken up in the rest. In the latter, intensive and locally-grounded IEC should be supported with door-to-door initiatives in areas where the prevalence is high, such as poor neighbourhoods.

Design and Printing:

New Concept Information Systems Pvt. Ltd., New Delhi

Phone: 2697 2748, 2697 2811