

NLEP – Quality of services Indicators - Significance and Action required

The note on “NLEP – Monitoring and Evaluations tools for implementation of new paradigms during 11th plan period”, issued vide letter No. M.12014/9/2007-Lep. (Coordn.) dated : 27th November 2007 indicated the different groups of indicator to be used in the programme and how to calculate them. Two separate notes issued vide letters of even number dated : 7th November 2007 and 4th January 2008 gave details of the indicators like prevalence, prevalence rate, incidence and case detection rate, Disability, MB, Child proportion – their interpretation and epidemiological significance.

This note is on the “Quality of services indicators” to be used under NLEP, their significance and actions required. Main Quality of services indicators are :

1. Proportion of Defaulters.
2. Number of relapses reported during the year.
3. Proportion of New cases correctly diagnosed.
4. Proportion of cases with new disabilities.

I. Proportion of defaulters

Defaulters are leprosy patients under treatment who does not complete the treatment within the specified period of 6 BCP in 9 months by PB and 12 BCP in 18 months by MB cases. The programme has specified that instead of waiting for 9 months or 18 months, cases under treatment should be followed up regularly so that the number of such defaulters remains at the lowest level. However, there may be many reasons for which patient may default from treatment, such reasons may be death, leaving the area, negligence, non – availability of the drugs in time etc.

As some of the reasons can be taken care of by the programme, the programme should find out the rate of defaulters and the reasons thereof. The Treatment Completion Rate (TCR) is now being assessed annually, through which the defaulter rates can also be calculated.

The indicator is to be calculated as below :

$$\% \text{ defaulters} = \frac{\text{Number of cases defaulted from taking treatment} \times 100}{\text{Number of cases started treatment during the year}}$$

In the same way defaulter rate for MB, PB, Male, Female, Rural and urban areas can be worked out.

How to ascertain the reasons of defaulting ?

This will be possible to be worked out during the TCR assessment itself if the reason for patients default is recorded by the PHC in the Treatment register. As a first step, the state leprosy officers should send instructions to the Medical Officers to ascertain and record reasons for defaulting by each patient routinely.

Alternatively, after treatment completion rate is calculated, the PHC staff have to trace and visit the defaulters and ascertain the reasons. They may not be able to meet the migrants and therefore will be a difficult exercise. So first option should be followed from the current year.

Action required :

Once the reason for defaulting by leprosy patients are ascertained, corrective action can be taken by the PHC/Urban Health Centre to minimize the problem. The District Leprosy Officer would therefore analyze the report from each PHC/Urban Health Centres and give necessary instructions for reducing the number of defaulters. Services of ASHA under NRHM may be suitably utilized for completion of treatment in any group where defaulting is expected.

II. Number of Relapses

A relapse case of leprosy is defined as the re – occurrence of the disease at any time after the completion of a full course of treatment. It is difficult to be certain that a relapse has occurred, as new lesions may appear in leprosy reactions also. The final diagnosis of relapse cases is therefore to be made by the Dermatologist at secondary level, where facilities for smear examination also exist.

How to collect the data ?

Relapse cases occur sporadically and are generally not part of any defined cohort, so these figures are difficult to analyze. Under the DPMR plan, suspected relapse cases are to be reported by the primary level institutions and confirmed relapsed cases are to be reported by the secondary level institutions. Thus the District Leprosy Office will have the record of number of relapse cases recorded (MB and PB) in each district during the year.

Action required :

The State Leprosy Office will have to analyze the data from each district. If any particular area shows high number of relapse cases, further investigation must be carried out, with the help of experts in the field from the Medical Colleges / Leprosy institutions.

III. Proportion of New cases correctly diagnosed

Providing quality leprosy services is the key component of the New Paradigms in NLEP. Correct diagnosis of each leprosy patient is the highest criteria for best quality services. While a non – leprosy patient being diagnosed and labeled as suffering from leprosy is very cruel to the person and the family, missing the correct diagnosis of a person suffering from leprosy is equally injurious to the person. Such failure to diagnose in time may lead to complications and disability which cannot be excused. The programme therefore emphasized on the regular assessment of the capacity of the programme components to diagnose leprosy cases correctly.

How to calculate the Indicator ?

The correctness of diagnosis should be assessed through regular supervision by the District Nucleus component. If there is any suggestion of significant over diagnosis, a sample of the new cases should be validated within three months of the diagnosis being made.

The indicator should be calculated as below :

$$\text{\% of New cases correctly diagnosed} = \frac{\text{No. of correctly diagnosed} \times 100}{\text{No. of New cases validated}}$$

How to collect the data ?

The district nucleus team should maintain PHC wise data on case validation carried out by them and send the information in their monthly report to the District Leprosy Officer in the prescribed format sent from the CLD.

The DLO would compile the PHC wise information six monthly / annually and work out the indicator as above for each PHC.

Action required

The DLO have to identify the persons involved for wrong diagnosis and arrange for their additional training and skill development. Continuous supervision will have to be ensured.

IV. Proportion of cases with new disabilities

Under the DPMR plan early detection of reaction and nerve involvement and their proper management has been given priority. In addition to adequate management of such case at the primary level and timely referral to the Secondary / Tertiary level institutions have been emphasized. Once implemented properly, cases developing complication and additional disability during the course of treatment should get minimized.

How to get the data ?

At present the programme does not have any system to know how many cases under treatment develop such disability during or after treatment. Under the DPMR plan all such cases, who develop new or additional disability are to be recorded and reported through the monthly progress reports.

The district leprosy officer to compile all such information for the district, PHC/urban area wise and work out the indicator annually.

How to calculate ?

The indicator should be calculated as below :

$$\% \text{ cases with disabilities} = \frac{\text{No. of cases developed new disability} \times 100}{\text{No. of cases put under MDT during the year}}$$

Action required :

Since the indicator gives feedback on service quality and referral services, PHC wise / urban area wise calculation of indicator will be very useful for taking remedial action.