Reviewer’s report

Title: The spatial distribution of leprosy cases during 15 years in a leprosy control program in Bangladesh, an observational study

Version: 1 Date: 7 May 2008

Reviewer: Aparna Pandey

Reviewer’s report:

Comments on the article entitled “The spatial Distribution of leprosy cases during 15 years in a leprosy control programme in Bangladesh: An Observational Study by Fischer EAJ et al sent for review

Abstract

- Under Background information as mentioned the study aims to identify spatial pattern of leprosy occurrence whereas in the Result they have reported occurrence of spatial temporal clusters. The aim needs to be clear from the beginning.

- What do authors mean by geographical risk factors? Does it mean environmental factors? Needs to be specified

- The term proximity to town is very vague? What does it really mean and how it is measured? Is it distance from the center of town or particular point? It needs to be defined precisely

Background

- Most of the literature quoted indicated geographic difference due to difference in socioeconomic conditions of host. The cases are more from the areas with prevailing poor socio-economic conditions It’s a well-known fact at the leprosy is a disease of Poverty. Then what are new authors want to tell.

- Proximity to water may have different meaning in district of Malawi than in a locality of Bangladesh where environment in general is humid. It’s doesn’t carry much meaning.

- Difference in accessibility of health care has also been reported as a factor. Authors have mentioned it’s never been reported. This type of statement to be better avoided. To my knowledge there is no dearth of literature to show relation between accessibility and utilization of health care

Material and Methods

- Not clearly written, hence it’s quite confusing. For example in the sub section study design authors have given a description of area, methodology and analysis. Hence there is repetition of same text in the sub sections of Study area and Statistical analysis. Rather it would have been enough to precisely mention the
study design in one sentence, some thing like retrospective cohort with a follow up component.

· There needs to be separate head for Data retrieval clearly mentioning the actual methodology followed. Similarly tracing of the cases by follow up should have been described separately.

· What do authors mean by sentences like there is more concentration on voluntary reported cases whereas in analysis section it is mentioned that they have tested for clustering of each mode of reporting separately. Moreover more than 50 % of the cases included have been detected by active means i.e. contact tracing, school survey, village survey etc.

· What I have understood the cases have been identified from the Leprosy Clinic records of DBLM were traced back, were plotted on GIS see the clustering. However the authors have written it in very vague and confusing manner, Hence I advise to rewrite the methodology

Results

Tables are not clear. Titles are not clear. eg. Table 1 tile is shows the cluster characteristics and leprosy situation. Similarly in Table 2 also Title4 is unduly long. Why mode of detection is mentioned when authors have depicted only voluntary reported cases. Time periods are also not uniform.

Discussion

Nothing is explained properly

Explanations given for temporal associations are very confusing. Why increased awareness is restricted to one particular period? Was an IEC campaign undertaken during that time?

Higher proportion of MB cases among missing cases also needs explanation

Concentration of leprosy cases in or near urban area is not a new phenomenon. Migratory patients also play role in it. Now urban leprosy control is posing much greater problem in India too.

Authors should reanalyse the cases and look for rural urban/ peri-urban differences. This will help in drawing attention of the programme planners for mobilising the resources more effectively