UPDATE
CONTINUING MEDICAL EDUCATION
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Whither integration?

Years ago when a programme for leprosy control was launched it was not uncommon to expect the common public conjuring up in their minds images of disfigurement and disability whenever the name leprosy was mentioned. Crowds of persons with physical disadvantage due to leprosy used to be found in and around public places which gave credence to the negative image of leprosy. This wrong perception led to stigma that discriminated against the persons affected by the disease. The consequence was that people with leprosy rarely went to health facilities on their own for diagnosis and management. This necessitated the introduction of a programme with vertical staff who would literally search for cases through house-to-house survey and bring them up for treatment. In spite of the availability of effective technology in the form of MDT, because of limited coverage the impact was far less than expected. The only way of improving coverage of MDT service including awareness generation was by making leprosy control a part of the general health service strategy or combining it with other related programme(s). In India, the decision to integrate leprosy into general health was taken about 5 years back. The intention was to transform leprosy control from the programme of the few to the few, to the programme of the many to all.

PHC in Vaishali district (Bihar)

The first experiment at integration was done in Tamil Nadu in 1997.An intense campaign of awareness generation, training of the staff and case detection prepared the general health service staff and the community. This model has been adapted by several states. The programme in Tamil Nadu had to face several hiccups: the vertical staff were reluctant to hand over leprosy control on a platter to the general health staff especially in urban areas; since they were not trained they could not be used for other programmes; and cadre difference brought in its own administrative indeterminateness. Some of these problems persist even now. The vertical staff is still visible unlike in Karnataka where they have disappeared into general health system. In Andhra Pradesh integration is still a nonstarter. It has succeeded to a large extent in states like Bihar for several reasons. None of the districts initially designated as endemic had a full complement of regular vertical staff. The districts had to fill the gaps with contractual staff. In initially low endemic districts the few staff who were involved in leprosy control programme were again contractual appointees. It was therefore not difficult for the Government to phase them out. The districts had the advantage of the presence of District Technical Support teams (DTSTs) that had been placed by ILEP. They played a crucial role in building the competence of the general health staff.

Overall, the situation is that integration, even though it is at varying stages of development in different states, has become an established fact. Programme managers have become acutely aware of the advantages of involving the general health in leprosy control.

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Several factors have enabled the accomplishment of the objective - effective technology in the form of MDT, prioritisation of activities, simplification of procedures including information system, flexibility in delivery of MDT and support from and effective collaboration between major partners. Yet several problems remain. They need to be addressed to render the system more responsive to the needs. The OPD attendance in a PHC in Bihar is only 20 to 30 as compared to 200 in a PHC covering 25000 population in Tamil Nadu. Because general drugs in general are in short supply. In the absence of active case detection (I am not advocating Surveys!) it is hard to expect people to report voluntarily. Case detection will go down dramatically (This's what has happened). We assume that leprosy is on the decline. It may not represent the actual situation. The purpose of integration will be lost if people do not have confidence in health system and therefore are reluctant to report to health facilities.

In almost all the states except in Karnataka integration has been only functional. Structural integration is far from real. For example in Bihar (in other states too), in each PHC in districts initially classified as endemic there are 5 to 6 paramedical workers and a Supervisor. Each worker attends the PHC one day a week and the rest of week he is supposed to do IEC. It is not surprising to learn that as many as 80% of the newly detected cases are referred by ANMs! The leprosy workers rarely participate in other programmes. Well-trained workforce is not used effectively. Integration does not mean making the general health staff involve in leprosy programme, it also means making the vertical staff participate in other programmes. This task has to be taken up on a priority basis. On the one hand, the trained vertical staff from leprosy control are not being used by leprosy or other programmes, on the other, programmes like TB control are appointing staff on contractual basis!

While there is integration of diagnostic and treatment service, other activities like management of complications and training need to become part of general health service. This needs identification of service points and their capacity building. Management of cases with disability should not remain the prerogative of NGOs.

Another question that needs to be answered is up to what level integration should be accomplished? Should we have specific or integrated programme officers at the district level? One has to weigh the advantages and benefits to the community and take recourse to appropriate action. Integrated epidemiological surveillance is another important need. Sentinel epidemiological surveillance centres could be established for every region consisting of 6 to 8 districts to monitor the progress in the implementation of major communicable diseases

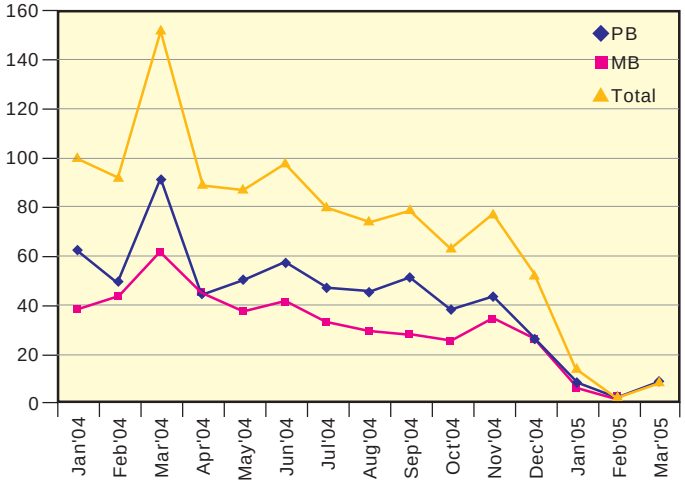
In an integrated system intense engagement of the community is essential to enable them to function as change agents and to create a demand for effective, easily accessible MDT service. The vertical programme could not achieve this. Do the general health staff have the capacity to do this? It is worth having a specialist in every district to disseminate adequate information on all important public health programmes to the community and encourage and engage their involvement as an important stakeholder.

Leprosy is no longer a dreadful or dreaded disease. Lot of changes have occurred, mostly for the better. One should not forget that even though the image of the programme has changed with the change in the image of leprosy, a lot more needs to be done to make the change sustainable and long lasting.

Elimination or eradication?

Elimination is a laudable and achievable milestone. It has brought in political commitment and resulted in the detection and cure of millions of persons affected with the disease. But one should ensure that the target does not become more important than effective, universal MDT coverage. The following example illustrates the overemphasis on accomplishment of target. The number of new cases detected in Anantapur district of Andhra Pradesh from 2001 to 2004 was 2637, 2182, 1575 and 1043 respectively. About 70% of the cases were PB.

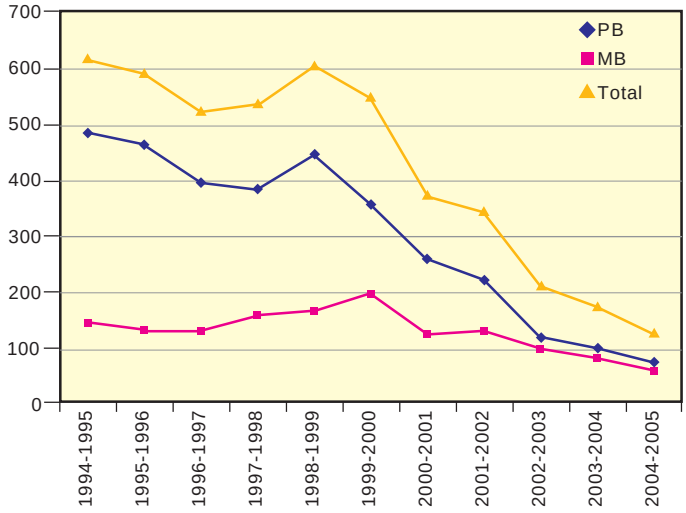
Case detection month-wise from January 2004 to March 2005 in Anantapur district



The sudden drastic fall in new case detection from January 2005 (14, 3, and 9 in January, February and March respectively) could be due to cessation of case detection or registration. The district like other districts in Andhra Pradesh is still to integrate leprosy. Till December 2004 the vertical staff through rapid enquiry survey detected cases. Very few cases reported voluntarily. Participation of the general health staff in leprosy programme has been less than optimal. Validation of cases by the District technical support team in 2004 revealed that 30% of the cases were wrongly diagnosed, reregistered, or non-existent. In 2004 on an average 80 new cases were detected. Even if one takes the figure for December (52) as the average new cases, in January there should have been 35 new cases or at least 20 MB cases. Only 14 cases were actually detected. It could mean that there are no cases of leprosy, which cannot be the case, or most of the cases were detected by surveys before and voluntary reporting contributed very little to new cases. At this rate the district will be able to eradicate leprosy by the end of 2005! As somebody said "You give the public health programme any target, it would be realized!"

The situation in Anantapur could be compared to that in Tumkur district in Karnataka which achieved elimination in 2000 itself. The prevalence in Tumkur in 1994-1995 was 1.77 and it came down to 0.76 in 2000-2001. It was 0.37 in March 2005.

New case detection (MB,PB, Total) from 1994-2005 in Tumkur district



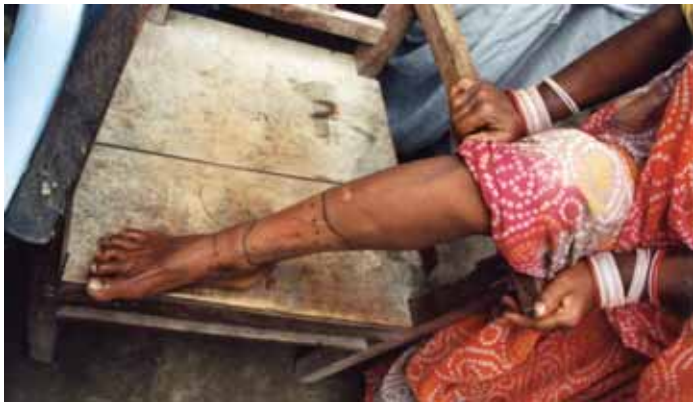
The district stopped active case detection in 2002 when leprosy was integrated into general health. The new cases detected from 2001 to 2004 were 371, 340, 208, 170 and 121. About 45% of the cases were MB. One does not see drastic reduction in new cases as in Anantapur.

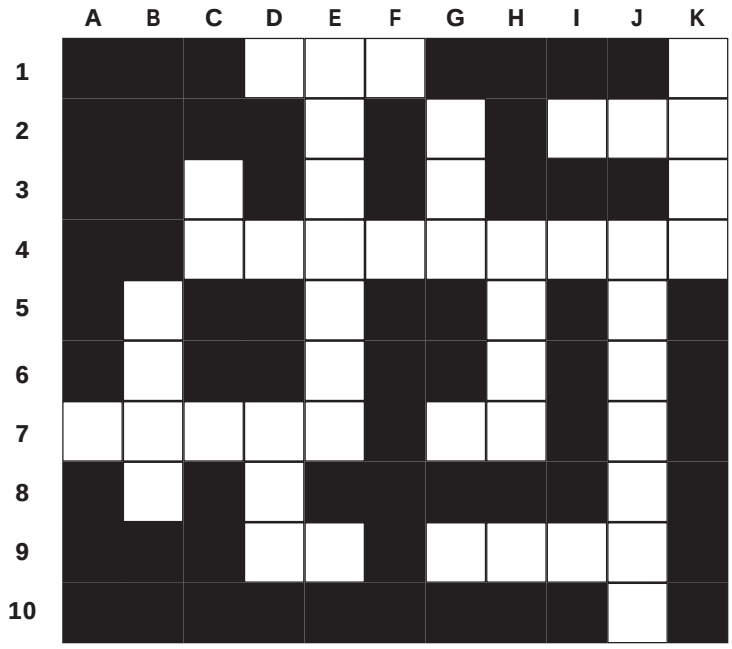
The results in Anantapur district do not have any scientific basis but they would have an enormous consequence on the programme. "One should remember that fractions are no more important than patients and behind every number there is a patient live with feelings". Persistence with a weakly functioning vertical system with a lackadaisical attitude and negligible voluntary reporting of cases (consequence of noninvolvement of the general health staff) will have an unsavoury effect. The state of Andhra Pradesh decided to eliminate leprosy by March 2005. You can draw your own conclusion.

Tattoo to stop leprosy !

It is interesting to note that in north Bihar one often finds people with tattoo marks on their body, which on careful scrutiny show that they are made along the border of a hypo-pigmented patch with sensory deficit.

The belief is that by placing the tattoo along the border of leprosy patch it acts like a 'barrier' preventing its spread. One can see the tattoo mark on the leg of the lady in the picture.





CROSSWORD - T1 (TB)

ACROSS:

1D What you see under microscope
2I Die Hard
4C Related to lung
7A Goes with smear
7G Too much to change
9D Some more before you stop
9G Can't stop with out

DOWN:

B5 Ensures good microscopy
C3 Outside lung
D7 Nodal point for TB control
E1 Beyond redemption
G2 Nodal person in TB control
H4 Replaced by RNTCP
K1 Most used tool but less effective
J4 I am back

"Where there is skill, there is a way"

Dr.Rajeswari, a school health medical officer, was one among the Medical Officers who was trained in NLEP by the NGO project (Poorna Sukha Leprosy Project) in Dindigul. In one of her routine health camps in a school, she came across a boy with loss of eyebrows and shiny skin (infiltration) all over the body. He did not have any anaesthetic patch. She found that both the Radial cutaneous nerves were thickened.

Diagnosis of lepromatous leprosy is not easy even by experienced medical staff. But in this case the Medical Officer of General Health could diagnose the disease correctly and institute proper treatment promptly.

ERRATA

The following text in Page no. 7, January 2005 issue of Update should be read as follows.

4. How do you manage this episode?

This patient has few nodules with mild tenderness. Treat the underlying cause. Symptomatic treatment is recommended if needed.

Summary

NO cause is found in 60% of cases
Drug (iodides, bromides, sulfonamides)
Oral contraceptives
Sarcoidosis or Löfgren's syndrome
Ulcerative colitis, Crohn's disease, Behçet's syndrome
Microbiology: any chronic infection (bacterial, viral, yersinia, tuberculosis, leprosy, deep fungal)

ANSWER TO CROSSWORD - L1 (Jan. 2005 Issue)

TB CONTROL PROGRAMME

'Why's in Tuberculosis Control Programme

Why some TB patients do not take treatment regularly?

REASONS	ACTION REQUIRED
Patient is not aware of • Consequences of untreated Tuberculosis • Duration of treatment • Frequency of doses • Importance of supervision (DOT) • Consequences of irregular treatment • Common side effects: Abdominal discomfort, giddiness • Other side effects • Procedures of follow-up sputum examination • Purpose of follow-up sputum examination • Relief within two months of treatment is temporary	• Adequate counseling of patient • Allot adequate time. • Cover all the important points. • Ensure that patient has understood. • Repeat counseling – at end of IP, second month of CP
DOT provider is not convenient to patient. DOT provider is not suitable.	• Select new DOT provider • On the job training to PHC staff on selecting DOT provider.
Lack of faith on government drugs	• Explain to patient that good quality drugs are supplied in RNTCP.
Delay in starting IP	• Training of PHC staff • Rectify problems in communication from MC to health facility, from health facility to field worker. • Ensure drug supply.
Delay in starting CP	• Ensure timely follow-up examination. • Ensure timely drug supply (whole drug box should be supplied to DOT provider when a TB patient is started on treatment).
Supportive treatment not available at health facility	• Feedback by STS to Medical Officer. • On the job counseling of Medical Officer during supervisory visits by MOTC, DTO.
Follow-up sputum examination inconvenient	• Patient has to visit MC to collect sputum cups and bring sputum specimen on the next day. If sputum cups are provided along with medicine box, follow-up (two sputum samples) examinations can be completed on one visit to MC.
Lack of knowledge of DOT provider	• Adequate counseling of DOT provider.
Lack of supervision by health staff	• On the job counseling of health staff during supervisory visits by MO-PHC, MOTC, DTO. • Review of RNTCP in monthly meetings at PHC.
Loss of wages	• It is possible to organise support from community leaders during IP. Most of the patients improve and start normal activities supporting themselves.
Lack of support from family	• Counseling of family members indicating their role in curing the patients.

How to prevent damage to microscope due to fungus?

- Hot, humid climate is perfect for the growth of fungus.
- Usually the lens, eyepiece and the prism are the parts that are affected by the fungus.
- In early stage it is the fungus that actually forms a layer over the lens/eyepiece/prism. At this stage it is not difficult to remove it. But if left like that the chemical secreted by the fungus eats into the lens and damages it. At this stage the parts are beyond salvage.

How can we prevent this from happening?

- While buying the microscope select the one with antifungus-coated lens.
- Keep the microscope away from water source (wash basin/ water sink, etc)
- Everyday before starting to use and at the end clean the lens with lens paper. Never use xylene to clean the lens. Through capillary action it gets absorbed into the gaps between the layers of the lens and damages it.
- At the end of the day keep the microscope in the cupboard with an electric bulb to keep it warm. Or keep some silica gel in a shallow plate near the base of the microscope. Remember that silica gel needs to be activated every day especially in humid environment. This can be done by warming it over a hot pan or keeping it in sunlight for about 6 hours. If there is no bulb or silica gel don't keep the microscope in a wooden box. Wood absorbs moisture and does not give it up easily. It provides the right environment for fungal growth. You can cover the microscope with plastic cover.

To serve with love.....

Mrs.Anandaselvi is an unemployed graduate, and an active member of the self-help women's group in Dindigul town. Her child was treated for leprosy and cured. She volunteered herself to be a DOT provider for a TB patient in her locality. She was trained in RNTCP and successfully administered the drugs with commitment and care to the patient. She also took active interest in the RNTCP activities. She referred four TB suspects for sputum examination and personally brought a TB suspect to the hospital for consultation. On sputum examination three among five suspects referred by her were found to be positive. She volunteered to be DOTS provider for them also. She ensures regularity in drug consumption by the patients. Mrs.Anandaselvi deserves appreciation for her determination to serve the society and help in the fight against TB.

Why do we do follow-up sputum examination for TB cases?

1. End of Intensive phase:

- Verify significant reduction in the bacilli
- Identify patients at high risk of failure
- Helps in the decision on extension of intensive phase
- Helps in evaluating the quality of sputum examination
- Indicates quality of patient monitoring during the intensive phase

2. In the middle of Continuation phase:

- To check patient evolution
- To detect possible failure

3. At the end of Continuation phase:

- To verify cure

NERVE FUNCTION ASSESSMENT

Voluntary Muscle Testing (For illustrations see page 7 & 8)

Voluntary Muscle Testing (VMT) : Why ?

Disabilities in leprosy patients can occur as a result of damage to nerves resulting in impairments of sensory, motor and autonomic functions, leading to loss of sensation and paralysis of muscles of eyes and extremities.

The nerves may be painful, thickened and tender before the impairment has set-in. Sometimes the nerves may feel normal (not thickened, not tender) even though there is sensory impairment and weakness in the muscles supplied by major nerves (silent neuritis). Voluntary Muscle Testing (VMT) helps in assessing the extent of nerve damage and resultant motor dysfunction. It is commonly used to assess the damage to ulnar, median, facial and lateral popleteal nerves.

Periodic VMT is essential after starting Prednisolone for neuritis. This is to assess the improvement after starting the drug and helps in management of neuritis by changing the dose and its final withdrawal.

How is Voluntary Muscle Testing (VMT) done?

Voluntary muscle testing is done by first checking the range of movement to see whether movement is normal, reduced or absent due to paralysis. If movement is normal, test against resistance. Press gently in the opposite direction while asking the patient to maintain test position, resisting pressure as strongly as possible. Then gradually press more firmly and judge whether resistance is normal, reduced or absent. The grading of the result can be done as follows:

S (Strong)	=	Able to perform the movement against full resistance
W (Weak)	=	Able to perform the movement but not against full resistance
P (Paralysed)	=	Not able to perform the movement at all.

VMT for Ulnar Nerve

Ask the patient to push his little finger out in the same plane as palm (FIG. 1A).

To test for weakness, push the little finger towards the hand while the patient tries to hold it in the test position(FIG. 1B).

The pressure should be applied at the base of little finger. Grade the muscle power as 'S', 'W' or 'P'. (Strong, Weak, Paralysed)

FIG.1A

FIG.1B

VMT for Median Nerve

Ask the patient to hold his thumb at right angle to the palm(FIG. 2A).

To test for weakness, push the thumb towards index finger while the patient tries to hold it in the test position (FIG. 2B).

The pressure should be applied at the base of thumb. Grade the muscle power as 'S', 'W', or 'P'. (Strong, Weak, Paralysed)

FIG.2A

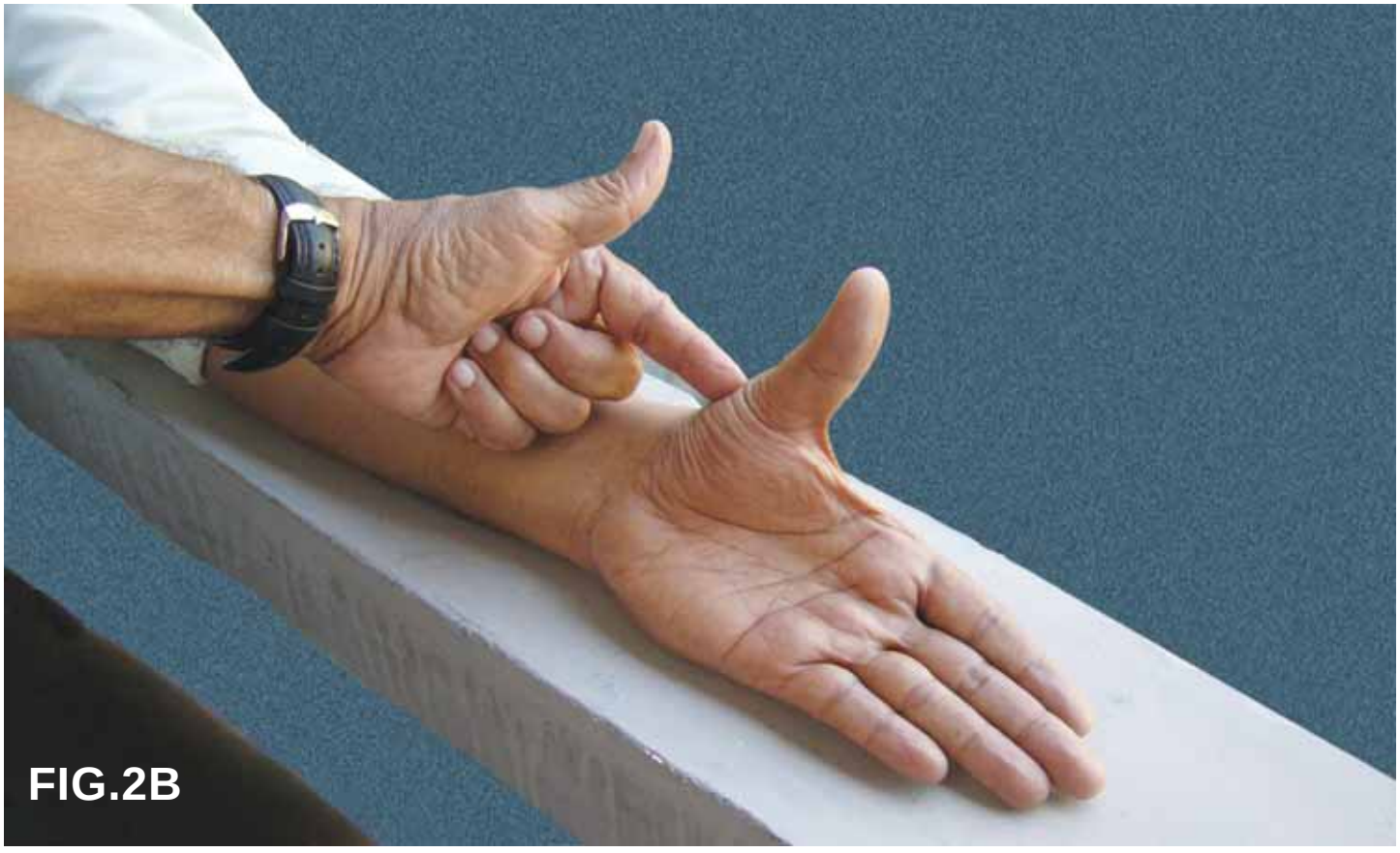


FIG.2B