

UPDATE

CONTINUING MEDICAL EDUCATION

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POD REVISITED

Leprosy is regarded as a serious public health problem mainly because of the disabilities it produces in some of those affected with it. It is, therefore, regrettable that very little attention has been given to one of the principle facets of leprosy control, prevention of disability. Every year about 1000 to 5000 new cases with disability are detected in India. The numbers can at best be conservative since there may be considerable underreporting of disability in some areas. The country is estimated to have one million patients with leprosy-related disabilities. Even if it is an overestimation, as suggested by some, the number would not by any means be small. It is unfortunate that the leprosy-disabled are neglected by themselves, ignored by their families and forgotten by the programme.

Till recently leprosy control was run by personnel meant exclusively for it. In a vertical programme with limited priorities, prevention of disability was restricted mostly to early detection and treatment of simple leprosy cases and those with reaction. Occasional distribution



of bandage, cotton and antiseptic cream was the 'POD activity' carried out by the leprosy control staff at the so-called mobile MDT clinics. Temporary hospitalisation wards established to address specially the disability problem succeeded in providing only temporary respite to a few patients. Management of persons with complications including disabilities related to the disease was, therefore, confined largely to specialised institutions mostly run by Non Governmental Organisations (NGO). Since the number of such institutions was limited, coverage of patients requiring

special attention remained a niggling problem. The number of patients with disability presenting themselves at the clinics was so many that leprosy continued to be regarded as a disease that produced horrifying disability and suffering. This negative image contributed to stigma and discrimination.

Leprosy disease burden has come down thanks to the efforts of thousands of health workers. Transition from focused action by the vertical programme to intensified extension of MDT service coverage through the involvement of the General health service has been smooth and has contributed to a large extent to the present leprosy situation. While integration has brought in rich dividends it has also brought into focus unsolved problems in leprosy control.

With integration there is a propensity again for the programme to lay emphasis on diagnosis and treatment rather than extending holistic service to the people in need. One tends to hear increasingly the argument that since integration is not yet mature one should not burden the general health staff with too many responsibilities which otherwise will impede them from participating in basic activities. Prioritisation based on established levels of competence and on compulsion of reaching the predetermined target is understandable but this in no way should deter us from looking at benefits from the individual patient's point of view. A programme which is more than 50 years old should be able to provide a broad spectrum of service that caters to patients with different set of problems. There should be no room for excuses like, "They are not well-equipped to

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“It is unfortunate that the leprosy-disabled are neglected by themselves, ignored by their families and forgotten by the programme.”

deal with consequence of leprosy”, “It is not a priority”, “It is difficult to implement.”

Prevention of disability should start with early diagnosis and prompt treatment of incident cases. It has been three years since integrated leprosy service delivery was initiated. After several campaigns and training sessions, both formal and informal, general health staff appear to be competent enough to manage leprosy. But management of complications including reactions and disabilities is far from

satisfactory. This is because of two reasons: the staff may not be competent to manage complications and a back up referral system with centres to manage patients with different problems is not yet established. There are reports of patients with complications getting no treatment or getting treatment which is far from what is minimally acceptable and expected. Chronic or recurrent reactions which are due mainly to mismanagement of cases are becoming increasingly common. Since about 15% of MB cases and 2% of PB cases are likely to get reaction there should be a mechanism in place whereby these patients are identified timely and treated promptly to avoid the development of deformities. Every Medical Officer in the general health should be able to identify reaction but the treatment of reaction cases, depending on competence, may be the prerogative of the Medical Officer or referral foci within the district identified for this purpose. The referral centre may be the district hospital or sub-district hospital or NGO project.

What do we do for patients already with deformities? The principal aim is to ensure that the deformity does not deteriorate or it is as much limited as possible. Also the possibility of reversing the deformity through reconstructive surgery should be explored. For the first group of patients what is required is self care under the guidance of health worker. Properly trained health worker will be able to provide the necessary guidance and counseling to patients with deformity so that they are able to take care of their disabilities. Since in a district each health worker may hardly have one to 5 cases with deformity it is not difficult for the worker to take up this task. The patient can be monitored and provided guidance during the routine village visits at least once a month. District hospital could be trained to manage complicated ulcers including septic surgery. Experience suggests that these things can be done better with the involvement of an NGO as a facilitator. Trichy and Salem districts in Tamil Nadu are standing examples of excellent collaboration between Government and NGO project which has resulted in the basic health workers in 20 PHCs in Trichy and 30 in Salem taking up POD activity seriously and implementing prevention of disability in their areas on their own (This will be extended to the remaining PHCs also so that by the end of 2006 all the PHCs in these two districts will be fully implementing POD).

Each district in the country may have an average of 500 persons with leprosy-related disability (it may vary from 100 to 3000). At least 20% of them will be eligible for correction of their deformity. Since majority of tertiary care centres are confined to the South, coverage is a serious problem. It is unfortunate that no major hospital at the state headquarters has taken up this responsibility. There are very few Government Institutions which are catering to the important segment of the community. Under the circumstance the establishment of reconstructive surgery service for

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leprosy-affected persons at Medical College hospital in Patna and Dharbhanga in Bihar through the coordinated effort of Government and Damien Foundation India Trust (DFIT) is indeed a laudable initiative. Surgeons and physiotherapists in these two centres were identified by the Government and trained by the visiting surgeon and physiotherapist from Damien Foundation India Trust. A set of surgical instruments was provided. Cases requiring surgery were continuously fed by the District Technical Support Team through the District Leprosy Officer. Following 3 to 4 supervisory training visits by the visiting surgeon and physiotherapist the staff in the two centres are able to manage patients on their own. Effort should be made to establish at least one such centre in every State preferably in a Government institution for the sake of sustainability. This is possible only if NGOs play the most important role of facilitators rather than implementers. A network of tertiary care centres run by Government or NGO across the country would fulfill the needs of hundreds of leprosy patients with correctable deformities.

“The aim of leprosy control should be the reduction not only of disease burden but of disability burden too.”

Finally, all the health facilities in the State should be provided with the list of referral centres managing reactions or disabilities or reconstructive surgery so that patients needing specialised care could be referred to these centres for effective management.

The aim of leprosy control should be the reduction not only of disease burden but of disability burden too. This will have a positive consequence on the perception of the disease by the community and improve the possibility of their active participation in the programme.

Village Health Nurses bring meaning to leprosy affected

Holy Family Hansenorium (HFH) project which is located in Fathimanagar, a village about 18 Kms from Trichy town in Tamil Nadu, has been providing service to leprosy-affected for the past five decades. The activities of the project related to Leprosy and TB control are supported by Damien Foundation India Trust (DFIT). From Survey Education Treatment (SET) activities implemented in a field area allotted by the Government with hospital back-up support through a large workforce of unipurpose workers to a programme, with limited staff, of supporting and strengthening the Government programme following integration the journey for the project has been exciting and gratifying. It has helped the Government in Trichy district to establish Prevention of disability (POD) care services. How the project has succeeded in accomplishing this is an interesting story worth sharing.

The project adapted the two adjacent districts-Trichy and Pudukottai. The project first had a discussion with the District Leprosy Officer (DLO) and sought permission to facilitate POD in the district. The intentions of the project were not clear to the Government staff- they thought that the project was interested in taking over leprosy control activities in the district. The field staff from HFH had to overcome initially the suspicion in the minds of the vertical staff who were still possessive about the programme and reluctance on the part of the General health staff to take up 'additional responsibility'. Persistence paid off. The project was asked to train the staff for implementing POD as per Government of India (GOI) guideline. The Medical officers and former leprosy staff were trained.





In spite of that POD was not implemented in the districts. Then the project with permission from the District Health Officer identified one block in each district to facilitate the introduction of POD. The key field staff of the HFH then met the staff of each Primary Health Centre (PHC) and discussed with them the possibility of introducing the POD component in their field area. List of cases treated before integration was not available. Initial list of cases who had been managed by the HFH before integration was handed over to the PHCs. Patients with disability were identified from the list by the Village Health Nurses (VHN) accompanied by the project field worker. Training (2003) was arranged first at the PHC and then at each Subcentre. All the Medical Officers were trained to manage leprosy and its complications. All the health workers were trained to recognise and refer reactions and manage patients with disability. The field staff from HFH demonstrated the benefits of selfcare to the patients and workers. Monthly combined field visits by the VHN and project worker was arranged. Gradually the VHNs were convinced about the immense benefits in the intervention. After 3 to 5 months of combined field visits, on-the-job training and guidance the VHNs were happy enough to carry out the activity on their own. When the VHNs and the former vertical staff realised the intentions of HFH and saw the benefit to patients, their initial reluctance was replaced by total committed involvement.

Patients were contacted once a month by the VHNs to monitor the status. If there was any complication the patient was immediately referred to the PHC or HFH depending on the severity. The VHNs were helped in their work by former leprosy staff (paramedical workers). Patients with disability were not issued any gauze or cotton or antiseptic cream to avoid dependency. Selfcare with available materials



(pot, stone, washed cotton ribbon cloth -for bandage-, oil) was the key intervention. The whole process took almost 6 months.

The enthusiasm of the VHNs is unbelievable. When asked what made them accept the responsibility and involve themselves in the programme their stock response is, "We never knew that we could bring so much difference to the lives of these people. They also did not know that such simple procedures could reduce their suffering and give meaning to their lives. The benefits from our efforts are immediately visible".

The project in collaboration with the DLO has initiated holistic service to leprosy affected in 14 PHCs of Pudukottai district and 17 PHCs of Trichy district. The total population covered is 659168 and 473839 in Trichy and Pudukottai respectively. In the year 2005 a total of 68 cases (29 MB) were detected in these PHCs out of which 26 were referred by VHNs, 4 by General practitioners and 27 reported voluntarily. On verification of cases wrong diagnosis was found to be 4%. There was no reregistration. The PHCs diagnosed and treated 7 cases of reaction (2 ENL) and 3 cases were referred to the NGO project because of complications. The PHCs referred 10 cases with deformity for reconstructive surgery. Total number of VHNs in the 31 PHCs is 174 of whom 159 are actively involved in leprosy control including prevention of disability. The total number of patients with disability in the 176 subcentres covered by these VHNs is 427 (33 patients with plantar anaesthesia, 236 with disabilities including plantar ulcers, 158 with disabilities without plantar ulcers). Of these 427 patients 303 were identified by the VHNs. Of the 427 patients 363 are found to practice selfcare.

**In public health, service is the name the providers give;
Not the one desired by those who receive.**

- Krishnamurthy

CASE HISTORY

**Every patient is a mirror cracked and dense.
We don't see in it what we don't wish to see.**

- Krishnamurthy

Ms. Devi (name changed) aged 24 years from Siwan District in Bihar had a patch on her right upper arm since one and a half years and she went to a local General Practitioner (GP) who treated her with Rifampicin (450mg daily), Dapsone (100 mg daily) and Clofazimine (50 mg daily) with chalmogra oil for local application for 2 months with no response. The patient spent Rs.500 for her treatment.

The traditional dai from the village asked the lady to consult the doctor at the PHC where the Medical Officer, Dr. Sushil Kumar Singh observed that the patch was erythematous with definite sensory deficit. The right ulnar was thickened but not tender. She was correctly diagnosed as PB leprosy and treatment was initiated. About two weeks after the start of treatment the patch became raised, red and there was severe pain in her right



elbow. The patient went to the PHC where a diagnosis of Type 1 reaction with ulnar neuritis was made. Prednisolone was started.

The PHC did not have prednisolone. Technical Support Team provided the drug to the patient.

What do we learn from the case history?

- *Delay in reporting to PHC (lack of awareness?)*
 - *First contact for patient was GP*
 - *Inappropriate management of disease by the GP*
 - *Referral by the traditional dai to the PHC*
 - *Correct diagnosis of the disease and its complication by the MO at PHC*
 - *Non-availability of prednisolone for managing reaction*
- ❖ ❖ ❖ ❖ ❖
- *Take complete history from patient- useful for diagnosis, management, community interventions (IEC, training of GPs, etc)*
 - *Do the sensory test correctly to elicit definite sensory deficit*
 - *Examine the whole body, examine the nerves before coming to a definitive diagnosis.*
 - *Every person affected with leprosy is at potential risk of developing deformity.*
 - *Early diagnosis and prompt treatment saves patients from adverse consequences.*

Checklist for supervision of records and reports

PATIENT CARD		
1	Availability of cards of UT cases	Yes No
2	Availability of blank cards	Yes No
3	Card is complete (all the items are filled)	Yes No
4	Card is up to date	Yes No
5	Contents are accurate	Yes No
6	Contents are correct (through verification from interview of patients)	Yes No
7	Verified by the Supervising Officer	Yes No
TREATMENT REGISTER		
8	Availability	Yes No
9	Maintained by whom	
10	Complete	Yes No
11	Up to date	Yes No
12	Accurate	Yes No
13	Correct (through verification from interview of patients)	Yes No
14	Verified by the Supervising Officer	Yes No
PROGRESS REPORT		
15	Availability (previous months of current year and annual for the preceding years)	Yes No
16	Sent on time (last report)	Yes No
17	Prepared by whom	
18	Complete	Yes No
19	Accurate	Yes No
20	Correct (through verification from treatment register)	Yes No
21	Verified by the Supervising Officer	Yes No

GOI CLARIFICATION ON TARGETS

In its response to the letter from ILEP coordinator expressing concern on setting up expected goals for 2006 GOI vide letter dated 29th December 2005 and signed by Dr. D.M. Thorat, DADG (L), has given the following explanation.

“It is therefore felt necessary to clarify that the goals indicated above are actually “expected outcome” by December 2005 and March 2006, results from a well managed quality leprosy programme which led to declining transmission potential of the diseases during the years. These goals therefore should not be construed as targets given to the States/UTs. However, female patients should receive equal opportunity to get diagnosed and treated and true new cases as being emphasized in all the meetings should not be left out of registration.

There is need for State / District authorities and DTSTs working in field to ensure that operational factors as being reported by NIHFW conducted LEM exercises, are minimal and in addition the States should strive to provide quality leprosy diagnostic and treatment services at all health facilities”

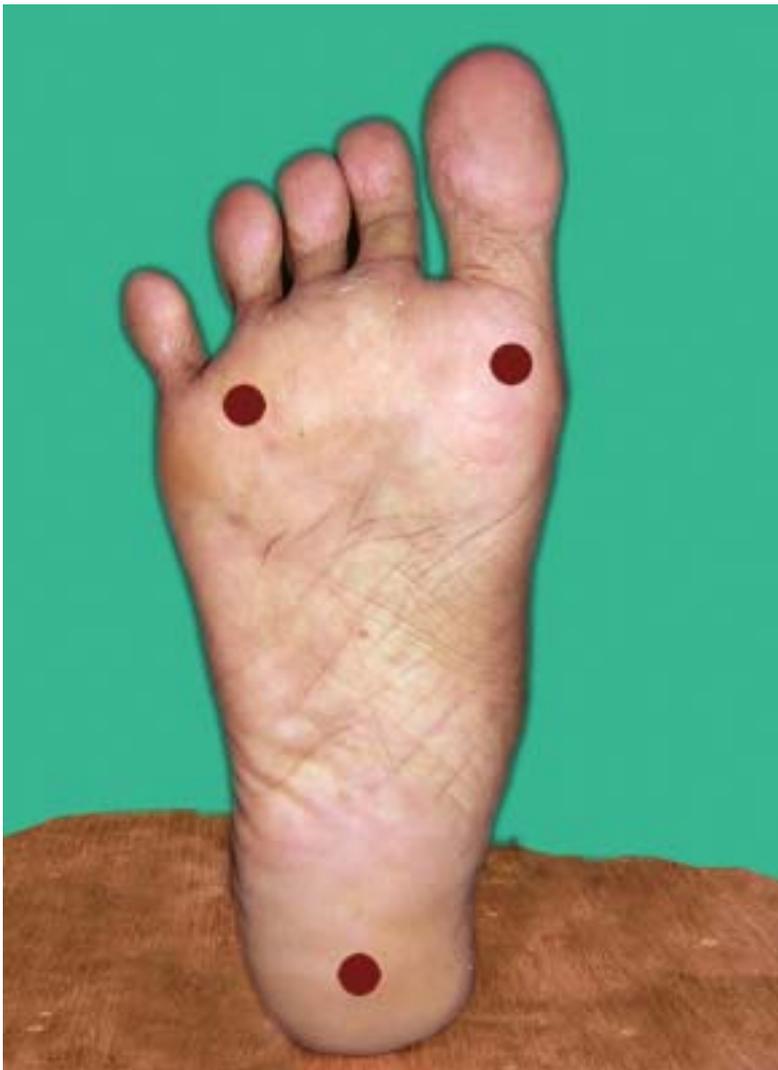
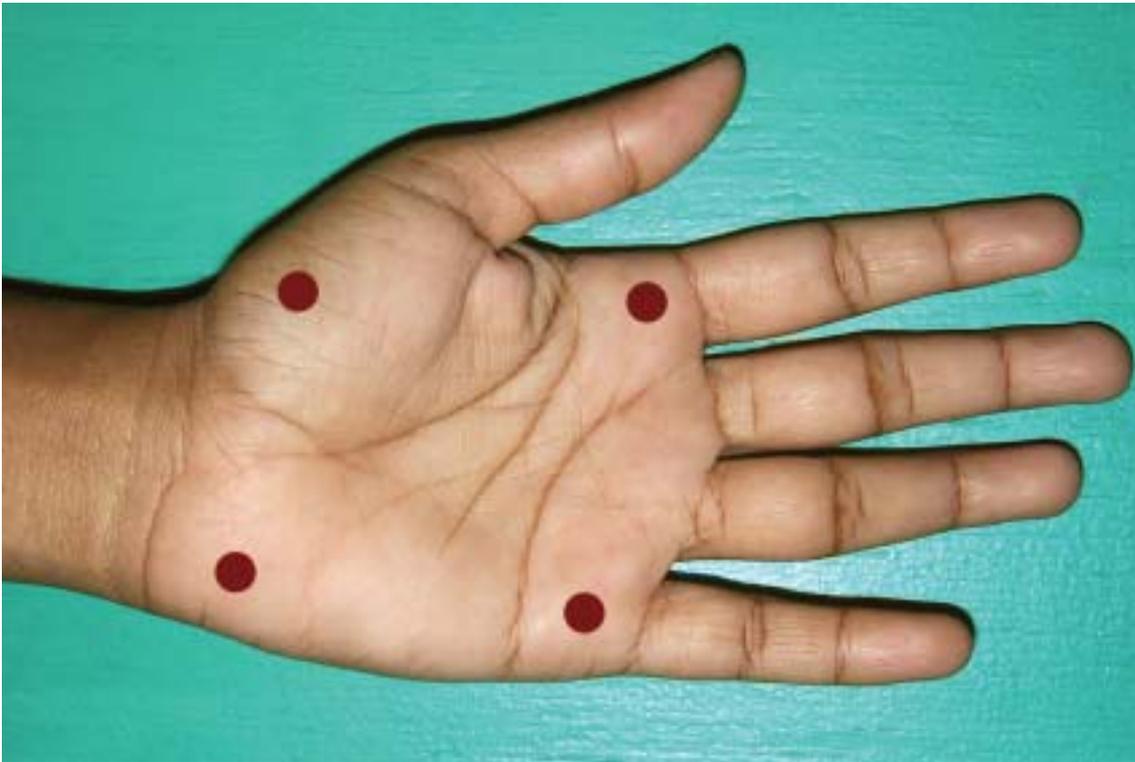
We thank the Government for the prompt response and clarification.

TB CONTROL PROGRAMME

Why some TB patients do not come for follow-up examination?

	REASONS	ACTION REQUIRED
1	Microscopy Centre is not accessible.	MO-PHC/ANM to make alternate arrangements: Sputum samples collected at patient's residence and transported by someone to Microscopy Centre (or) sputum smears are prepared and sent to MC.
2	Microscopy Centre is not functioning.	DTO to ensure that LT is made available; lab has adequate supplies (chemicals, slides, sputum cups, etc);
3	Sputum result is not reported. Sputum result does not reach PHC.	MO-MC to supervise lab. Ensure that sputum microscopy is done and results are despatched to concerned PHC in time.
4	Sputum result is not entered in records at PHC.	MO-PHC to review the sputum result and ensure that results are entered in patient record; results are entered in patient record with DOT provider; action is initiated based on the sputum results (extension of IP / failure).
5	DOT provider is not aware of follow up procedures / does not refer the patient.	Adequate counselling of DOT provider at start of treatment; Mark dates for follow up in patient record with DOT provider;
6	Patient is not aware of follow up procedure. Patient is not aware of need for follow up sputum examination.	Adequate counselling of patient at start of treatment by MO, LT, ANM and DOT provider.
7	Too many visits to Microscopy Centre/ loss of wages.	Sputum cups should be supplied along with RNTCP medicine pack. DOT provider and patient should know the procedure; Patient should collect early morning sputum sample and report to Microscopy Centre where spot sample would be collected. Two samples could be given on a single visit to Microscopy Centre.
8	No supervision	MO-TC to supervise MC. MO-PHC to review every month. Periodic visits to patients and DOT providers by any of the health staff (MO / MPHS / ANM / STS). STS to check follow up examinations done at MC / report to PHC on absentees.

Sensory test for identifying nerve dysfunction



The suggested spots for testing sensation over the **palm** and **sole**.

Test for sensation over these spots.

Follow basic principles of sensory testing.

(See *UPDATE* issue July 2001
-Topic Sensory Test)