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SUPPORT TO LEPROSY CONTROL IN INDIA THROUGH ILEP TECHNICAL TEAMS

Introduction:

Of all the public health programmes in India, Leprosy control is inimitable for the exceptional involvement of large number of well-meaning Non Governmental Organisations (NGO), both international (ILEP- International federation of Anti-leprosy associations) and local. Whatever may be the primordial reason it has contributed significantly to the progressive development of leprosy control in India. One conspicuous feature of this development has been the excellent collaboration between the Government and NGOs, based on mutual strengths, which has in fact become a model worthy of emulation by other public health programmes.

Evolution- from Hospital-based to technical support:

The NGO involvement in leprosy control passed through three important phases: first, providing hospital-based care to leprosy-affected persons; second, public health based survey, education and treatment in specific allotted populations; and final, offering functional support to the Government programme. Initially, in the absence of organized leprosy control, NGO-run hospitals were the principal providers of leprosy services. With the introduction of leprosy control through a vertical programme, the Government sought the help of NGOs in improving leprosy service coverage by extending their area of operation beyond the hospital into the field in specified geographic areas. Finally, with the integration of leprosy service the role of NGOs had to be redefined: functional support, not area



support, became the key feature. Considering their competencies and proficiencies, capacity building of the general health staff and provision of secondary and tertiary care service (management of complications and reconstructive surgery) became the mainstay of NGO involvement.

Dense concentration of NGOs in the Southern part of the country coupled with the fact that Government programme there was reasonably efficient meant the programme in the

south had a head start over that in the North. Leprosy control with MDT was started in the south in 1983 whereas it could be launched in the whole state in Bihar only in 1998. States like Bihar, Jharkhand, Orissa, Uttar Pradesh and West Bengal had serious problems in implementing leprosy control because of weak infrastructure, and technical and operational inadequacies. For example

a careful review of the situation in Bihar in 1996 revealed that: a) only 50% of the vertical infrastructure required as per the norms was present; b) only 40% of the general health infrastructure was present; c) there was a ban on recruitment of new staff (this was necessitated because of paucity of funds); d) the programme officers rarely had transport facility for moving in the field; e) the vertical staff who were managing the programme had little competence because of lack of good training; f) there was only one training institute in the state to train the vertical staff; g) there was little or no monitoring and supervision of the programme;

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Support to Leprosy Control in India through ILEP Technical Teams - Contd. from page 1

h) case detection was poor, discharge of cases was negligible and there was scarcity of drugs; and i) these problems were compounded by the fact that two-thirds of the state was inaccessible at least one-third of the year because of natural calamities like flooding or manmade social disturbances.

District Technical Support Teams:

Taking into consideration all these problems it was decided that each of the districts (covering a population of 1 to 2 million) in the region could be provided with experienced personnel with adequate competence to guide the programme staff. The idea was a take off on the earlier scheme of leprosy consultants being appointed by Government of India for a cluster of districts on visit-the-district-whenever-required basis. The consultants, paid by Government of India, were not regular appointees and they used to visit the districts once in three months. This did not have much impact on the programme. The districts in the north needed a resident expert who could provide continuous guidance at least in the initial phase of MDT (Multi drug therapy) implementation. Thus was borne the District Technical Support team (DTST). The initiative was taken first by one of the ILEP members and it was endorsed in a joint meeting between a few ILEP members, Government of India and World Health Organisation (WHO) in 1996. The mandate was that the teams would assist the programme officer at the district level in planning, organizing, supervising, monitoring and evaluating the leprosy control programme. The main task of the team was to build the competence of the different cadres of general health and vertical staff so that they would be able to implement all the prescribed activities as per schedule and bring about a change in the leprosy situation. Each team consisted of one Medical Officer and one or more Non Medical Supervisors with extensive experience in running leprosy control. The team was provided with jeep for mobility. Each team was given charge of one to three districts depending on the nature of problems, size and spread of population. The DTSTs were placed by ILEP members. The members of the DTSTs were either from the Government programme (retired from Government service) or from NGO projects mainly from the south.

A quick look at the structure of General health system in India is necessary to have a clear understanding of the DTSTs' functional arrangements. Public health programmes in a district are managed by District health officer who is assisted by District Leprosy Officer (DLO) in managing leprosy control. Below the district one finds Primary health centre (PHC). Each PHC covers a population of 150000 to 200000 in the North whereas in the Southern states it covers a population of 25000 to 30000. Primary health centres are responsible for providing preventive and curative services including leprosy. Below the PHC one finds subcentres, one for every 5000 in the South and 10000 to 15000 in the North. Each subcentre has a male and a female health worker. For every four health workers there is a supervisor. In addition to a subcentre there is also Anganawadi worker one for every 1000 population to assist in child health.

Until 2001 leprosy control activities were implemented exclusively by vertical staff, there was negligible involvement of the general health staff. Vertical infrastructure of leprosy control was poorly staffed. The vacancies to some extent were filled by workers newly recruited on contract basis. But there were neither training institutions nor trainers to train these workers. The consequence was that MDT coverage was woefully inadequate and under-detection and over-retention of cases was common. Cases were detected through various surveys. Leprosy-affected persons were managed by the vertical staff at roadside mobile clinics. MDT services were not available at Primary health centres and there was no involvement of the health workers at the subcentres. There was little

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publicity to enable people to report voluntarily. The District Technical Support Teams were placed at the time to build the competence of the vertical staff and bring a qualitative improvement in the programme. Short trainings (3 days) were organised for the vertical staff. This was followed by continuous on-the-job guidance by the DTST.

Case detection improved ¹ by two-fold and discharges by two and a half fold. Still, MDT coverage was poor. It dawned on the programme managers that the only way of improving coverage was through integration. In the aftermath of integration the responsibility of the team shifted to strengthening the integration process.^{1,2} All the general health staff were trained by the teams. This was followed by continuous on-the-job coaching. MDT services were made available on all days at all the health facilities. Quality of diagnosis improved with verification of sample of patients by the teams and discussion with demonstration with the Medical Officers of health facilities whenever there was discrepancy in diagnosis. Frequent interactions with the peripheral workers yielded the intended result- suspects referral showed a sharp increase. MDT treatment was made available to patients close to their home either through worker or through a volunteer identified by the worker. Maintenance of records improved and treatment completion rose to 85%. With the simplification of information system correct and complete reports were generated on time. The team moves around in the district meeting general health staff, patients and community members and providing on-the-job training and playing the advocacy role.³ At the district and PHC the focus is on planning issues and at the middle and peripheral level the accent is on implementation issues. The team acts as a liaison between the district, state and the central programme officers.

At present there are 152 DTSTs supporting 267 districts (out of a total of 582 districts in the country) in 10 initially-endemic states, all managed by ILEP members. The annual cost of sustaining one team is about \$18600 with an initial additional \$11600 for a jeep. This is an enormous input

which would be difficult to sustain for a long time. In the short span of five years much has been achieved. One can see that major objectives of integration have been realized. Around 90% of health facilities provide MDT services, suspect referral by peripheral health workers is very good, wrong diagnosis is less than 5% and treatment completion is about 85%. Even though it is difficult to relate the impact directly to the intervention, in the absence of any other tangible input one can say that DTSTs have made a significant difference to the programme. Of course, some problems remain. Management of patients with complications is still a big question mark. Referral system is not yet established. There is also the vexing problem of overdependence of the general health staff on the teams especially in areas like planning, supervision, monitoring and training. DTSTs are often regarded as a panacea for all the ills in the programme. This is against the ground rules of sustainability. This will have to change. The Government has planned to have a district nucleus consisting of a Medical Officer and paramedical with expertise in the specified areas. The District Technical Support Team will have to assist the nucleus in developing competence for these tasks so that it will be in a position to take over the responsibility from the team. The sooner it is done the better because the final aim of the team is to achieve a qualitative improvement in the programme that is sustainable without outside assistance.

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Holy Family Hansensorium, Fathimanager celebrates fiftieth anniversary

Holy Family Hansensorium, Fathimanager, one of the NGO projects supported by DFIT, has completed 50 years of continuous yeoman service to persons affected with Leprosy. Founded in 1955 by Rt. Rev. Dr. James Mendonca, the then Bishop of Tiruchirapalli, it provides specialized service to persons with leprosy related complications, assists the

Government in training of general health staff in Leprosy and manages persons with HIV/AIDS through its 70 bedded hospital with reconstructive surgery unit and dedicated staff. We wish HFH many more success in their relentless efforts at bringing change in the lives of many unfortunate men, women and children.

Operational guidelines for Leprosy control activities

(World Health Organisation)

Executive Summary

The *Global Strategy for further reducing the leprosy burden and sustaining leprosy control activities (2006 – 2010)* has been widely welcomed and endorsed. The overall goal is to provide access to quality leprosy services for all affected communities following the principles of equity and social justice. The purpose of these *Operational Guidelines* is to help managers of national health services to implement the new Global Strategy in their own countries. This will be done as they develop detailed policies applicable to their own situation, and revise their National Manual for Leprosy Control.

Leprosy services are being integrated into the general health services throughout the world; a new emphasis is given here to the need for an effective referral system, as part of an integrated programme. Good communication between all involved in the management of a person with leprosy or leprosy related complication is essential. These Guidelines should help managers to choose which activities can be carried out at the primary health care level and for which aspects of care patients will have to be referred. This will depend on the nature of the complication and the capacity of the health workers to provide appropriate care at different levels of the health system.

The promotion of self-reporting is now crucial to case detection, as case finding campaigns become less and less cost-effective. It is important to identify and remove barriers that may prevent new cases from coming forward. The procedures for establishing the diagnosis of leprosy remain firmly linked to the cardinal signs of the disease, but the accuracy of diagnosis must be monitored. The Guidelines suggest a greater emphasis on the assessment of disability at diagnosis, so that those at particular risk can be recognized and managed appropriately.

The treatment of leprosy with MDT has been a continuing success; neither relapse nor drug-resistance are significant

problems and the regimens are well tolerated. Clear procedures are given for managing irregular treatment with MDT. Leprosy reactions are a serious complication affecting some patients. The Guidelines contains this aspect, with additional references under Further Reading. A key decision for programme managers is to determine how and at which level of the health system leprosy reactions are to be managed in their country. Different countries must develop their own detailed guidelines on this issue.

Prevention of disability (POD) is also described in some detail as there is a need for much greater coverage with basic POD activities. This is an important component of 'quality leprosy services' emphasized in the Global Strategy. Items mentioned under Further Reading will be essential for programmes planning to build capacity and increase their service provision in this area. Rehabilitation may include a medical component (such as reconstructive surgery) but its scope is much broader. It is likely that some people affected by leprosy would benefit from socio-economic rehabilitation (for example, vocational training or a small loan). Staff in the health services need to be familiar with what is being done in the locality, and know how and where to refer people who need these services. Recording and reporting are essential to maintain quality in any programme. The indicators selected in the Global Strategy are useful for monitoring and evaluation, and they determine which data must be recorded. The data needed to monitor POD activities have not been collected routinely in the past, so this represents a significant change – national managers must therefore decide for themselves which indicators will be used to ensure quality as these will vary from country to country. Programme management is a broad subject; the topics covered in this Section are those that are central to the running of integrated leprosy control services, including supervision, supply of MDT, partnerships, training and programme evaluation.

Beginning with this issue, we are reproducing with permission from WHO the document "THE OPERATIONAL GUIDELINES FOR LEPROSY CONTROL ACTIVITIES".

TB CONTROL PROGRAMME

Why is sputum conversion low in some situations?

	Reasons	Actions required
1	Wrong categorisation	<ul style="list-style-type: none"> • DTO, MOTC to verify a sample of patients periodically. • Feedback to concerned medical Officer. • Ensure proper history taking. • If MO is busy organise one person in health facility for history taking. • Refresher training (minimum once a year).
2	Irregular treatment	<ul style="list-style-type: none"> • Counsel patient & find out problems. • Rectify the problems. • Regular supervision by STS, health worker.
3	Self administration	<ul style="list-style-type: none"> • Organise suitable DOT provider. • Training to DOT provider. • Regular supervision by STS, health worker. • Training of PHC staff if needed.
4	Divided doses	<ul style="list-style-type: none"> • Counselling to patient, DOT provider • Training to PHC staff
5	Drug side effects	<ul style="list-style-type: none"> • Counsel patient. • Arrange treatment for side effects. • Consume drugs after food. • Consume drugs in the evening.
6	DOT provider not convenient	<ul style="list-style-type: none"> • Organise suitable DOT provider.
7	Sputum exam not done at end of IP Sputum exam not done at end of extended IP	<ul style="list-style-type: none"> • Organise timely referral of patients for follow up sputum examination.
8	Patient and DOT provider not aware of the of need for follow up sputum examination	<ul style="list-style-type: none"> • Counselling to patient • Training to PHC staff • Training to DOT provider
9	Microscopy centre not easily reachable	<ul style="list-style-type: none"> • Alternate arrangement for transporting sputum specimens to MC • If it is problem for many patients – the possibility of shifting MC to any other health facility nearby
10	False positive errors in sputum microscopy	<ul style="list-style-type: none"> • Training to Lab Technician on AFB microscopy and maintenance of microscope • Provide good microscope & reagents • Supervision by STLS
11	Lab Technician post vacant	<ul style="list-style-type: none"> • DTO to arrange recruitment of Lab Technician and train them in AFB microscopy
12	Sputum results not recorded in TB register	<ul style="list-style-type: none"> • MOTC, DTO to verify TB register periodically. • Ensure updating of TB register
13	Sub standard drugs	<ul style="list-style-type: none"> • Prepare list of reputed brands • Get approval from concerned authorities for purchasing anti TB drugs

Disabled as an Enabler

Mr. K.K. Raman owns a small fast food restaurant in Salem town. Being physically challenged (both his lower limbs are affected by polio) does not deter him from engaging himself in social service. He is a popular figure in the locality. His popularity is not only due to his demeanor, which makes him endearing to the public but also to his attitude towards the people in need of assistance. People approach him for various services like obtaining ration card, admission to school or applying for job. Little wonder that when the health worker of the area approached him to be a DOT provider he accepted the responsibility with alacrity.

He didn't stop with one TB patient – he has so far helped 25 TB patients take the drugs under his direct supervision. Health worker from MCH Subbarayanagar and field staff of St.Marys Leprosy & TB center visit him regularly to provide guidance and encouragement. RNTCP needs more people like Mr. K.K. Raman willing to slide smoothly into



the orbit of social assistance. In fact, there are. Look for them, they are there!

DOT by community volunteers Vs health workers

Generally the health staff were initially less than willing to involve community members as DOT providers for various reasons, most of them not justifiable. The initial reluctance however was replaced by widespread acceptance by health staff in Nellore and Anantapur districts when they saw the results. A review of the effectiveness of their participation compared to the Government staff in terms of cure rate among Cat 1 TB patients indicates that they are as effective as Government health workers.

RNTCP District	Cure rate among Cat I TB patients	
	Dot Provider	
	Health Worker	Community Volunteer
Nellore	178/222 (80%)	150/184 (81.5%)
Anantapur	526/629 (83.6%)	866/1032 (83.9%)

Advantage of using community volunteer:

- Free service to TB patients.
- Known person to TB patient - feels comfortable.
- Nearer to patient – no loss of time, wages.
- Possibility of convenient timing.
- Free publicity on benefits of RNTCP to the community.
- Lessens workload of the health workers.

Success depends on adequate preparation and supportive supervision of community volunteers.

HAPPENINGS

- Dr. Etienne Declercq, Medical Advisor, Damien Foundation Belgium visited India from 1st to 12th May 2006. During this period, he visited Arisipalayam, Bangalore, Anantapur and Delhi and reviewed the activities of leprosy/ TB and POD along with Dr. Vijayakumaran, Chief Medical Advisor (South).
- 34th Trust Meeting was held at DFIT Office on 8th April 2006. Mr. Paul Jolie, President of Damien Foundation Belgium, chaired the meeting.
- In-service training in RNTCP was imparted to Bihar Technical Team staff at Anantapur in 3 batches.
- In-service training in POD was imparted to Technical Team staff working in Bihar/Jharkhand at Arisipalayam project in 3 batches.

Self care of hands

1. The Deformity (Ulnar paralysis of both hands). (Fig. 1.)
2. Inspecting hands daily for signs of redness, injury. (Fig. 2.)
3. Soaking the hands at least for half an hour in water. (To make the skin soft and supple). (Fig. 3.)
4. Scrapping the hard skin (callous) using a rough stone. (To remove hard skin and to even the edges of wounds if present). (Fig. 4.)

5. Applying oil (preferably Neem oil) while the skin is still moist. (To retain moisture on the skin). (Fig. 5.)
6. Exercising. (Straightening the finger joints to prevent contracture and stiffness). (Fig. 6.)
7. Using garden implements with caution. (To prevent friction and heat boils when working with tools). (Fig. 7.)

Note: *If a wound is present, the hand should then be dressed with a clean cloth. (To protect the wound from dirt).*



Fig. 1. The Deformity
(Ulnar paralysis of both hands)



Fig. 2. Inspecting hands daily
for signs of redness, injury



Fig. 3. Soaking the hands at least for half an hour
in water. (To make the skin soft and supple)



Fig. 4. Scrapping the hard skin (callous) using a rough stone. (To remove hard skin and to even the edges of wounds if present)

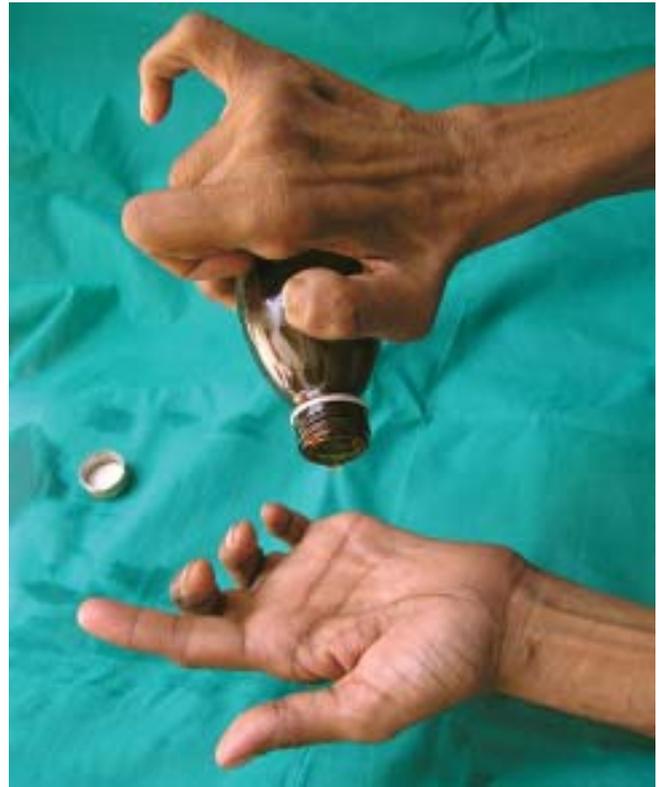


Fig. 5. Applying oil (preferably Neem oil) while the skin is still moist. (To retain moisture on the skin)



Fig. 6. Exercising. (Straightening the finger joints to prevent contracture and stiffness)



Fig. 7. Using garden implements with caution. (To prevent friction and heat boils when working with tools)