focus

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'focus' Series No. 1, July, 2004
LEAP : Leprosy Elimination Action Programme

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Focus on Leprosy Elimination and Integration with General Health Care (GHC) System

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'FOCUS'

'FOCUS' is the first in the series of booklets to provide an update of knowledge, views, opinions and guidelines on leprosy elimination from all stakeholders : Governments, Corporations and other national bodies.

Integration is the need of the hour. It makes economic and social sense to integrate leprosy into the public health system. However, multiple tasks are to be undertaken by all concerned to make integration a reality in Maharashtra.

'FOCUS' is also aimed to disseminate and share information on various aspects of leprosy elimination tasks ahead. Sharing of views and experiences is crucial for formulation and implementation of future strategies.

Hope you find it useful !

A. Antony Samy
Chief Executive
ALERT-INDIA

29th July, 2004

RAIPUR DECLARATION

National Conference on Elimination of Leprosy,

Raipur 27th to 30th January 2004

The National Conference on Elimination of Leprosy took place from 27 to 30 January 2004 at Raipur - (Chhattisgarh) at the initiative of the International Leprosy Association. It was cosponsored by World Health Organization (WHO) the International Federation of Anti Leprosy Association (ILEP) and the Nippon Foundation / Sasakava Memorial Health Foundation. It was held under the auspices of Govt. of India and Govt. of Chhattisgarh and support by the International Leprosy Union, the Hind Kushta Nivaran Sangh, the Indian Association of Leprologists, IDEA, and the Leprosy Elimination Alliance.

The National Conference, after -

- Reviewing the current leprosy situation in the country and the different states

- Appreciating the progress made in reducing the burden of leprosy in the country through widespread application of MDT along with related activities,

- Expressing concern over the high prevalence and case detection in some of the states particularly the States of Bihar, Jharkhand, Orissa, Uttaranchal, Chhattisgarh and West Bengal,

- Further expressing concern over a general tendency towards complacency. As a result of initial success,

- Recognizing the urgency of the situation in view of the approaching target date of Dec 2005,

Urges the National and State Programme to -

1. **PROMOTE** more vigorously integration of leprosy within General Health Services so that service coverage is increased effectively and the goal of leprosy elimination reach in time.

2. **INTENSIFY VIGOROUSLY** their efforts towards case detection and treatment.

3. **DISSEMINATE** IEC messages on signs and symptoms of leprosy, its curability through MDT, and availability of treatment of all health facilities so that patients can self report in time.

4. **TAKE** steps to rehabilitate leprosy-affected persons in a cost effective manner so that they can be fully assimilated within the family and the community as useful members.

5. **ENSURE** that leprosy patients continue to get the necessary services even after leprosy is eliminated as a public health problem.

6. **ADDRESS** the following specific problems or issues, the resolution of which is vital to the attaining of the goal of elimination of leprosy, these being -

- Continued problem of detection of all the backlog and hidden cases
- Delayed diagnosis
- Over diagnosis
- Re-registration
- Inadequate / Inappropriate training GHS workers hindering their effective participation in the integrated setting.
- Inability to dismantle unnecessary vertical elements in the programme.

7. **DEVELOP** strategies in collaboration with all stakeholders to identify and focus on specific geographic areas or populations of high endemicity and ensure that more intensified decentralized time bound plans are developed and implemented on an urgent basis taking due consideration of the priority problems mentioned above. ⬢

Strategies

of the National programme

to reach the unreached

and provide the services necessary to eliminate leprosy :

1. Identify the unreached in rural, tribal and slum areas and plan SAPEL / LEC projects as necessary.

2. Establish an efficient mechanism to appropriately link these people with primary health care centres.

3. Promote MDT in areas that remain cut off during rains, floods or snow, promote MDT also among the migratory population.

4. Encourage industrial health care institutions to provide orientation and training on diagnosis and MDT among industrial workers.

5. Get cadets from NCC, Scouts, NSS and similar institutions, as well as teachers and students from schools, to take part in special camps to reach the unreached.

'Progress Towards Leprosy Elimination',
An Interview with Dr. Ashok Kumar,
Deputy Director-General of Health Services (L)

in - Leprosy Elimination Alliance, April-June, 2002.

Line of Action

suggested to implement the recommendations of National Workshop for defining **specific strategy for Elimination of Leprosy from Urban Areas** held in New Delhi, 14th - 15th October, 2003

A. Mega and Metropolitan Cities: (population >2.5 million) :

1. **Fourteen cities** that come under this group are Delhi, Mumbai, Kolkata, Chennai, Bangalore, Ahmedabad, Lucknow, Kanpur, Nagpur, Pune, Hyderabad, Bhubaneswar, Jaipur and Bhopal.

2. **Identify the Health facilities** available under control of different organizations, Private Hospitals and NGOs to provide MDT services.

3. **Identify the willing stakeholders** which include potential partners for participating in the leprosy elimination viz. Multilateral and bilateral Agencies, Central Govt., State Govt., Local Civic bodies, NGOs and Philanthropic groups.

4. **L**ocal body Government of the Municipal Corporations and District Administration shall be the **pivotal agency for implementation** of MDT service delivery through their Health institutions.

5. **Identify and delegate responsibility** to organize and coordinate the activities to one **Nodal Point** either under the municipal corporation or any other organization with full coordination from the District administration / Leprosy organization.

6. **Organize sensitization meetings** seeking willingness of different stakeholder organization also including social groups viz. women, religious group, minority organizations, Migrant group and other marginalized segments.

7. **F**orm an **Urban Leprosy Elimination Committee** to decide on all the activities to be carried out for leprosy elimination in the Urban area. The committee also decides on the sharing of responsibilities and resources (money, material and manpower) by different organizations.

8. **T**he **District Leprosy Society** under chairmanship of the District Collector / Executive officer of the Zillah Parishad, begins the process and give full support to the Urban Leprosy Elimination Committee on all matters.

9. **Funds for leprosy control activities available with the DLS is for urban areas also** is for IEC, RCS operation, MCR footwear,

MDT supply, Supply of reporting and recording forms, Supportive drugs, LEC in slum areas, providing training to the Health staff of participating organizations etc.

10. **GOI directly provides** assistance to the Local NGOs under the SET scheme which has been recently modified.

11. **Plan Integrated MDT services in the urban area,** keeping in view GOI policies, which may include.

a) **L**eprosy Diagnosis and Treatment facilities from all available Health Centers under different organization, Hospitals, Private Practitioners etc.

b) **I**EC activities should be integral component of each partner following standardized messages. Interpersonal communication would receive priority and will be the main support from the special groups joining as partner. Such IPC is to improve voluntary reporting.

c) **A**s an outcome of the IEC, any suspected leprosy affected person should be referred to the nearest health center for diagnosis by a medical officer and for initiating treatment.

d) **L**ocal NGOs under SET scheme or otherwise can provide diverse support to leprosy elimination like IEC, prevention of deformity and care services, Assist Health center in Treatment, follow up of Leprosy Patient and retrieval of defaulters, conducting LEC in slum areas or migrant groups, management of complicated leprosy cases in referral centers, RCS operations, supply of MCR footwear and rehabilitation.

12. **Prepare a Memorandum Of Understanding (M.O.U.)** to be signed by all the partners as an agreement to work together for leprosy elimination in the urban area.

13. **Develop a system of Record keeping and reporting** by each center involved in MDT service delivery using formats approved under SIS. Monthly reports from each center to be collected and compiled at the identified Nodal Center before forwarding same to the District Leprosy Officer for inclusion in the District report. Indicators used under the programme will also be used for the urban leprosy elimination for assessment of progress.

14. **Develop a system of MDT drug supply** indenting and collection from the District Medical store under the chief medical and Health Officer of the district and keep at the Nodal Center from where each Health Center providing services can recoup their stock.

15. **A**t this stage of the Leprosy elimination and existing problem of frequent population movement visiting the Metropolitan cities from other states for various reasons, strict vigil is essential to keep only definite cases of leprosy on record for MDT treatment. WHO definition of new case should be followed strictly. **For this a system of validation of new leprosy cases detected will be essential** as indicated in the SIS guidelines, which should be adopted to suit particular urban area and its constituent

institutions. Medical Officer with available District Technical support team, District Nucleus, other supervisory Medical Officer with Leprosy case handling experience to be short listed to carry out routine new case validation and Register cleaning activities.

16. **GOI guidelines on case registration in Medical Colleges and other Hospitals** in urban areas, as also use of **Accompanied MDT** to be made part of urban leprosy elimination plan.

17. **Constant supervision** to monitor the urban leprosy elimination activities should be done through identified officials of partner organizations, who report to the Nodal Officer, for remedial action and discussion in the committee meetings. ●

Leprosy : a disease that can be eliminated

Over the last 15 years there have been significant advances in reducing leprosy prevalence, thereby reducing the grossly disfiguring consequences, pain and suffering, and social stigma it causes.

The programme to eliminate leprosy will help in :

- alleviating and preventing the suffering of the affected individuals;
- reducing the transmission of the disease;
- supporting and strengthening activities of local health services;
- reducing the social stigma and ultimately changing the image of leprosy.

Ref. : "The Final Push Towards Elimination of Leprosy- Strategic Plan 2000-2005"
World Health Organisation

B. <u>Medium Sized City</u> : (population >5 lakh and upto 2.5 million) :

1. **A** good number of city comes under this group. The states/UTs may have to **identify the urban areas** in which the proposed elimination of urban leprosy plan need to be incorporated. Following criteria for selection may be used :

   a) **P**revalence of high leprosy case load as compared to the District / State average.

   b) **P**oor system of MDT Service delivery.

   c) **L**arge urban, Peri Urban areas not covered with regular Health System.

   d) **A**vailability of alternative health care infrastructure.

2. **Identify the Health facilities** available under control of different organizations, Private Hospitals and NGOs to provide MDT services.

3. **Identify the willing stakeholders** which include potential partners for participating in the leprosy elimination viz. Multilateral and bilateral Agencies, Central Govt., State Govt., Local Civic bodies, NGOs and Philanthropic groups.

4. **L**ocal body Government of the Municipality and District Administration shall be the **pivotal agency for implementation** of MDT service delivery through their Health institutions.

5. **Identify and delegate responsibility** to organize and coordinate the activities to one **Nodal Point** either under the municipality or any other organization with full coordination from the District administration / Leprosy organization.

6. **Organize sensitization meetings** seeking willingness of different stakeholder organization also including social groups viz. women, religious group, minority organizations, Migrant group and other marginalized segments.

7. **F**orm an **Urban Leprosy Elimination Committee** to decide on all the activities to be carried out for leprosy elimination in the Urban area. The committee also decides on the sharing of responsibilities and resources (money, material and manpower) by different organizations.

8. **T**he **District Leprosy Society** under chairmanship of the District Collector / Executive officer of the Zillah Parishad, begins the process and give full support to the Urban Leprosy Elimination Committee on all matters.

9. **Funds for leprosy control activities available with the DLS is for urban areas also** for IEC, RCS operation, MCR footwear, MDT supply, Supply of reporting and recording forms, Supportive drugs, LEC in slum areas, providing training to the Health staff of participating organizations etc.

10. **GOI directly provides** assistance to the Local NGOs under the SET scheme which has been recently modified.

11. **Plan Integrated MDT services** in the urban area, keeping in view GOI policies, which may include.

    a) **L**eprosy Diagnosis and Treatment facilities from all available Health Centers

under different organizations, Hospitals, Private Practitioners etc.

b) **I**EC activities should be integral component of each partner following standardized messages. Interpersonal communication would receive priority and will be the main support from the special groups joining as partner. Such IPC is to improve voluntary reporting.

c) **A**s an outcome of the IEC, any suspected leprosy affected person should be referred to the nearest health center for diagnosis by a medical officer and for initiating treatment.

d) **L**ocal NGOs under SET scheme or otherwise can provide diverse support to leprosy elimination like IEC, prevention of deformity and care services, Assist Health center in Treatment, follow up of Leprosy Patient and retrieval of defaulters, conducting LEC in slum areas or migrant groups, management of complicated leprosy cases in referral centers, RCS operations, supply of MCR footwear and rehabilitation.

12. **Prepare a Memorandum Of Understanding (M.O.U.)** to be signed by all the partners as an agreement to work together for leprosy elimination in the urban area.

13. **Develop a system of Record keeping and reporting** by each center involved in MDT service delivery using formats approved under SIS. Monthly reports from each center to be collected and compiled at the identified Nodal Center before forwarding same to the District Leprosy Officer for inclusion in the District report. Indicators used under the programme will also be used for the urban leprosy elimination for assessment of progress.

14. **Develop a system of MDT drug supply** indenting and collection from the District Medical store under the chief medical and Health Officer of the district and keep at the Nodal Center from where each Health Center providing services can recoup their stock.

15. **A**t this stage of the Leprosy elimination and existing problem of frequent population movement visiting the Metropolitan cities from other states for various reasons, strict vigil is essential to keep only definite cases of leprosy on record for MDT treatment. WHO definition of new case should be followed strictly. **For this a system of validation of new leprosy cases detected will be essential** as indicated in the SIS guidelines, which should be adopted to suit particular urban area and its constituent institutions. Medical Officer with available District Technical support team, District Nucleus, other supervisory Medical Officers with Leprosy case handling experience to be short listed to carry out routine new case validation and Register cleaning activities.

16. **G**OI **guidelines on case registration in Medical Colleges and other Hospitals** in urban areas, as also use of **Accompanied MDT** to be made part of urban leprosy elimination plan.

17. **Constant supervision** to monitor the urban leprosy elimination activities should be done through identified officials of partner organizations, who report to the Nodal Officer, for remedial action and discussion in the committee meetings. ●

C. Townships : (population >1 lakh and upto 5 lakhs) :

1. **A** large number of Townships are covered under this group. The State/UTs may have to identify the Townships in which the proposed elimination of urban leprosy plan need to be started. Criteria for selection may be -

a) **P**revalence of high leprosy case load as compared to the District / State average.

b) **I**ncomplete and inadequate state provided MDT services.

c) **I**nadequate out reach services in urban areas under transitional phase having inadequate infrastructure and facilities for MDT services.

d) **M**DT services available only in Govt. of Health Facilities although other health facilities run by private, Trust run by philanthropist organization and NGOs are available.

2. **Identify the Health facilities** available under control of different organizations, Private Hospitals and NGOs to provide MDT services.

3. **Identify the willing stakeholders** which include potential partners for participating in the leprosy elimination strategy viz. urban local body, State Govt., Organization, NGOs and Philanthropic organizations.

4. **Choose a model strategy for urban leprosy elimination** suitable for the Township in consultation with the partners from the **following suggested options.**

a) **U**rban local body ownership for MDT service delivery.

b) **M**ainstreaming MDT services into existing service network through institutionalized partnership.

c) **U**rban leprosy elimination through NGO participation with the context of integration.

d) **C**ombination of all the options structured into one.

5. **Identify and delegate responsibility** to organize and coordinate the activities to one **Nodal Point** either under the local body or any other organization with full coordination from the District administration / Leprosy organization.

6. **Organize sensitization meetings** seeking willingness of different stakeholder organizations also including social groups viz. women, religious group, minority organizations, Migrant group and other marginalized segments.

7. **F**orm an **Urban Leprosy Elimination Committee** to decide on all the activities to be carried out for leprosy elimination in the Urban area. The committee also decides on the sharing of responsibilities and resources (money, material and manpower) by different organizations.

8. **The District Leprosy Society** under chairmanship of the District Collector /

Executive officer of the Zillah Parishad, begins the process and give full support to the Urban Leprosy Elimination Committee on all matters.

9. **Funds for leprosy control activities available with the DLS is for urban areas also** for IEC, RCS operation, MCR footwear, MDT supply, Supply of reporting and recording forms, Supportive drugs, LEC in slum areas, providing training to the Health staff of participating organizations etc.

10. **GOI directly provides assistance** to the Local NGOs under the SET scheme which has been recently modified.

11. **Plan Integrated MDT services** in the urban area, keeping in view GOI policies, which may include.

a) **L**eprosy Diagnosis and Treatment facilities from all available Health Centers under different organizations, Hospitals, Private Practitioners etc.

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c) **A**s an outcome of the IEC, any suspected leprosy affected person should be referred to the nearest health center for diagnosis by a medical officer and for initiating treatment.

d) **L**ocal NGOs under SET scheme or otherwise can provide diverse support to leprosy elimination like IEC, prevention of deformity and care services, Assist Health center in Treatment, follow up of Leprosy Patient and retrieval of defaulters, conducting LEC in slum areas or migrant groups, management of complicated leprosy cases in referral centers, RCS operations, support of MCR footwear and rehabilitation.

12. **Prepare a Memorandum Of Understanding (M.O.U.)** to be signed by all the partners as an agreement to work together for leprosy elimination in the urban area.

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14. **Develop a system of MDT drug supply** indenting and collection from the District Medical store under the chief medical and Health Officer of the district and keep at the Nodal Center from where each Health Center providing services can recoup their stock.

15. **A**t this stage of the Leprosy elimination and existing problem of frequent population movement visiting the Township from other

states for various reasons, strict vigil is essential to keep only definite cases of leprosy on record for MDT treatment. WHO definition of new case should be followed strictly. **For this a system of validation of new leprosy cases detected will be essential** as indicated in the SIS guidelines, which should be adopted to suit particular urban area and its constituent institutions. Medical Officer with available District Technical support team, District Nucleus, other supervisory Medical Officers with Leprosy case handling experience to be short listed to carry out routine new case validation and Register cleaning activities.

16. **GOI guidelines on case registration in Medical Colleges and other Hospitals** in urban areas, as also use of **Accompanied MDT** to be made part of urban leprosy elimination plan.

17. **Constant supervision** to monitor the urban leprosy elimination activities should be done through identified officials of partner organizations, who report to the Nodal Officer, for remedial action and discussion in the committee meetings.

The Line of Action suggested above are not exhaustive and additional items may be drawn up by the implementing agencies suitable for the urban locality.

Overall, the objective of the leprosy elimination in urban areas will be to develop a coordinated system of MDT services involving all willing partners and organizations, keeping in mind its sustainability even after elimination is achieved. ●

ROLE OF NGOs : MODIFIED S E T SCHEME, GOI

- Extracts from the circular dated 8th July, 2004 -

Directorate General of Health Services, (Leprosy Division), Nirman Bhavan, New Delhi-110011.

The Scheme encourages voluntary organizations to work for elimination of leprosy by Survey Education and Treatment of leprosy cases in an area under their control for implementation of NLEP activities.

The various activities that can be undertaken by the NGOs are :

Planning,

Surveillance and Information System,

IEC,

Capacity Building,

Prevention of Impairments and Deformities,

Rehabilitation,

Referral,

Advocacy,

Case Detection and MDT Delivery

and District Technical Support Teams.

Unlike previous SET scheme w.r.t. defined population / health unit for NGO's operation, it is recommended in this modified pattern of SET scheme that a suitable NGO / VO should first identify the area of activity (as mentioned above) and then identify the geographical areas where the activity is to be / can be carried out depending upon its capabilities. Then NGO can submit detailed proposal indicating activity, various aspects of implementation along with financial requirements.

The implementation of SET scheme in a defined geographical area with limited population coverage on vertical pattern need not to be continued.

All the above mentioned activities are important and NGOs may take up for carrying out one or more depending upon the expertise and infrastructure available with them.

However, following activities were identified as **priority activities :**

Promotion of early case detection and prompt MDT;

Capacity Building;

IEC and Advocacy;

POID. ●

Role of GHC in Leprosy Elimination

Integration of Anti-Leprosy Activities with the General Health Care

11th February, 2004

As per GOI's instructions, it is necessary to ensure integration of anti-leprosy activities with the general health care. Hence, diagnosis and treatment centers being run by your organisation need to be handed over to the Govt./Corporation agency responsible for general health care services. However, this decision can not be translated into action without empowering the local staff with necessary skills for diagnosis, treatment and management. Hence, you are requested to:

A) **C**ontinue present clinics on "as is" basis till 28th February, 2004.

B) **C**arry out orientation training of local staff to whom responsibility for diagnosis and management is to be entrusted.

C) **H**and over all the records and other articles with reference to registered cases to local/Govt./Corporation staff.

D) **A**ssist the Local/Govt./Corporation staff to take up the responsibility for diagnosis and management till 31st March 2004 and

Withdraw finally from clinics and undertake following 1 to 8 activities.

1) **L**iaison with respective primary health centre/urban health institution.

2) **S**pecial IEC drives.

3) **C**apacity building of staff of PHC and corporation.

4) **S**pecial drives for detecting hidden cases in endemic and high risk pockets.

5) **S**pecial attention on migratory population, work site, slums, labour populations brick works, building sites etc.

6) **A**wareness generation and involvement of school children.

7) **R**egular POD activities.

8) **S**ocio-economic rehabilitation of cured leprosy patients.

Area of operation / population to be served by NGOs shall be reallocated by concerned ADHS (Leprosy).

Sd/-
Joint Director of Health Services,
(Leprosy) Pune - 1.

Circular: No. Jt. DHS/Lep/D102/2604-743/2004
Office of the Joint Director of Health Services (Leprosy) Pune - 1. 11/2/2004

Extracts from the minutes of JDHS meeting : dated 11/6/2004, PUNE

Following decision were taken after discussion

1 **S**top MDT distribution immediately and hand over to health post.

2 **M**PW should refer 'suspect' to MO for diagnosis and treatment.

3 **N**GO should stop fixed clinics and engage leprosy technicians / health workers for IEC activities.

4 **N**GO should discuss with ADHS, district MO and municipal corporation before starting special survey.

5 **N**o patients should be compelled to get admitted in institute; only genuine or dependent patients should be admitted.

6 **U**nder the instruction of Central government no skin smear of patients should be taken.

7 **U**se different media for awareness of leprosy.

8 **I**nvolve school students, teachers, anganwadi staff, NCC and MSW in leprosy programme.

9 **H**ow to examine oneself for leprosy? Either by standing in front of the mirror or be examined by relatives. This knowledge should be given to people.

10 **W**e should be aware that MDT drugs are made available in every health centre.

11 **I**n order to detect hidden cases, NGO should arrange special survey upto July-2004.

12 **S**end proposal of POID through ADHS to this office.

13 **T**hose who have been cured from leprosy their rehabilitation and follow-up should be under taken by NGO. In the same way collect information about defaulters and their number.

14 **W**henever grant is released from government, it will be distributed without delay.

15 **W**ithout awareness, elimination will not be possible, so increase the IEC activities in the community. ●

Role of Municipal Health Services

Brihan Mumbai Municipal Corporation

Regarding integration of the Leprosy Services with the Public Health Services under National Leprosy Eradication Programme.

With reference to the above, according to the policy of Central & State Govt and the Mumbai Mun. Corp., the goal of leprosy elimination (1 or less than 1 case per 10,000 population by 2005) is to be achieved.

To achieve this goal, it is necessary to detect more and more new cases of leprosy as soon as possible and provide them with the (MDT) treatment.

The growing population of Mumbai, inadequate number of leprosy workers (1 to 1.25 lakh population / leprosy worker) and looking at the population load on the leprosy workers, it is not possible to maintain the quality of the leprosy elimination programmes in the whole work area of Municipal Corporation.

Presently in Mumbai leprosy programme work is done by 7 NGOs (65% of work area), State Govt (25% of work area) and Acworth (10% of work area)

Today there is major fall down in the number of leprosy cases than that of earlier. This has caused many restrictions on the NGOs. So they are facing many difficulties in doing leprosy work efficiently and effectively as earlier.

Today the number of leprosy in Mumbai is 1.7 / 109,000 (Active leprosy cases – 2020). New Case Detection Rate is 2 / 10,000. If we look at the ward and health post level status report, then generally in each ward 75 – 80 patients are under treatment, at one Health Post level, there are 10 – 15 leprosy patients and every month 1 -2 new cases are detected which is very less.

With the view to attain the goal of leprosy elimination in Mumbai, it is essential to widen the scope and coverage of leprosy programmes in Mumbai with the help of the efficient and experienced officers and workers working for the leprosy programme today.

The Central and State Govt. has given clear directions for the integration of the leprosy programmes with the general health services of Mumbai Municipal Corporation.

According to that, the National Leprosy Eradication Programme is being integrated at the hospitals / dispensaries and Health Post level under the Dept. of Public Health and Mumbai Municipal Corporation.

Due to the integration of leprosy services, there will be no difficulties or obstacles in the day to day functioning of the hospitals / dispensaries, Health Posts, and also there won't be any additional work load on the Health officers / health workers.

It is expected that :

- The Health Post workers should detect leprosy suspect cases and provide health

education along with other diseases during the area visit or day to day home visit done by them.

- Diagnosis of the suspected cases and starting of the treatment is to be done by the Medical Officer / Full time Medical Officer.

- P.H.N. in the dispensary / Health Post should give MDT packets to the patient once a month and maintain the record in respective registers.

Now onwards regularly, during the daily working hours, along with the other health services –leprosy diagnosis, treatment and leprosy health education should be started in the hospitals / dispensaries and Health Posts under your authority. This should be implemented immediately.

Work expected from the Medical Officers and Health Workers in the dispensary / Health Post.

Sr. No.	Designation	Health Institution	Expected Work
1	Medical Officer	Hospitals / Dispensaries	1. Regular diagnosis of the suspected cases 2. Start the treatment 3. Provide counseling like other diseases
2	Full time Medical Officer	Health Posts	
3	Pharmacist	Hospitals / Dispensaries	1. Give MDT (BSP) once a month to the old and new patients 2. Note in the Registers 3. Prepare monthly reports
4	P.H.N. / deputed by Health Post	Health Posts	
5	M.P.W. / A.N.M.	Health Posts	1. Provide Health Education during home visits 2. Detect leprosy suspect cases and send them to Health Post for examination and treatment 3. Take note of the suspect patients
6	CHW	Health Posts	Give leprosy health education along with other health programmes and send the suspects to the Health Post

All the above mentioned officers and workers are trained for leprosy with 2 / 3 days' separate training and with 1 day training under Revised Leprosy Detection Campaigns. Yet the leprosy organizations / leprosy workers and D.T.S.T. are allowed to organize re-orientation training for one or half a day.

All dispensaries, hospitals and Health Posts will be regularly provided with MDT (BSP) medicines stock, necessary forms for reports,

registers etc., by the District Leprosy Officer.

Dept. of Medical Health Officer, with the help and coordination of the local leprosy organizations / leprosy officers and workers, should complete the process of leprosy programme integration at the hospitals / dispensaries and Health Post level under their authority. At the same time all the respective persons in the above said hospitals / dispensaries and Health Posts should give proper orders to get done the expected leprosy work.

By maintaining the regular coordination with the respective heads of the leprosy organizations / leprosy officers / workers, the leprosy programme should be implemented and monitored with their guidance. Leprosy elimination is not only a social responsibility but also the responsibility of every health officer and health worker. Therefore efforts should be made to make your area leprosy free as early as possible.

Sd/-
Executive Health Officer,
(BMMC)

(No. HO / 58861/ No.1) (Date : 3/3/2004)

(Issued to Medical Health Officers of all the Municipal Wards)

Leprosy : a disease of poverty

Leprosy is a leading cause of permanent disability in the world. Although leprosy is not fatal, the chronic symptoms often afflict individuals in their most productive stage of life and therefore impose a significant social and economic burden on society.

In addition to its economic impact, leprosy imposes a heavy social burden upon affected individuals and their families.

Patients are often shunned and become isolated within their communities. Mocking and social stigmatization are frequent behaviours toward affected individuals.

Because persons with chronic manifestations of the disease are often unable to work or to marry, they become dependent for care and financial support leading to further insecurity, shame, isolation and consequent economic loss.

Ref. : "The Final Push Towards Elimination of Leprosy- Strategic Plan 2000-2005"
World Health Organisation

Handing Over

On Integration of Anti-Leprosy Activities with the General Health Care

World Health Organisation

To achieve elimination, it is important that MDT services should be available and accessible at the most peripheral level so that patients can get treatment at their nearest health centre. The integration of MDT services within the general health services is regarded as the key to achieving elimination.

The rationale behind this approach is that the general health services are relatively more widely distributed, and have close and frequent contact with the local community.

Involving the general health services will also improve case-finding and case-holding activities. In addition, such integration will help to demystify the disease and increase awareness about the disease in the community.

With integration, more health centres are expected to be providing treatment, and the caseload in each centre will be relatively low in comparison to the attendance at monthly or weekly leprosy clinics opened by the specialized / vertical programmes.

Integration will help in maintaining MDT services at the peripheral level, especially in areas where prevalence is declining.

Several national programmes, even in countries with very high prevalence, have integrated leprosy services, mainly because of the urgent need to expand MDT coverage.

However, it is important to have an element of a specialized programme in all endemic countries, either at the central level or – in some larger countries – at intermediate level.

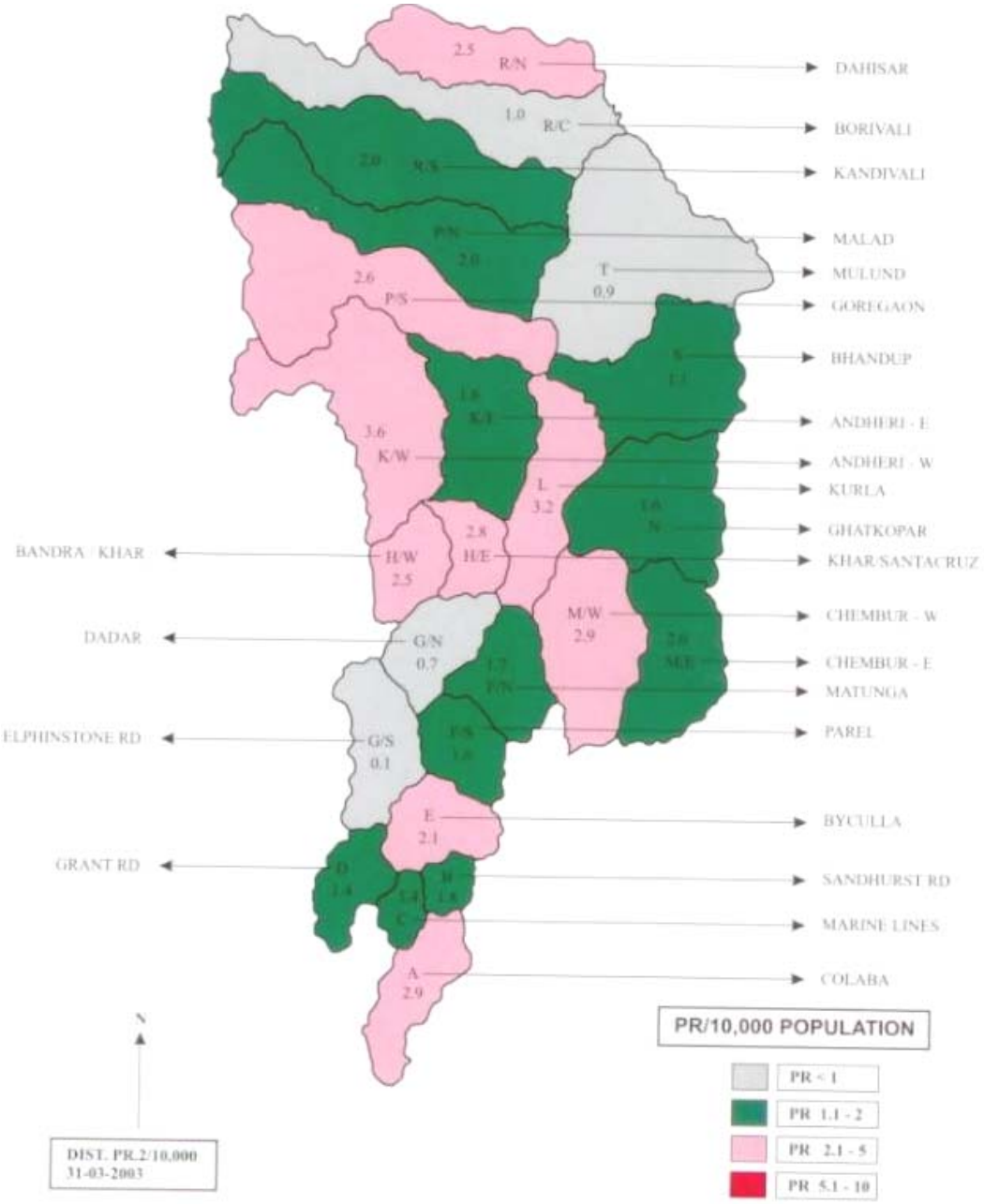
This specialized element for leprosy will be needed for providing technical guidance, for monitoring and evaluating the progress of elimination, for training and for research purposes.

Referral centres will also support the general health services in diagnosing difficult cases and in providing certain specialized care to patients with complications.

Although the intensified and focused implementation of the strategy will reduce the leprosy burden to very low levels, and therefore liberate resources to address other health priorities in the community, new cases of leprosy will continue to occur after 2005. In addition, a significant number of individuals disabled because of past leprosy will need attention. The national programmes, in partnership with all relevant agencies working in the field, through integrated health systems at the most peripheral levels, will continue to provide the best possible care. ●

Ref. : "The Final Push Towards Elimination of Leprosy - Strategic Plan 2000-2005"
World Health Organisation

KNOW THE STATUS OF LEPROSY IN YOUR WARD – MARCH, 2003



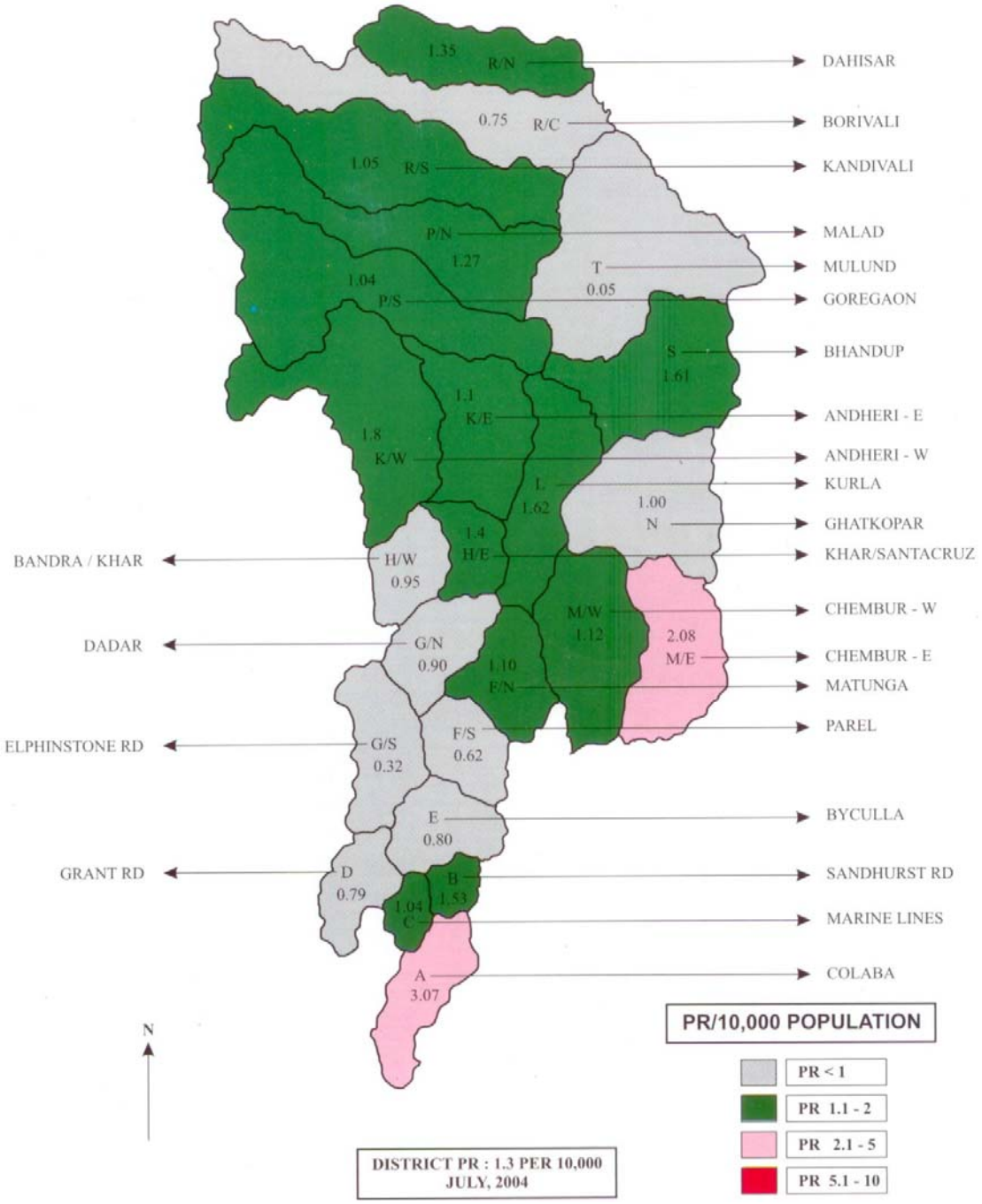
NLEP - MUMBAI

WARD-WISE LEPROSY STATUS

SR. NO.	WARD	POPULATION	BAL. ACTIVE CASES		PR/10,000	
			AS ON MARCH 2004	AS ON JULY 2004	MARCH 2004	JULY 2004
1	A	1,98,394	45	61	2.2	3.07
2	B	1,43,475	18	22	1.25	1.53
3	C	2,30,000	9	24	0.39	1.04
4	D	3,91,000	16	31	0.40	0.79
5	E	4,69,137	37	38	0.78	0.80
6	F/S	4,00,287	44	25	1.09	0.62
7	F/N	6,26,799	70	69	1.1	1.10
8	G/S	4,60,000	17	15	0.36	0.32
9	G/N	6,60,000	73	60	1.1	0.90
10	M/E	6,96,000	201	145	2.8	2.08
11	M/W	4,10,000	50	46	1.2	1.12
12	L	8,54,731	189	139	2.2	1.62
13	N	6,35,000	84	64	1.3	1.00
14	S	6,94,000	105	112	1.5	1.61
15	T	3,49,000	32	20	0.9	0.05
16	H/E	5,75,364	95	82	1.6	1.4
17	H/W	4,70,000	45	45	0.9	0.95
18	K/E	8,45,153	112	100	1.3	1.1
19	K/W	7,30,676	171	131	2.3	1.8
20	P/S	4,41,275	53	46	1.2	1.04
21	P/N	8,12,585	112	104	1.3	1.27
22	R/S	6,15,527	60	65	0.9	1.05
23	R/C	4,74,252	38	36	0.8	0.75
24	R/N	2,86,786	53	39	1.8	1.35
TOTAL		**1,24,69,441**	**1,729**	**1,519**	**1.4**	**1.2**

Mumbai District PR 1.3 per 10,000 (including O.P.A. cases)

KNOW THE STATUS OF LEPROSY IN YOUR WARD – JULY 2004



NLEP : MUMBAI DISTRICT LEPROSY SOCIETY

HEALTH POSTS-WISE STATUS OF LEPROSY ON 31st July, 2004

I. MUMBAI CITY : (MC)

BMMC WARD	SR.NO.	NAME OF HEALTH POST (HP)	POPULATION	BAL. ACTIVE CASES AS ON 31-7-04	PR/10,000
A	1	Colaba HP	97,068	27	2.78
	2	Palthan Road (Musafeer Khana) HP	1,01,326	34	3.35
B	3	Janabai Rokade HP	70,420	12	1.7
	4	Jail Road HP	73,055	10	1.36
C	5	Chandanwadi HP	1,15,048	10	0.86
	6	Zawbawadi HP	-	-	-
	7	Panjrapol HP	1,15,049	14	0.86
D	8	Khetwadi HP	97,750	06	0.6
	9	Nana Chowk HP	97,750	07	0.7
	10	R.S. Nimkar Marg HP	97,750	09	0.9
	11	Banganga HP	-	-	-
	12	Bane Compound HP	97,750	09	0.9
E	13	Batliboy Compound HP	73,000	05	0.6
	14	Kasturba Hospital HP	60,367	09	1.5
	15	Soutter Street HP	1,45,600	19	1.3
	16	Tadwadi HP	70,000	02	0.3
	17	Nawab Tank HP	54,962	02	0.4
	18	Rea Road HP	65,208	01	0.2
F South	19	F/South Ward Office HP	49,838	01	0.3
	20	Naigaon HP	51,482	05	1.0
	21	2nd October HP	62,105	06	1.0
	22	Kidwai Nagar HP	58,000	06	1.1
	23	Ramtekdi HP	55,162	02	0.4
	24	Abhyudaya Nagar HP	68,700	03	0.5
	25	Rajkamal HP	55,000	02	0.4
F North	26	L.B.S. Market HP	55,578	01	0.2
	27	Don Bosco HP	57,500	-	-
	28	Wadala HP	86,054	15	1.8
	29	Korba Mithagar HP	91,918	17	1.9
	30	Rawali Camp HP	96,342	09	1.0
	31	Antop Hill HP	1,00,169	21	2.1
	32	Transit Camp HP	1,39,238	06	0.5
G South	33	Prabhadevi HP	75,000	-	-
	34	Worli Koliwada HP	80,000	04	0.5
	35	Sasmira HP	75,000	01	0.13
	36	Jijamata Nagar HP	80,000	05	0.62
	37	Currey Road HP	75,000	-	-
	38	Welfare Centre HP	-	-	-
	39	M.H. School Comp. HP	75,000	05	0.66
	40	Rotary Club HP	-	-	-
G North	41	Gulbai HP	75,000	02	0.26
	42	Gokhale Road (South) HP	80,000	06	0.75
	43	Mahim HP	75,000	-	-
	44	Welkar Wadi HP	75,000	07	0.93
	45	Urban Health Centre HP	90,000	14	1.55
	46	Kumbharwada HP	90,000	07	0.77
	47	Pilla Banglow HP	85,000	19	2.23
	48	Shastri Nagar HP	90,000	05	0.55

II. EASTERN SUBURBS : (ES)

M East	49	Bainganwadi HP	1,20,000	24	2.0
	50	Mankhurd HP	1,20,000	15	1.2
	51	Lotus Colony HP	56,000	21	3.7
	52	Centenary HP	65,000	13	2.0
	53	Cheeta Camp HP	65,000	14	2.1

M East	54	Deonar HP	70,000	12	1.7
	55	Ayodhyanagar HP	75,000	14	1.8
	56	Nimboni Baug HP	45,000	08	1.7
	57	Shivaji Nagar HP	80,000	24	3.0
M West	58	Tilak Nagar HP	65,000	07	1.07
	59	Chembur Naka HP	70,000	04	0.5
	60	Chembur Colony HP	70,000	10	1.4
	61	Pestom Sagar HP	70,000	09	1.2
	62	Lal Dongar HP	50,000	05	1.0
	63	Ghatla Village HP	35,000	07	2.0
	64	Subhash Nagar HP	50,000	04	0.8
L	65	Buddha Colony HP	72,000	09	1.2
	66	Bail Bazar HP	86,142	25	2.9
	67	Mohili Village HP	1,00,000	13	1.3
	68	Match Factory HP	72,000	06	0.8
	69	Neharu Nagar HP	54,000	06	1.1
	70	Kamgar Nagar HP	77,000	04	0.5
	71	K.B. Bhabha Hospital HP	57,000	06	1.0
	72	Chunabhatti HP	42,154	13	3.0
	73	Asalfa Village HP	72,000	09	1.2
	74	Kajupada HP	67,434	15	2.2
	75	Amar Nagar HP	55,000	03	0.5
	76	Tunga Village HP	1,00,000	30	3.0
N	77	Varsha Nagar HP	55,000	07	1.27
	78	Pant Nagar HP	48,000	04	0.8
	79	Parksite HP	65,000	07	1.07
	80	Rajawadi HP	60,000	10	1.66
	81	Ramabai HP	80,000	14	1.75
	82	Sainath Nagar HP	60,000	03	0.5
	83	Sarvodaya Nagar HP	70,000	10	1.42
	84	Kirol Village HP	70,000	02	0.2
	85	Sant Muktabai Hospital HP	75,000	05	0.66
	86	Ganesh Nagar/Laxmi Nagar HP	52,000	02	0.38
S	87	Bhandup HP	71,000	09	1.2
	88	Tagore Nagar HP	1,00,000	19	1.9
	89	Tulshetpada HP	65,000	15	2.3
	90	Kanjur Village Health Post	73,000	05	0.7
	91	Shivaji Talao HP	88,000	02	0.2
	92	Subhash Nagar HP	65,000	11	1.7
	93	Kannamwar Nagar HP	50,000	05	1.0
	94	Tembipada HP	58,000	03	0.5
	95	Hiranandani Garden HP	71,000	29	4.08
	96	Morarji Nagar Paspoli Village HP	53,000	14	2.6
T	97	Veer Savarkar Hospital HP	55,000	01	0.1
	98	Nanepada HP	60,000	06	1.0
	99	D.D.U. Marg HP	50,000	05	1.0
	100	Agrawal Hosp. HP	70,000	02	0.2
	101	P.J.K. Mun. Maternity Home HP	64,000	04	0.6
	102	Mulund Colony HP	50,000	02	0.2

III. WESTERN SUBURBS : (WS)

H East	103	Kherwadi HP	81,650	25	3.06
	104	Government Colony HP	69,420	14	2.01
	105	Bharat Nagar HP	48,000	-	-
	106	V.N. Desai Hospital HP	76,816	09	1.1
	107	S.V. Nagar HP	78,347	11	1.4
	108	Kalina HP	75,659	09	1.1
	109	Vakola HP	73,472	10	1.36
	110	Golibar HP	72,000	04	0.5
H West	111	Bandra Bhaba Hospital HP	80,000	23	2.87
	112	Dr. Ambedkar HP	80,000	07	0.87
	113	Shastri Nagar HP	80,000	08	1.0

H West	114	Sherli Rajan HP	75,000	01	0.13
	115	Khotwadi HP	80,000	02	0.25
	116	S.V. Road HP	75,000	04	0.53
K East	117	Shirodkar HP	58,000	03	0.5
	118	Neharu Road HP	77,426	16	2.0
	119	Sarvodya Nagar HP	1,09,280	10	0.9
	120	Squatters Colony HP	95,000	10	1.0
	121	Natwar Nagar HP	81,000	05	0.6
	122	Ajagaonkar Plot HP	63,000	06	0.9
	123	M.I.D.C. HP	82,513	08	0.9
	124	Marol HP	85,000	15	1.7
	125	Tarun Bharat HP	50,851	06	1.1
	126	Sambhaji Nagar HP	89,000	05	0.5
	127	Sahar HP	55,816	16	2.8
K West	128	Bhardawadi HP	70,411	15	2.1
	129	Oshiwara HP	73,245	21	2.9
	130	Tata Compound HP	76,760	09	1.2
	131	Mumbadevi HP	-	-	-
	132	N.J. Wadia HP	1,30,232	24	1.8
	133	Anand Nagar HP	64,432	18	2.8
	134	Neharu Nagar HP	85,285	05	0.6
	135	Lokandwala HP	64,531	08	1.2
	136	Juhu HP	74,833	11	1.5
	137	Varsova HP	90,948	20	2.2
P South	138	Pahadi HP	1,54,632	21	1.35
	139	Pandurang Wadi HP	71,923	05	0.6
	140	Teen Dongri/Yashwant Nagar HP	73,545	08	1.08
	141	Chincholi HP	66,419	-	-
	142	Siddharth Nagar HP	74,756	12	1.6
P North	143	Malwani No. 1 HP	80,713	24	2.9
	144	Malwani No. 2 HP	92,742	11	1.1
	145	Nemani HP	72,682	14	1.9
	146	Valnai HP	72,772	06	0.8
	147	M.W. Desai HP	79,842	01	0.1
	148	Tank Lane HP	81,239	05	0.6
	149	Kurar Village HP	81,173	10	1.2
	150	Appapada HP	81,374	14	1.7
	151	Pathanwadi HP	81,073	07	0.8
	152	Dindoshi Vasahat HP	88,975	12	1.3
R South	153	Dahanukarwadi HP	1,41,427	16	1.13
	154	Akurli Road HP	74,217	07	0.94
	155	Charkop HP	91,662	05	0.55
	156	Babrekar Nagar HP	71,113	09	1.27
	157	Dhamupada/Samata Nagar HP	77,318	11	1.43
	158	Centenary HP	82,472	05	0.6
	159	Hanuman Nagar HP	77,318	12	1.55
R Central	160	Charkop Sec. 5 HP	60,924	03	0.49
	161	Rajda HP	55,111	06	1.08
	162	Eksar Road HP	72,283	12	1.66
	163	Babhai HP	80,170	03	0.49
	164	Gorai HP	-	-	-
	165	Borsa Pada HP	67,814	04	0.58
	166	Rajendra Nagar HP	65,355	04	0.61
	167	Tata Power HP	72,595	04	0.55
R North	168	Navagaon HP	62,890	06	0.95
	169	Ashokvan HP	60,432	08	1.32
	170	Y.R. Tawade HP	68,518	10	1.45
	171	Anand Nagar HP	66,146	09	1.36
	172	CCD HP	28,800	06	2.08

India's strategy for Leprosy Elimination

"Thanks to good planning and efficient implementation, the NLEP by and large succeeded in controlling leprosy.

The prevalence rate fell from 57.6 cases per 10,000 population during 1981, to 3.23 per 10,000 population in March 2003.

Fifteen States/UTs achieved the status of leprosy elimination (PR <1/10,000), while six more States/UT are very close to this goal (PR 1-2/10,000).

Some highlights of India's strategy for leprosy elimination :

decentralization ;

integration of leprosy services with general health services ;

training of GHC and NLEP staff ;

surveillance for early detection and prompt MDT treatment ;

special projects for urban slums, remote areas etc. ;

information campaigns through selected and mass media ;

disability prevention and care ;

monitoring and evaluation**"**.

Dr. G. P. S. Dhillon, Dy. Director - General of Health Services (Leprosy), Govt. of India. *(in Leprosy Elimination Alliance, January-June 2004)*